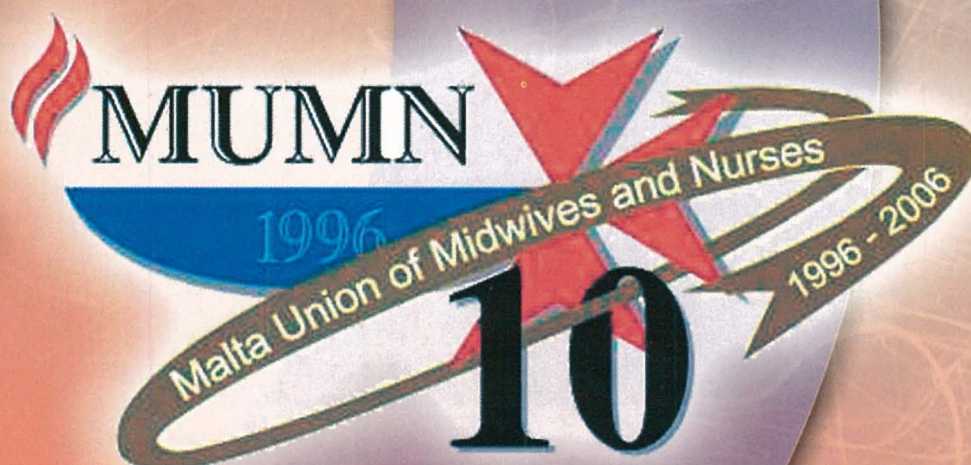


IL-MUSBIEH

MALTA NURSING AND MIDWIFERY JOURNAL



- Mentoring
- Is-Suwicidju
- Cancer Truth
- Nutritional Care
- Urinary Catheters
- Digestive Distress
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MALTA UNION OF MIDWIVES AND NURSES
Hargha Nru. 32 - Settembru 2006

L-10 ANNIVERSARJU

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Ritratt tal-faċċata minn Joe Camilleri

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

Il-bord editorjali jiggarantixxi id-dritt tar-riservatezza fuq l-indirizzi ta' kull min jirċievi dan il-Ġurnal.

Cirkulazzjoni: 2136 kopja

Dan il-Ġurnal jitqassam b'xejn lill-membri kollha u lill-entitajiet oħra, li l-bord editorjali flimkien mad-direzzjoni tal-MUMN jiddeciedi fuqhom.

Kull bdil fl-indirizzi għandu jiġi kkomunikat mas-Segretarja mill-aktar fis possibli.

Għaxar Snin ta' Hidma Sfiqa

Għaxar snin għaddew bħar-riħ, bħall-ħolma. Għaxar snin ta' hidma sfieqa lejn il-Midwives u n-Nurses. Għaxar snin li żgur għamlu impatt lejn il-kura u l-attenzjoni li nagħtu lejn il-klijenti/pazjenti kollha tagħna.

Il-bidu ta' din il-Union għaxar snin ilu kien wieħed sempliċi ħafna u modest għall-aħħar. Grupp ta Nurses/Midwives iddeċidew li ma jistax ikun nibqgħu naqalgħu fuq rasna kif konna. Iddeċidew li ma nistgħux nibqgħu nimxu ma xi union li setgħa kellha agenda politika partigġjana. Iddeċidew li ma naqgħux fin-nassa ta' l-insularita', tal-medjokrita'. Kien iż-żmien li fl-aħħar, wara diversi attentati li fallaw fil-qasam trejdjunjonistiku tan-Nursing f'pajjiżna, nistabilixxu Union Settorali għalina u kif suppost.

Kien hemm min kien sorpriż u kien hemm minn lagħab imħatri kemm se ndumu mwaqqfin. Kien hemm ukoll minn fixkel u għad hemm min irid jilgħaba tal-iblaħ magħna. Dawn kollha kienu żbaljati u jekk għad hemm min hu xettiku, nistidnuh jissuggerixxi xi ħaġa alternattiva mill-MUMN, biss wieħed irid iżomm f'moħħu x'akkwistajna jew x'jiġri ġaladarba ma teżistix aktar il-Union tagħna. Wieħed m' għandu jneħhi qatt minn moħħu li l-maġġoranza tan-Nurses/Midwives f'Malta huma msejbin mal-MUMN. Ma nistgħu qatt inreġġgħu l-arloġġ lura.

Ma nistgħux ma nsemmux x'gara mid-dsatax ta' Settembru 1996 'l hawn, jiġifieri wara l-ewwel Laqgħa Ġenerali tal-MUMN ġewwa Ғaž-Żabbar. Mindu ħadna s-'sole recognition' dan il-'grupp' ma baqgħax aktar *pressure group* izda beda' b' hidma immedjata favur in-Nurses u l-Midwives f'Malta b'mod konkret u tanġibbli.

Kien bidu iebes izda kuraġġuż. Ma baqax passiv għal kull ingustizzja li ssir magħna n-Nurses, tiġi minn fejn tiġi. Kiteb u talab b'mod formali, organizza laqgħat u ipprotesta ma' kull entita'. F'kelma waħda ma qagħadx ċiċi beqqi. Il-Union żammet f'moħħa dejjem il-*professional status* tagħna u għalhekk kienet dejjem involuta f'kull materja li tiġi proponuta rigward l-avvanz akkademiku tagħna.

Sar ħafna xogħol fuq riformi, eżerċizzju korrettorju, *collective agreements* f'kull sptar u qasam mediku f'Malta u Ghawdex. Kienet involuta fit-taħditiet għall-bdil fl-Ordinanza tal-*Medical and Kindred Professions* biex tinbidel f'liġi msejja *Health Care Professions Act*. Liġi li saħansitra tirrigwardja l-għoti tal-*warrant* mill-President tar-Repubblika. Kienet strumentali fuq l-*issue* tal-*specialisations*. Ғadet sehem f'diversi lagħat dwar l-Unjoni Ewropea permezz tal-MEUSAC. Qajmet diversi *issues* dwar Saħħa u Sigurta' fuq il-post tax-xogħol, saħansitra għandna persuna appuntata apposta għalhekk. L-MUMN kienet ukoll strumentali biex tbiddel il-*course* li kien qed isir tal-EN Conversion u anke fuq l-*issue* tal-IV Course. Kienet effettiva wkoll għalkemm b'ċertu ristrezzjonijiet minn kull *management* dwar eżerċizzju ta' *deployment* ta' Nurses/Midwives godda. Ġew iffirmati diversi ftehim dwar *vacation leave*, *TOIL* eċċ u allura ftehim li jaffetwaw il-kundizzjonijiet tax-xogħol tagħna. Il-Union kienet partecipattiva f'riformi tal-pensjonijiet u għada għaddeja fuq il-kwistjoni tal-*early retirement*. Tajjeb insemmu wkoll l-*issue* tal-Ligi Industrijali u d-dritt tal-*strike* tas-servizzi essenzjali. Ma rridux ninsew zġur il-gwadann tal-*point system* tal-Continous Professional Development (CPD).

L-MUMN giet rikonoxxuta internazzjonalment speċjalment b'kuntatti mal-ILO, PSI, EPSU, WHO, EFN, ICN, RCN, CNF etc. Ma nistgħux ma nsemmux konferenzi kbar li ġew organizzati f'pajjiżna u oħrajn ta' dimensjoni mondjali li gejjin.

L-organizzazzjoni tal-MUMN bħala Union dinamika kienet tirrikjedi li jkollha ufficiċċju ċentrali b'ħaddiem *full-time*, ħlas ta' *menswalita'* bid-*direct debit*, ufficiċċini f'kull sptar, ġurnal li joħroġ kull tlett xhur, struttura amministrattiva u eżekuttiva kredibbli, sotto-komitati li jaħdmu, attivitajiet soċjali, partecipazzjoni f'laqgħat, konferenzi u seminars f'Malta u barra, twaqqif tal-**Benevolent Fund**, inizzjattiva nurse/midwife tas-sena, eċċ eċċ.

Żgur li ser ninsew numru ta' *issues* oħra jekk naqbdun nsemmu dak kollu li akkwistajna bis-saħħa tal-Union tagħna. Baqa' ħafna xi jsir. M' għandna qatt naqgħu qalbna. Ngħidu grazzi lill kull min ħadem fi hdan l-MUMN speċjalment b'mod volontarju u konsistenti. Grazzi lill-ex membri f'kull Eżekuttiv/Kunsill tul dawn l-aħħar għaxar snin għall-impenn li wrew. Grazzi lill-membri kollha li juru *support* kontinwu mad-dirigenti tal-Union u jemmu bis-shieħ li l-MUMN biss tħares l-intresssi veri tagħna lkoll u ħadd aktar. Ejja biss inħarsu 'l quddiem.

message from the president

Dear Colleagues

This issue of 'Il-Musbieh' has a unique value as it is part of the activities the Union is organising to commemorate its tenth anniversary. Ten years have passed since that very first day on the 19th of September 1996 when a considerable number of Nurses and Midwives accepted an invitation by the then action committee set up by the newly established Malta Union of Midwives and Nurses. It was an encouraging start and I can remember very vividly that during my first speech as the President of our Organisation I requested for your support. At that time on the first day the action committee was overjoyed as we managed to achieve a membership of more than 200 nurses and midwives. Now our Union represents more than 98.4% of Nurses and Midwives in Malta and is also one of the leading Trade Unions in our Country.

This was achieved by the hard work of us all, every single member, through direct involvement or by support, each and every one of you contributed to this successful story. It was and always shall be an uphill struggle and it must remain like that otherwise when we think that we arrived at the climax it will be the start of our downfall. What has been achieved for our professions so far must be considered as a stimulus to continue with this momentum. I must say that even though we made a huge stride in the right direction we still have so much to do to see that our professions enjoy the same status as other professions especially those in the Health care set up. Unfortunately we are still considered as doctors' servants and this is sometimes our fault too.

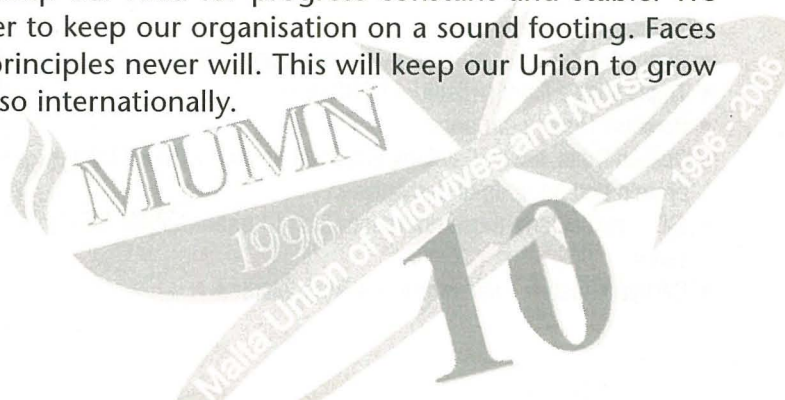
When we met at our first General Conference in Zabbar ten years ago I brought forward on behalf of the committee a list of priorities that must be addressed. Top of the list was to improve the professional and academic level of both Nurses and Midwives. A priority, which I am proud to say that, has been almost fulfilled and established recently by the signing of the last sectoral agreement. I said almost, as we still are insisting that Nurses should be issued with a warrant as their licence to practice like most other professions. The professional advancement was enhanced by the decision to abolish the course leading to certification in Nursing and limiting Nursing studies from a diploma level and above. Priorities such as improved salaries and new comfortable uniforms were also achieved. Now we have other priorities and challenges ahead. The issue of introducing early retirement incentives for Nurses and Midwives was never surrendered and the Council is still persisting after such a scheme. This is being requested, as there is scientific evidence that due to our nature of work Nurses and Midwives suffer various medical and psychological conditions. We are not requesting a unique incentive, as such scheme is available to most Nurses and Midwives in many Countries throughout the world.

Collectively and united we shall keep our road for progress constant and stable. We must keep working hard altogether to keep our organisation on a sound footing. Faces in the helm may change but the principles never will. This will keep our Union to grow not only on a local scenario but also internationally.

Rudolph Cini

President

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Believing in a Concept

When one believes in a concept, in an idea, one should hold on to such. It might not be an easy task particularly when this idea is taken on board and seriously directed at being transformed into something more materialistic. A new concept brings with it change; and change always comes at a cost. 'Progress is impossible without change; and those who cannot change their minds cannot change anything'. George Bernard Shaw.

This recount goes back to its origin in 2002. Having been practising for 18 years in Gastroenterology, and holding the subject at more than just 'work level', I had been noticing an increase in Colo Rectal Cancer (CRC) figures locally. In conjunction with this, as a member of the Society of Gastroenterology Nurses and Associates, USA, we had just been asked by our society to report back on the international situation with regards to this disease. In the United States, this disease had reached such a high level, that screening had been in practice on a national scale already for two years.

Locally this concept of screening was still unheard of, and regrettable, I must admit is still very far away from becoming a reality even to this day. It is sometimes inconceivable to ask someone to have their Colon checked when there are no symptoms. The saying 'let sleeping dogs lie' is an issue here, and to those that are not aware of which dog is the worst, you can't blame at all. But for those of us that practice in diagnostics, particularly in the Gastroenterology division, finding a colon tumour in a 'potential' candidate is somehow frustrating.

So why screen then? Because screening can save lives - and so it has been proved. Screening should take place when at an asymptomatic phase. Screening is a tool used to help in the identification of potential pathology before such pathology presents itself. When clients come for screening while already seeing blood or having altered bowel habits, I don't screen them but send them for surveillance. When symptoms are present, investigations are required and then followed by surveillance. Screening should serve as a filter. It should filter those cases that would need further investigations, from those that are of a low potentiality level. Screening for CRC is just an indicator - the initial step towards further investigations when necessary.

Screening is also intended to serve as an educational and informative tool - through it people are informed on what to look for, educated on many things like dietary and elimination issues.

Who should we screen?

- Over age 50 or 10 years prior closest relative diagnosed
- Those with a Family History of CRCancer
- Personal History of Cancer
- Certain Diets, low in Calcium, selenium and fibre. Those high in protein and fat (animal derivative)
- IBD - particularly those not responding to treatment for over 8 years
- Certain Lifestyle - sedentary, smoking, alcohol.

*We are professionals
enough and should hold
our heads high for this.
Ask for support, but
when given the shoulder,
keep tight to your holds*

But let me not divert from the aim of this article, for which I have no intentions of teaching colleagues of mine on screening; I have more to learn than teach. The issue here is on how one should hold on to a concept, even through rough times. And those that have been through such health promoting issues know what I am writing about. Some 'colleagues' of ours don't seem to accept the

fact that we Nurses are professional enough to embark on such issues like screening programs. If it is an idea coming out from a Nurse, all hell breaks loose. All possible excuses are invented to dishearten the individual, sometimes even going to 'threatening' levels. Going back to 2002, I had worked hard on establishing a detailed screening program through the support and professional backing of peers and esteemed institutions such as the ACG (American College of Gastroenterologists) and Harvard College.

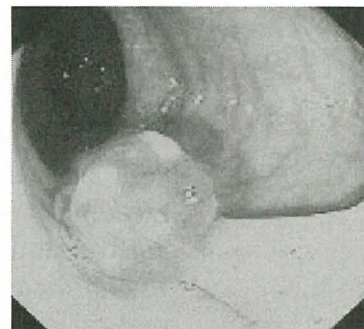
I had also been diplomatic enough to ask our local Consultants for analysing and commenting on such a program. I had full support from some, while others disregarded the program as 'a useless' approach. At moments, I was on my own trying to convince the many.

I kept on believing in this screening campaign, and asked my Directors for their support. They fully supported my proposal and even offered an official launch program with full paraphernalia.

Four years have passed since. We are running a program that is now asked for by the majority of doctors. We are even getting referrals for this program from doctors themselves. We have assessed over 200 cases since then, referred 35 cases for the second phase (Colonoscopy) and had a very high positive outcome of 98%. But what is most rewarding is the fact that we have educated many about this second most common cancer related killer. A higher awareness factor is more evident nowadays. We have clients calling us throughout the year, not only through March. Whole families turn up for screening and surveillance when one family member is affected. The message is getting through, and that is the whole concept and main intention.

So what's the moral of the story? Believe in your capacities, in concepts you know are important, applicable and sustainable. We are professionals enough and should hold our heads high for this. Ask for support, but when given the shoulder, keep tight to your holds. Twenty-four years in Nursing is proof enough. Nothing ventured, nothing gained.

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kelmtejn mis-segretarju ġenerali

Għeżież Kollegi,

F'dawn l-aħħar ġimgħat kellna attività kontinwa fuq l-elezzjonijiet sabiex jiġu ffurmati *Group Committees* ġodda tal-Union sabiex inħarsu l-interessi tan-Nurses u l-Midwives fuq il-post tax-xogħol. B'sodisfazzjon ninfurmakhom li r-rispons kien eċċellenti. Eżempju prattiku huwa l-*Group Committee* ta' l-Isptar Monte Carmeli fejn filwaqt li fi snin preċedenti kien ikollna ċertu diffikultajiet sabiex jingħaqad kumitat, din id-darba għandna l-lussu li applikaw 9 Nurses biex jiġu eletti 5.

Din il-Union ilha tirsisti sabiex in-Nurses jibdwew jirċievu l-*Warrant* mingħand il-President tar-Repubblika bħal ma jirċievu professjonisti oħra fosthom il-Midwives. Għal xi raġuni jew oħra dejjem sibna l-awtoritajiet mhux daqshekk herqana li jagħtu dan ir-rikonoxximent tal-*professional status* lilna n-Nurses. Waqt laqgħa li l-Kunsill ta' din il-Union kellu mat-tmexxija tal-Partit Laburista ġie miftiehem u maqbul bl-iswed fuq l-abjad li fl-eventwalità li dan il-partit ikun fil-Gvern, in-Nurses jibdwew jirċievu wkoll il-*Warrant*. Huwa pass pożittiv immens anki fid-dawl li dan il-ftehim jista' wkoll jagħti kontribut għat-tehid tad-deċiżjoni li dan il-Gvern għad irid jieħu fuq din l-istess materja, peress li sakemm qed nikteb dan l-artiklu, l-MUMN għad m'għandiex deċiżjoni aħħarija jekk in-Nurses hux ser jibdwew jirċievu l-*Warrant* jew le. Din il-Union tassigura, li marbut ma din it-talba m'hemm l-ebda kontribuzzjoni finanzjarja ta' l-ebda tip.

B'mod unanimu, l-Kunsill tal-Union iddeċieda li jibqa' jirsisti u jressaq l-argumenti tiegħu favur l-*Early Retirement Scheme*. Issa aktar minn qatt qabel, il-Union għandha argumenti sodi wara t-talba tagħha. Konxji li t-triq mhux faċli li naslu għall-oġġettiv tagħna però nafu wkoll lin-Nurses u l-Midwives huma determinati li jakkwistaw dan l-inċentiv u għalhekk fil-futur qarib inhegġiġkom li toqgħodu attenti għas-sejthiet tal-Union.

Problema ta' *supporting staff* teżisti kważi kullimkien speċjalment fl-Isptar San Luqa. Din il-Union ma tistax tifhem kif is-swali u postijiet tax-xogħol oħra spiċċaw b'ammont fqir ta' *cleaners, ward clerks, nursing aides, health assistants, porters, couriers* eċċ. Din is-sitwazzjoni qed toħloq problemi kbar lin-Nurses u l-Midwives b'tali mod li qed tirriżulta f'riskju sostanzjali fuq il-ħajjiet tal-pazjenti. L-MUMN mhux ser tittolera din is-sitwazzjoni aktar u lesta li tirrikorri għal kull pass permess bil-liġi sabiex tiddefendi kemm il-ħajja tal-pazjenti kif ukoll l-interessi tal-membri tagħha.

L-aħħar darba li poġġejna bil-qiegħda biex nitkellmu fuq dik l-imsejha Riforma kien 13 il-xahar ilu. Mingħajr tlaqliq ngħid li meta ltqajna bejn Marzu u Gunju 2005 fuq aspetti ġenerali, ma kienx hemm qbil fuq 80% ta' l-affarijiet li tpogġew fuq il-mejda. Suppost kellna nerġġhu niltaqgħu f'Ottubru tas-sena l-oħra imma ma smajna xejn aktar. Iż-żmien li jiftaħ Mater Dei qiegħed dejjem joqrob però fl-istess waqt mhux qed isiru laqgħat. Għandna dritt li nkunu infurmati bil-pjanijiet tal-Gvern għaliex dawn jirrigwardaw direttament il-membri tagħna.

Il-proċess ta' ħrug fis-sejthiet ta' applikazzjonijiet għal *specialist posts* fin-Nursing u l-Midwifery naqas drastikament tant li l-ftit li ħargu din is-sena huma sejthiet li suppost ħargu s-sena l-oħra. Ma nistax nifhem kif f'nifs wiehed id-Diviżjoni tgħid li trid tara l-professjonijiet tan-Nursing u l-Midwifery jimxu 'l quddiem u f'nifs ieħor l-żżomm il-brejkijiet fuq dawn is-sejthiet tant importanti fl-iżvilupp ta' dawn il-professjonijiet. Nispera li dan ma jfissirx xi nuqqas ta' rispett lejn in-Nursing u l-Midwifery.

Dan ix-xahar l-MUMN tagħlaq l-10 sena anniversarju mit-twaqqif tagħha. Sar ħafna progress minn meta twaqqfet din il-Union però għad baqa' wkoll ħafna x'isir. Konvint li bl-għajnuna tagħkom jirnexxielna nkomplu ngħollu il-livell ta' Nurses u l-Midwives bl-oġġettiv prinċipali jkun li l-pazjenti tagħna jirċievu kura dejjem aħjar.

Colin Galea

Segretarju Ġenerali

□ mumn@maltanet.net

Tagħrif fuq il-proċedura tal-Pensjoni

Peress li xi membri spiss jitolbu xi tagħrif fuq il-proċedura tal-pensjoni, ħsibna li nagħtu xi dettalji.

Pensjoni tat-Teżor: Biex tkun intitolat għall-pensjoni sħiħa trid mhux anqas minn 30 sena servizz (ara formola A). Jekk ikollok anqas minn 30 sena servizz tiegħu pensjoni mnaqqsa-pro rata (ara formola B).

Dawk impjegati, qabel il-15 ta' Jannar 1979 għandhom l-għażla li jbiegħu 1/6 tal-pensjoni u jieħdu s-somma. B'hekk pensjoni jieħdu nofs is-salarju bażiku (ara formola Ċ). F'dal każ is-somma tinħadem fuq is-salarju bażiku ta' xahar, u mhux ta' 4 ġimgħat, multiplikat b' 25. Dan dejjem jekk impjegat għandu/ha 30 sena servizz.

Fejn jirrigwardja l-pensjoni tan-*National Insurance*, wieħed jagħmel tajjeb li jiċċekkja mad-Dipartiment tas-Servizzi Soċjali biex ikun jaf x' pensjoni hu intitolat għaliha. Tajjeb ukoll li tlitt xhur qabel l-eta' tal-pensjoni jmur japplika fl-istess dipartiment għall-pensjoni.

Importanti hafna, li meta wieħed jirċievi l-avviż tal-pensjoni intitolat għalih, wieħed għandu tletin ġurnata żmien biex jappella jekk ma jkunx jaqbel mal-ħlas tal-pensjoni.

Formula A: - salarju bażiku ta' xahar x 2 : 3

Formula B: - salarju bażiku ta' xahar x 2/3
x numru ta' snin fis-servizz : 30

Formula Ċ: - salarju bażiku ta' xahar x 1 : 2

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International
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Florence Nightingale
International Foundation

Press Information . Communiqué de presse . Comunicado de prensa

Nurses are Getting Orphaned Girls Back to School. The Girl Child Education Fund gains steam in southern Africa

Geneva, Switzerland, 24 April 2006 – Forty orphaned girls in Africa are attending school this year, thanks to the Girl Child Education Fund, a new initiative of the International Council of Nurses (ICN), and its sister organisation, The Florence Nightingale International Foundation (FNIF). The girls are in Kenya, Swaziland, Uganda and Zambia where the programme is administered by the national nurses' associations. The associations received applications from many prospective students and identified the neediest girls. Each beneficiary of the ICN/FNIF fund has lost a nurse parent and would otherwise be unable to continue their education. Ten students were selected in each country; of the total, 15 students are attending primary schools and 25 are enrolled in secondary grades.

One girl's story

Joyce (not her real name) is seven. She lost her single mother, a nurse, in December of last year and now lives with her teenaged aunt and four other orphaned siblings in a one-room house, with no indoor plumbing or electricity. They make a small living selling vegetables they raise in the backyard. Although primary school tuition fees have been officially abolished in her country, the costs for the uniform, books and Parent-Teacher Association fees required for Joyce to start grade one were beyond their means. Now, with the support of the Girl Child Education Fund, Joyce is enrolled in a local school.

"Girls still account for 60 percent of the estimated 113 million out-of-school children in sub-Saharan Africa," stated ICN President

Hiroko Minami. "Despite the unprecedented global focus that the Millennium Development Goals have brought to this issue, millions of girls continue to be denied their right to education. The nursing profession is keen to do its part to ensure girls have access to education. To our knowledge, the Girl Child Education Fund is the only effort targeting the children of health care professionals."

National coordinators in each country will monitor the students throughout the academic year, ensuring that tuition and other mandatory school fees are paid and providing the required uniforms, books and school supplies.

"We have been touched by the generous response that the Fund has received from the global nursing community," stated Dr Minami. "We are indebted to nurses and their associations around the world who, individually and collectively have provided the funds that will profoundly change the lives of the daughters of our deceased colleagues."

Contributions to the Fund can be made online at the ICN (www.icn.ch) or FNIF website (www.fnif.org).

Editor's Note: The Florence Nightingale International Foundation is a registered Charity in the United Kingdom, formed for the purposes of supporting the advancement of nursing education, research and services for the public good. The Foundation is domiciled in Geneva at the offices of the International Council of Nurses.

The International Council of Nurses is a federation of 129 national nurses' associations representing the millions of nurses worldwide. Operated by nurses for nurses, ICN is the international voice of nursing and works to ensure quality care for all and sound health policies globally.

For further information contact Linda Carrier-Walker

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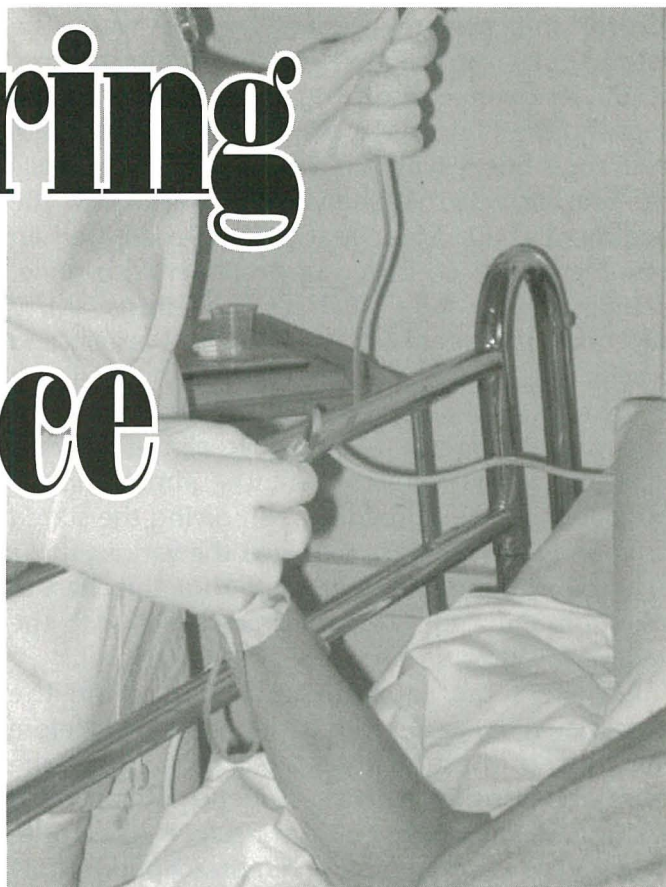


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A Mentoring Experience

by **Tonio Pace** SN, *Operating Theatres KGH*,
 ✉ tonio.n.pace@gov.mt



PART 1

On Tuesday 14th February 2006, I attended my first lecture at the Institute of Health Care, which was an introduction to the Mentorship Nursing Course, as part of the Continuing Professional Development. I must acknowledge that this class had been run in a truly professional way by our course convenor. The course was run over 3 months circa, mainly consisting of 7 lectures, presentations and practical work. The course was run over 3 months circa, mainly consisting of 7 lectures, presentations and practical work. A good advantage to these lectures was that they were taught on a Monday and repeated on Tuesdays and Wednesdays in order to enable all shift workers to attend. I was impressed with all the material that was available to us. Throughout the sessions, each one of us was assigned to mentor a student nurse for three sessions, already working in a particular area. In each session I was obliged to utilise different methods of teaching, learning, assessing and evaluate the outcomes.

I first contacted Anne*, my student by telephone. I introduced myself briefly as being her mentor and expressed my views on what needed to be discussed on our first meeting. During this conversation Anne, a 2nd year Diploma student, briefed me on what she needed to strengthen both her knowledge and practice on. I made it clear that on our first meeting, I needed to have a list of the topics in which the student herself needed more training on, prior to her exams. We set out the dates for our next meetings. When all was set and agreed, I phoned the ward where Anne was allocated at the time, and booked an appointment

with the unit's Nursing Officer. I presented myself at the ward, where I primarily requested permission from the unit's Nursing Officer, explaining what sessions would be carried out on his ward and that various patients might be asked to allow Anne to carry out procedures under supervision. My requests were fully granted by the Nursing Officer. I later asked for some feedback on the student herself, relating to her behaviour towards staff and patients, approach, knowledge and whether willing to learn. I was glad that the feedback I got was totally positive. Personally, I felt even more eager to meet Anne because the positive feedback encouraged me to look forward to meeting my student and the sessions respectively. However I thought of myself as being seen an 'intruder' by the ward nurses, a feeling I remember used to be discussed in the wards I worked on a few years back, as soon as a mentor was allocated to a student already working on our ward. What I also felt uncomfortable about, was having to leave the operating theatre environment to go to the ward. This is because theatre time is unpredictable and might hinder any sort of appointment away from theatre.

On our first meeting which was punctual, Anne handed me a sheet with the topics she felt she needed more hands-on practice with. I appreciated the fact that she immediately showed trust in me, which automatically encouraged me even more

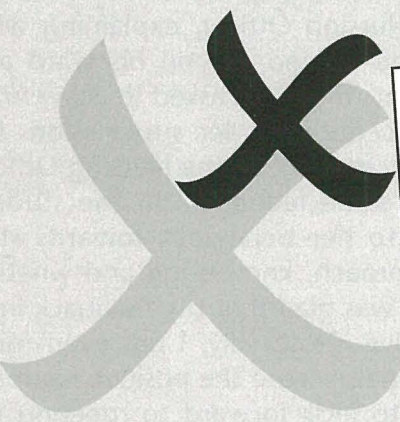
to delve into what my student's worries were. The listed topics represented insulin administration, aseptic technique and drug administration. After knowing the student's learning needs, we discussed each topic briefly with Anne stating that what really worried her was that she was unfamiliar with the treatment chart. So at that point, I presented an actual chart which I filled up together with Anne, detailing every item, such as Oral drugs, IM/IV injections, subcutaneous drugs such as Insulin and Calciparine. I made it a point that the nurse giving out the drugs should note that the drug had been signed by the doctor. I also named all the different sites on the four paged chart, the importance of the date and the signature when giving the stated drug and the difference between the various times of administering. I then handed Anne the chart to take home, in order to familiarise herself with the various facades.

On the same session, Anne worked on the preparation of insulin prior to administering. Before this I asked my student to brief me on what she knew about insulin, why do diabetic patients need insulin, the various types, why insulin is given after meals, various regimes of insulin prescriptions, how is insulin injected, which are the recommended

sites for administration, and the types of syringes used. I cannot say that Anne was prepared for such questions, so I made it a point that she should look up the information. I myself also made it a point to look out for the same information update, which I did as I have not been using such practice for the last seven years. The practical part consisted of a real scenario of insulin preparation. My student was not sure on what the latest protocol stated regarding the swabbing of the insulin vials and the patient's arm. She was even unsure on whether to aspirate the empty syringe with the right amount of air before filling the chamber with insulin. It was here that I emphasised that she should look up for the latest updates. In the meantime, I supervised my student during the whole set up. Throughout the practice, I kept back from interrupting her actions in order to keep her calm and not make her nervous. I remarked at the end of the session, with Anne taking notes.

(*The student's name has been changed due to Data Protection)

Part 2 to be published on the next issue of *Il-Musbieh*.



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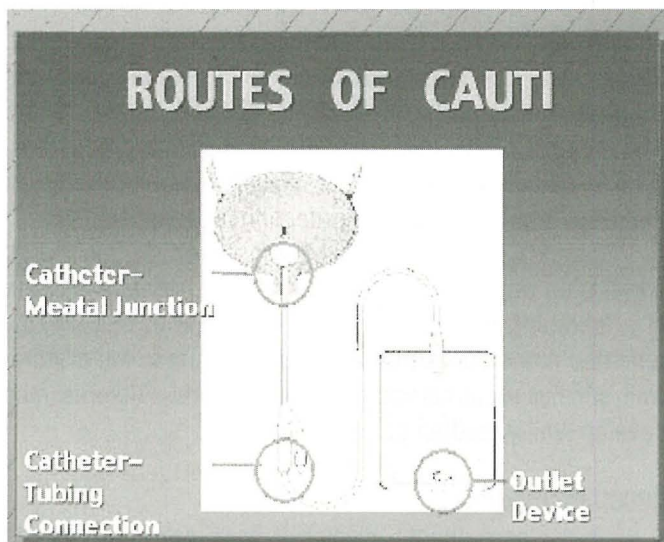
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The Prevention and Management of Urinary Tract Infections in Patients with a Urinary Catheter

Nosocomial Infections (Hospital Acquired Infection) is a world-wide problem since prevalence studies of hospital infections in many countries have shown that about one in ten hospitalised patients acquire an infection while being hospitalised. Urinary tract infections are by far the commonest type of HAI and urinary catheters are the major risk factor for nosocomial UTI.

The risk of infection is associated with the duration of catheterization (Pellowe and Pratt, 2004). However, bacteriuria and urinary tract infections are not synonymous (Godfrey and Evans, 2000; Trautner and Darouiche, 2004). More than 90% of cases of catheter-associated bacteriuria are symptom-free (Tambyah and Maki, 2000), whereas urinary tract infections are associated with signs and



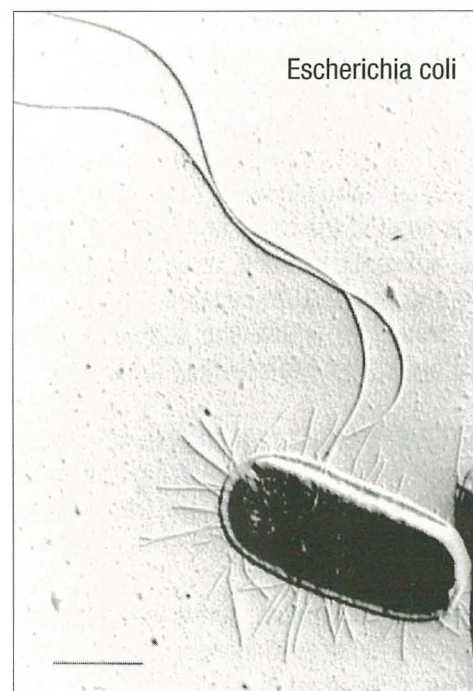
symptoms of infection such as fever, pain, cloudy foul-smelling urine and, in older people, confusion (Parkin and Keeley, 2003).

NB: CAUTI stands for Catheter-associated Urinary Tract Infection

There are three ways in which bacteria can enter the urinary tract in patients with a catheter:

1. Introduction at the time of catheterisation
2. From the catheter lumen (the intraluminal route)
3. Via the space between the walls of the catheter and urethra (the periurethral route) (Tenke et al, 2004).

Most nosocomial UTIs are caused by gram-negative coliform bacteria, particularly *Escherichia coli*, *Pseudomonas* species, and organisms from the enterobacter group.



Insertion Procedure

- Make sure that all of the following items are available:
- Sterile indwelling urinary catheter with a closed continuous drainage system.
- Sterile syringe filled with sterile water for blowing up the balloon of an indwelling catheter
- Pair of sterile surgical gloves
- Antiseptic solution (2% chlorhexidine gluconate or 10% povidone-iodine)
- Sponge forceps with non-woven swabs
- Towel with a hole
- Single-use packet of lubricant
- Light source (flashlight or lamp) if needed
- Basin of clean warm water, soap, a face cloth and a clean dry towel
- Yellow Plastic bag for disposal of contaminated items

STEP 1: Prior to starting the procedure:

- Have women separate their labia and gently wash the urethral area and inner labia.
- Have men retract their foreskin and gently wash the head of the penis and foreskin.

STEP 2: Wash hands with soap and clean water and dry with a clean dry towel or air dry. (Alternatively, if hands are not visibly soiled, apply 5 mls alcohol handrub)

STEP 3: Put sterile gloves on both hands.

STEP 4: Use as small a catheter as consistent with good drainage.

STEP 5: For health workers who are right-handed (dominant hand), stand on the patient's right side (and on the left side if left-handed).

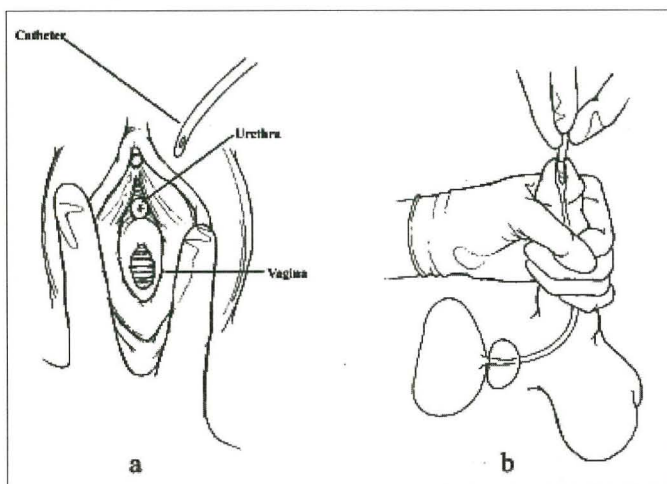
STEP 6: For women, separate and hold the labia apart with the nondominant hand and prep the urethral area two times with an antiseptic solution using either cotton applicators or a sponge forceps with gauze squares.

STEP 7: For men, push back the foreskin and hold the head of the penis with the nondominant hand; then prep the head of the penis and urethral opening two times with an antiseptic solution, using cotton applicators or a sponge forceps with gauze squares.

Note: With indwelling catheters, do not disconnect the catheter from the drainage tube.

STEP 8: If inserting a straight catheter, grasp the catheter about 5 cm (2 inches) from the catheter tip with the dominant hand and place the other end in the urine collection container.

STEP 9: For women, gently insert the catheter as shown in about 5–8 cm (2–3 inches) or until urine flows. For children insert only about 3 cm (1.5 inches).



No. 8–10 French is generally used for children and 14–16 for women. No. 16–18 is used for men unless a larger size is specified.

STEP 10: For men, gently insert the catheter as shown in picture. Note: Do not force catheter if resistance occurs.

Note: If the catheter is accidentally inserted into the vagina, do not remove it. Re-prepare the urethral area with antiseptic solution and insert a new catheter into the urethra; then remove the one in the vagina.

STEP 11: If inserting an indwelling catheter, push another 5 cm (2 inches) after urine appears and connect the catheter to the urine collection tubing if not using a closed system.

STEP 12: For an indwelling catheter, inflate the balloon, pull out gently to feel resistance and secure the indwelling catheter properly to the thigh (for women) or lower abdomen (for men).

STEP 13: For straight (in and out) catheterization, allow the urine to slowly drain into the collection container and then gently remove the catheter.

STEP 14: Place soiled items, including the straight catheter if it is to be disposed of, in a plastic bag or leakproof, covered waste container.

STEP 15: Remove gloves by inverting and place them either in a plastic bag or waste container.

STEP 16: Wash hands or use an antiseptic handrub as above.

Justification for use of a lubricant

The female urethra is approximately 4cm long and is a flattened, convoluted tube – it is not shaped like a hose pipe. It is lined with urothelial cells and when not in use it lies flat, like a ribbon (de Courcy-Ireland, 1993). The underlying tissue has a good blood supply and contains both nerves and collagen, which tends to reduce the elasticity of the urethra and make it prone to trauma during invasive procedures, such as catheterization. If the urothelium is traumatised then the protective barrier against infection is breached.

It therefore makes sense to attempt to reduce this risk by performing an atraumatic catheterisation, through the use of a lubricant. If the urethra is traumatised in this way by repeated catheterisation then local reactions in the urethral wall, such as urethritis and ultimately urethral strictures, may develop (Vaidyanathan et al, 1994).

Recommendations

1. Catheter care should consist of good personal hygiene around the meatal area carried out on a regular basis (1-3)
2. In terms of catheter composition, catheters which have been impregnated with silver may reduce the incidence of catheter associated bacteriuria, however, there is no clear evidence regarding which patient groups are likely to benefit from this strategy, nor on the cost effectiveness of its implementation (4)
3. Adding anti bacterial solutions to drainage bags has no effect in reducing the incidence of catheter associated infection (5,6)
4. Catheters should be removed from post operative patients as soon as possible. Indwelling catheterisation is preferable to intermittent catheterisation for some groups of post operative patients in the reduction of complications (7)

NB Guidelines for the Prevention of Catheter-associated Urinary Tract Infections can be found on <http://www.slh.gov.mt/pdf/Urinary%20catheters.pdf>

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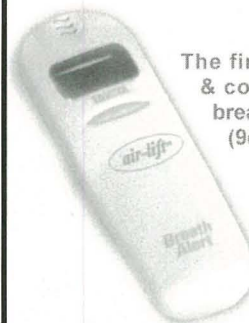
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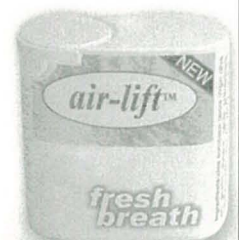
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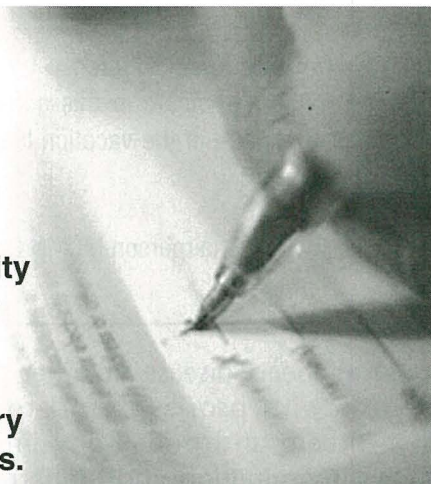


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REPORT OF THE QUESTIONNAIRE FOR NURSES AT SVPR JUNE 2006

Aim: To have a clear picture of the Vacation Leave availability situation in order to take necessary measures.



Number of days of Leave Entitlement from Previous Year 2005 (Accumulation). 187 Half Days - 394 Full Days = 5,336 hrs.

Leave booked 2006	1 to 5	16.6%
	5 to 10	43.5%
	15 to 20	6.5%
	20 or more	3.7%
Leave cancelled	1 to 5	49.0%
	5 to 10	19.4%
	10 to 15	5.6%
	15 to 20	0.9%
	20 or more	1.9%

Results: Overall Leave Cancelled 76.6%

Leave availed 23% (Covering up system introduced after last questionnaire)

Leave not booked 3.4%

Any Long Leave taken / covered during 2006?

Yes 35% No 65%

Number of Leave taken / covered in Long Leave: average of 7 Days. Do you agree with the existing system of Vacation Leave, or do you prefer to find someone else to fill up your place when you need a Vacation Leave if a substitute is not available from the office all year round?

Yes 34.3% No 65.7%

Do agree with existing system of Long Leave and commitment especially during the Night?

Yes 18.5% No 81.5%

Overall Comments: These are some of the comments in questionnaire for Nurses carried out in June 2006.

- Vacation Leave is our right.
- Always begging to have leave. Nurses are rendered as Beggars.

- Working Overtime to substitute your colleague means that one has no VL but exchanging duties. If you find a substitute you have to work for him or her in return.

- NO - D/N.O VL unfair as they have to force each other to substitute their VL.

Very stressful situation.

- Those who do not work overtime means that it is very difficult to have leave.

- Overtime is not a must. Leave entitlement = duties as overtime?????

- Vacation Leave is a Must.

- Consecutive leave cancellation is putting a lot of stress on nurses.

- Working Overtime for substitutes = may find substitutes = may take leave. No overtime for substitutes = no substitutes = No leave. Leave is not Leave but "Change of Duties"

- Commitments lead to over-fatigue and over-stress in workplace, at home, family and housework.

- Booking leave haphazardly hoping to have some days availed.

- Commitment for LL on Night duties is obligatory from the nurses' point of view but not from the administration. Commitment is not one way traffic. Cancellation of commitment a night before is not fair and adding insult to injury commitment has to be honoured 3 hours before night duty is worse. Nurses have their family plans too. No guarantee of commitment on Night duty leads to cancellation of LL for another nurse who is trying to find replacement for the following A Duty. On the other hand LL is being cancelled as no replacements available for night duty.

- It is not fair to share personal problems especially medical ones in order to have the leave availed.

- More support needed from the administration staff to search for those nurses on off duties to ask if they are available to work overtime vice leave.

- Skeleton staff is our normal staff compliment.

- Increase the number of nursing staff from 1 to 2 in each shift.

- Working the full 46.6hrs + Overtime is not a joke.

- Staff is being forced to work extra duties, because if they do not work for others, nobody will work for them.

- Cancellation of important Medical appointments is not fair. It is not always easy to make appointments on off duty especially if they are urgent. Besides we are nurses we are human beings.

- Mind is at rest to have LL when you find substitute.

- Why only 4 nights have to be availed and Day duties always cancelled? Nurses have families too. Family plans are being disrupted.

Continues next page...



- Availability and cancellation is a very short notice.
- Find substitutes from other hospitals and health centres.
- We are fed up.
- Something has to be done.
- Relieving Pool is desperately needed.

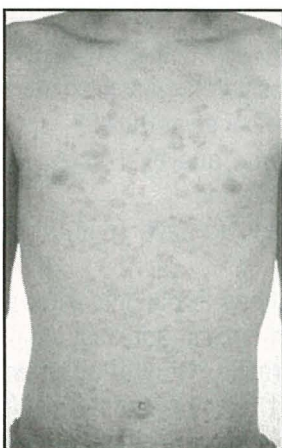
On behalf of the Group Committee I would like to thank all members who participate in this questionnaire in order to have a clear picture of the vacation leave availability and its implication.

Raymond Chetcuti

Chairperson MUMN Group Committee SVPR

✉ mumn@maltanet.net

MORE THAN JUST SKIN DEEP



Health care professionals often perceive psoriasis, like many skin conditions, as a relatively minor complaint. But this relapsing, lifelong condition that affects about 2% of the population is much more than a cosmetic problem.

"Psoriasis may not be life threatening, but it sure is life changing" says Moira Ferry, president of the Psoriasis Association Malta

"as an Association we are doing our utmost to raise awareness to as wide an audience as possible on the physical and emotional toll this condition has on sufferers"

Apart from the physical discomfort and disability, psoriasis can produce a number of psychological problems. The impact on the quality of life of psoriasis patients is comparable to that seen in

arthritis, heart disease or other disabling illnesses. People with psoriasis tend to suffer from low self-esteem and poor body image. They often face discrimination and embarrassment in public places simply because others fear that psoriasis is contagious – psoriasis is not contagious.

This is just one of the facts that the Psoriasis Association Malta will emphasize during World Psoriasis Day in October. Its aim is to educate others that psoriasis is common, non-contiguous, lifelong and more than just a "skin problem". The Association works year-round to improve the lives of people with psoriasis and psoriatic arthritis, but World Psoriasis Day is a special opportunity to raise awareness about these diseases.

The Psoriasis Association Malta values the role you as a healthcare professional play in patients' lives. By telling your patients about the Psoriasis Association Malta, you expose them to comprehensive information about their disease and invaluable emotional support. Please help the Psoriasis Association Malta reach as many people as possible with this condition.

PAM
PSORIASIS ASSOCIATION MALTA

For more information please contact us **Psoriasis Association Malta**

c/o 35 Triq l-Imsieba, Mosta • Tel: 21437606 or 21416288

Website: www.pam.org.mt • Email: info@pam.org.mt

The Malta Hospice Movement :: CAREER OPPORTUNITY

The increased demand for our services has created the following career opportunities: **B.Sc. Nursing/ Staff Nurses/Enrolled Nurses** (*full time basis and part time, mornings*).

The successful applicant will form part of our Multidisciplinary Palliative Care Team to give care and support to patients and their families. Therefore, together with knowledge and skills that ensure nursing competence, the successful applicants should have excellent communication skills and the right attitude to provide effective palliative care. Training in palliative care will be given and a commitment to professional and personal development is expected. Remuneration will be commensurate with the level of skills and nursing experience.

Every application will be acknowledged and treated in strict confidence. This, together with a detailed C.V. should reach Hospice by not later than Friday, 20th October 2006 and addressed to: The General Manager, The Malta Hospice Movement, 39, Good Shepherd Avenue, Balzan BZN 07, hospice@onvol.net or phone: 21440085/6.



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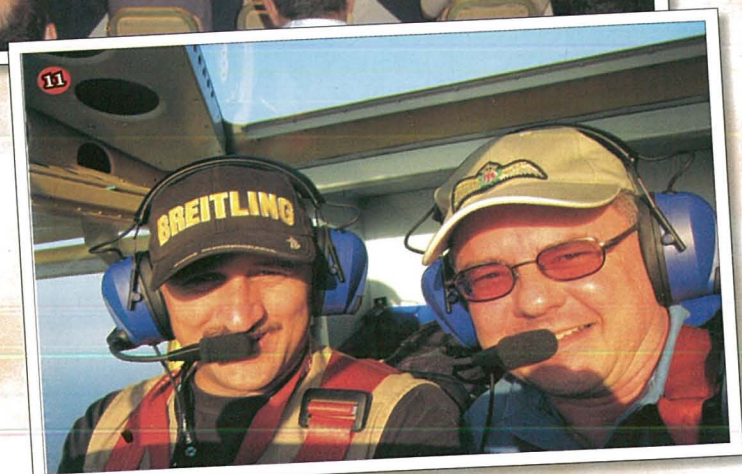
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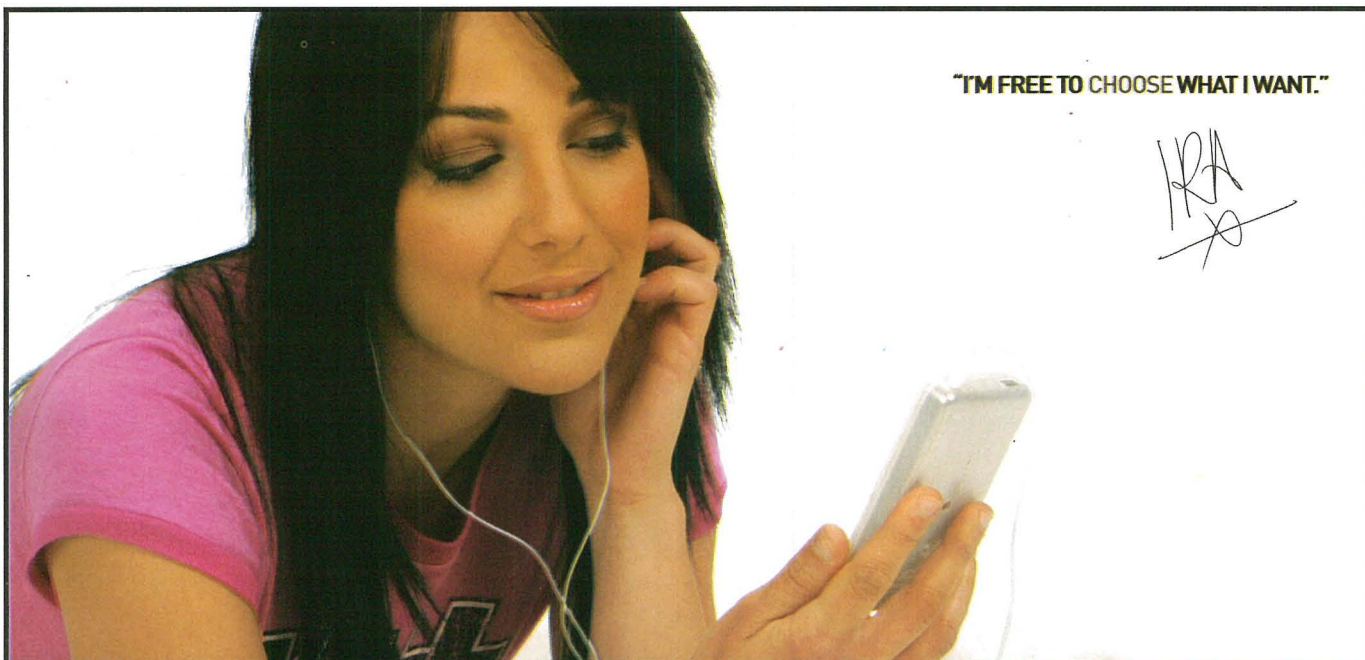
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Always the better value



1. The International Council of Nurses decided that the ICN Conference 2011 will be held in Malta. As part of the preparations for this important event Mr. Tesfamicael Ghebrehwet, ICN Consultant visited our country to see what facilities we can offer.
2. A BBQ was organised by the Entertainment & Cultural Group Committee as part of the 10th year anniversary celebrations. Well done to Simon Vella and his colleagues as we really had a good time.
3. Mr. Joseph Galea, Deputy Nursing Officer, MCH, was awarded the MCH Employee Award 2005. (Thanks to Medikura who supplied the photo).
4. Ms. Helen Borg, Midwife, KGH, was awarded the MUMN Annual Award 2005. Our congratulation goes also to the other three contestants Mr. Frankie Mifsud, Ms. Cathrine Farrugia and Mr. Saviour Zammit.
5. As part of the 10th year anniversary MUMN reached an agreement with the MiddleSea Insurance to offer all our members special insurance policy packages. A seminar was organised for the MUMN representatives to be better informed so that they can answer queries from our members.
6. Ms. Marlene Cassar, Nursing Officer, Dental Out-Patients, was awarded the SLH Employee Award 2005. (Thanks to Medikura who supplied the photo).
7. Some weeks ago our Midwives were called to assist an irregular immigrant, miles out at sea, who was about to give labour. This procedure was rather unusual and all Midwives need to be congratulated for their sterling service.
8. Again, MUMN this year organised the 7 a-side football tournament between all hospital employees from various sections. This was really a success. Well done to the Wonderland Team who won the league and the trophy.
9. The Malta Association of Psychiatric Nurses (MAPN) was launched within MUMN. Colin Galea, General Secretary was invited to the launching where he also addressed those present.
10. MUMN organised a seminar for its Representatives to discuss innovations and new practices in tradeunionism. This seminar was applauded by all those who attended as it gave a new perspective and new ideas for the near future.
11. Another activity as part of the anniversary celebrations was FLY FOR CHARITY. This activity was popular as it gave the possibility to many to see our beautiful island from the skies. Special thanks go to Mr. Simon Borg who voluntary organised and contributed to this activity where financial aid was also given to the Id-Dar tal-Providenza.
12. The Pensioners Group Committee organised an activity on the 17th April 2006 with his Excellency Mons. Mario Grech.



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Providing High Standard Nutritional Care

I am sure you all know about the Clinical Nutrition Services Team, made up of a Consultant Gastroenterologist and two Clinical Nutrition Nurses. At the moment this unit is undergoing a new face-lift and the team is undertaking new projects. This is why I have decided to tell you about some of our plans, in order to make you aware of them and to ask you to cooperate with us in the coming days.

One major project is the setting up of a Nutrition Committee for St. Luke's and Mater Dei Hospitals, which will include a number of different professionals who directly deal with patient care where his nutritional needs are concerned. These include our team, the dietitian, speech language pathologists, pharmacists, representatives of nurses, catering and other departments as required. This will officially be launched in the near future under the authority of the C.E.O. for St. Luke's Hospital and Mater Dei Hospitals. Its role will mainly be to deal with patient care where his nutritional needs are concerned, as well as with the feeds, equipment and other needs related to such care.

Also, the Clinical Nutrition Nurses will be introducing new Guidelines for Nasogastric Tube Insertion and the Position Checking. This will be approved by the newly set up Nutrition Committee and by the Nursing and Medical management of the hospitals. It will state how the ward nursing staff should insert nasogastric tubes and how the position of the newly inserted nasogastric tube should be checked, before feeding is started, to ensure the safety of the patient and also to safeguard the nurse who performs the insertion. It would advocate the safe checking of a nasogastric tube position using pH paper, which will be provided to the ward nursing staff for their use whenever required. To ensure maximum patient safety, the performing of a Chest X-Ray will be advised whenever a doubt as to whether the nasogastric tube is in the correct position exists. This has a two-fold advantage. Primarily it is the safest and most accurate method of ensuring that a nasogastric tube is in the stomach. This would also safeguard the nurse performing the insertion from liability and indemnity claims. Other methods that are used, such as auscultation using a stethoscope and even litmus paper are unsafe and inaccurate (The Royal Marsden Hospital Manual of Clinical Nursing Procedures, 2005)¹. More details will be provided to all nursing staff later on through in-service lectures and demonstrations.

Apart from these projects we have in mind to



provide a course for nurses on The Aseptic Changing of a TPN Bag that will provide a certificate of attendance and also one of competence in the technique. We are already providing community follow-ups to our patients who are discharged and have also launched a website for nurses and the public, where anyone can receive information about or request our services and can download certain information leaflets and literature that we provide to patients and their carers on enteral and parenteral nutrition. The website address is <http://cnsmalta.tripod.com>. At the end of 2006 or the beginning of 2007 we are planning to organize a conference on nutrition aimed towards healthcare professionals. The Clinical Nutrition Team believes that nutrition forms the basis of a healthy recovery from illness and strive to promote the best care to our patients. We welcome any suggestions and feedback about our services and also promise to cooperate with all nurses in the interest of the patients that we all care for.

Geoffrey Axiak

S.R.N., B.S.c (Nursing), P.G. Dip. (Nutrition & Dietetics)

Clinical Nutrition Nurse-in-Charge

Clinical Nutrition Services-SLH

✉ geoffrey.axiak@gov.mt

<http://www.geocities.com/cnsmalta>

¹ The Royal Marsden Hospital Manual of Clinical Nursing Procedures, 6th Edition. (2005) pp.431-433, 441.



NURSING MATTERS

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

International Classification for Nursing Practice (ICNP®)

April 2006

The International Classification for Nursing Practice (ICNP®) is a unified nursing language system. ICNP® is a compositional terminology for nursing practice that facilitates cross-mapping of local terms and existing terminologies.

Vision of the ICNP®

ICNP® is an integral part of the global information infrastructure informing health care practice and policy to improve patient care worldwide.

Strategic goals for ICNP®

- Serve as a major force to articulate nursing's contribution to health and health care globally.
- Promote harmonization with other widely used classifications and the work of standardization groups in health and nursing.

Elements of the ICNP®

The ICNP® can be used to represent Nursing Diagnoses (Nursing Phenomena), Nursing Interventions (Nursing Actions), and Nursing Outcomes.

Participation in ICNP® Development

- ICN encourages and facilitates participation of individuals and groups in the ongoing development and maintenance of the ICNP®.
- Nurses and organisations are encouraged to use ICNP® in clinical practice and to carry out research and development projects involving ICNP®.
- Nurses with similar interests in ICNP® are encouraged to apply to become ICN-Accredited ICNP® Research & Development Centres. Centres set their own work plan objectives and meet every two years at ICNP® Consortium meetings.
- ICN retains copyright for the ICNP®. Permission to translate, publish, reproduce and distribute is granted on a case-by-case basis. Contact the ICNP® Programme Director if you plan to

use ICNP® in research, education, practice, or clinical information systems development.

Benefits of the ICNP®

- Establishes an international standard to facilitate description and comparison of nursing practice;
- Serves as a unifying nursing language system for international nursing based on state-of-the-art terminology standards;
- Represents nursing concepts used in local, regional, national and international practice, across specialties, languages and cultures;
- Generates information about nursing practice that will influence decision-making, education and policy in the areas of patient needs, nursing interventions, health outcomes, and resource utilization;
- Facilitates the development of nursing data sets used in research to direct policy by describing and comparing nursing care of individuals, families and communities worldwide;
- Improves communication within the discipline of nursing and across other disciplines;
- Encourages nurses to reflect on their own practice and influence improvements in quality of care.

Communicating About ICNP®

- The ICNP® Bulletin is published twice a year and is available on ICN web site in English, French and Spanish.
- Multiple translations of the ICNP® Version 1.0 are underway. Watch the website for announcements of availability of translations.
- ICNP® Catalogues are being developed for application in nursing specialties, select practice area priorities, and care delivery settings.
- The next ICNP® R&D Centres Consortium meeting is scheduled at the CNR/ICN Conference, Yokohama Japan, May 27 – June 1, 2007.

Fact Sheet

A hardcopy of the ICNP® Version 1.0 is available from ICN
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For Further Information:
Amy Coenen, ICNP® Programme Director
coenena@uwm.edu
FAX: 414 229 6474

FREING YOURSELF FROM DIGESTIVE DISTRESS

Laurie Udesky

"Food, glorious food," begins the chorus of young boys in *Oliver*, the musical based on the Charles Dickens's classic, *Oliver Twist*. "Hot sausage and mustard. While we're in the mood, cold jelly and custard!" the residents of the orphanage continue in their ode to an imaginary feast, an antidote to their daily gruel.

Although the poorhouse fare may be foreign to many, the cravings evoked in the boys' ditty conjure up the passionate relationship that many of us have with food and eating. Whatever the depth of that relationship, a delectable dish often remains in memory with much more potency than any sort of digestive upset the treasured food may have caused.

Even those who aren't enamored with food but eat simply because it's necessary may wolf down their lunch only to find it biting back a couple hours later. And what do too many of us do when our stomachs bloat, cramp, or send us running to the bathroom? We reach for an elixir, a mint, pill or potion to tame the unquiet tummy.

Not that there's anything wrong with seeking some quick relief. But if you're suffering from chronic discomfort and find yourself diving for the antacid on a regular basis, you should probably see a doctor to make sure you don't have an infection or organic disease. If medical tests fail to point to any culprit, you may be diagnosed with a "functional" digestive disorder such as irritable bowel syndrome (IBS) or chronic constipation that can't be traced to any organic disease. In this case, changing your lifestyle is usually the best way to permanently free yourself from digestive distress.

Functional disorders such as irritable bowel syndrome, heartburn, gas, and chronic constipation and diarrhoea are often connected to life in the 21st century: too much rushing around in traffic, grabbing fast food, skipping meals, then unwinding with a big dinner and a few cocktails late at night.

Diet, in fact, has such a strong connection to so many of these ills that stomach specialists often tell their patients to keep a log of every bit of food or drink they consume so they can pinpoint the source of their distress and make some lasting changes.

The daily diary

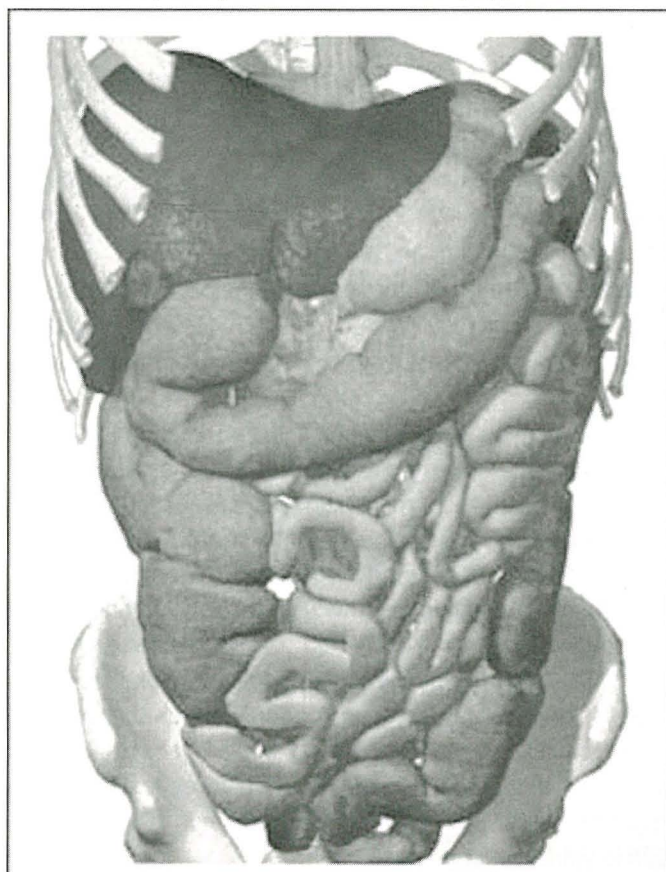
People who have had stomach problems for months or years often have no idea what foods trigger their pain. To figure out possible sources, Gary Gitnick, MD, chief of the division of digestive diseases at the University of California at Los Angeles School of Medicine, advises that the food journal include when you eat something, how much you eat, where you ate it, if you were doing anything else at the time, and any symptoms

you're feeling. (He also suggests recording your mood and emotions at the onset of any digestive symptoms.) Your diary should include everything you put in your mouth, including things like chewing gum, candies, and mints.

After a few weeks of keeping the diary, you can get a better sense of which foods are unfriendly to your digestive tract, and begin creating a diet that is well balanced and tailored to your needs. You may also want to consult with your doctor or a nutritionist to find out what foods are most likely to produce the symptoms you have. Removing a food item from your personal menu doesn't necessarily mean avoiding it altogether. It may mean cutting it out until the symptoms go away.

Foods that bite back

If you have heartburn (also called acid indigestion) -- with the classic symptoms of a bitter taste in your mouth, a burning sensation in the back of your throat, or pain in your upper abdomen -- there are foods and beverages you might consider avoiding. These include drinks containing caffeine such as coffee, cola drinks, black tea, and hot chocolate. Also avoid teas, candies, and gum with mint. Oil of peppermint relaxes



the valve between the oesophagus and stomach and allows stomach acid to back up into your oesophagus. High-acid foods such as lemons, oranges, grapefruit and tomatoes may also aggravate your condition. Cutting back or eliminating your alcohol intake may help, too, as will eliminating nicotine.

If you suffer from bloating or excess gas, you may want to steer clear of the top ten gassiest foods known to humans: cabbage, cauliflower, broccoli, brussels sprouts, turnips, dried beans, onions, garlic, leeks, and milk products (for people who lack an enzyme that digests milk). In trying to unearth the source of a pain or discomfort, bear in mind that some reactions to foods are almost immediate -- like heartburn, while others, like gas, can hit you hours after you ate the offending food. (Each individual is different, however, so you may be able to tolerate some gas-producing foods that others can't.) Carbonated drinks, olestra (artificial fat), and sorbitol (an artificial sweetener in candy and chewing gums) can also result in excess gas, as can chewing any kind of gum (because you tend to swallow air).

Having a cluster of symptoms that includes abdominal pain, bloating, and constipation alternating with diarrhoea may lead to a diagnosis of irritable bowel syndrome. As far as foods go, the American College of Gastroenterology (ACG) recommends avoiding the gas-producing foods listed above. Also steer clear of carbonated drinks, which can produce more gas, and try eliminating dairy products. Intolerance to milk sugar, or lactose, is seen in 40 percent of patients with IBS, according to the gastroenterologists' organisation. (If you're indeed intolerant of dairy products, you may need calcium supplements.) Consuming fibre in the form of wheat bran or other types might also be helpful, according to the ACG.

If you have chronic diarrhoea, the top foods to avoid are the artificial sweetener sorbitol, prune juice or other fruit juices, unpeeled fruits (such as apples, grapes, plums or pears), fatty or fried foods, caffeine, raw vegetables, and milk products (if you lack the enzyme lactase). Olestra, artificial fat found in some potato chips and other processed foods can cause bouts of diarrhoea and "leakage" in susceptible individuals. Foods that are helpful are the so-called BRAT foods -- as in bananas, rice, apples (without skin or applesauce), and toast. Fibre supplements such as Metamucil, made from vegetable powder, can also help stop diarrhoea by making stools bulkier.

For those who suffer from constipation, lasting relief often comes from the grocery store, not the pharmacy. Each year, Americans spend \$725 million on laxatives, according to the American Gastroenterological Association (AGA), which notes that many times they're unnecessary or even harmful. The main cause of constipation may be a diet high in animal fats and refined sugar and low in fibre from vegetables, fruits, and whole grains. There are other causes of constipation -- including medications, pregnancy, hormonal disturbances, and travel. One major cause cited by the AGA is laxative abuse. The more laxatives you take, the more your body depends on them to function until finally your intestine becomes insensitive and fails to work properly.

If you suffer from functional constipation, you can often find relief getting regular exercise, increasing your intake of fluids (some experts advise drinking eight or more 8-ounce glasses of non-caffeinated liquids a day), and eating a diet rich in fruits and vegetables. Fibre supplements help by making stools softer and more bulky, as long as you always take them with one and preferably two glasses of water.

Get moving

Whatever your condition, consider adding some form of exercise to your routine. It's not only good for you on many other fronts, but exercise also can help keep your digestive tract buzzing along as it should. "I think that most doctors would agree that regular exercise helps promote normal intestinal function, which in turn helps pass gas, reduces bloating and cramping, and results in more regular bowel movements," writes Gitnick.

Just remember that certain types of digestive problems may preclude some forms of exercise. For example, Gitnick notes that people who suffer consistently from heartburn should refrain from jarring or high impact exercises. Instead of aerobic dancing, jogging, or the step machine at the gym, Gitnick suggests walking or swimming as an alternative. Thirty minutes to an hour a day should be enough, and if you have to break it up into 10- or 15-minute segments each day at first, that's okay.

For people with severe symptoms, exercise and dietary changes may not be enough; prescription medicine may be necessary. If you have a irritable bowel syndrome and experience extremely painful abdominal cramps, your doctor may prescribe anti-spasmodic drugs. If heartburn and sores in the oesophagus are your problem, your doctor might recommend taking medication known as a proton-pump inhibitor, which blocks the production of stomach acid.

Another key to better digestive health is reducing your stress. If your day is shaped by stress, you may want to learn a relaxation technique to calm your nerves, whether it's some form of meditation, a breathing exercise or just listening to music. If you make exercise, relaxation, and dietary changes a part of your routine, you'll probably find that the stomach troubles that were once part of your daily life are fading into the past.

Laurie Udesky is an award winning health and medical journalist based in San Francisco.

References

Gary Gitnick, M.D., with Karen Cooksey, *Freedom from Digestive Distress*, Three Rivers Press, New York, 2000.

American College of Gastroenterology, *Consumer Health Guide to Irritable Bowel Syndrome*.

American Gastroenterological Association, *Consumer Guide to Constipation*.

If you think you may have a medical emergency, call your doctor or 112 immediately.

Is it Time for a Change?

By **Melissa Tennen**, HealthAtoZ writer
Healthy Living: Blueprint for Health Wellness Centre

The messages are trumpeted everywhere - eat better, exercise, lose weight, lower your blood pressure and cholesterol levels, and watch your stress. It's like a broken record. But wait. Maybe it's time for you to do something.

Take stock of your health. Is your weight higher than you would like? Do you rarely exercise? Do you smoke? Do you skip the doctor's office? Do you reach for the potato chips instead of carrot sticks?

If you answered "yes" to any of these questions, then it's time to make changes and improve your life. Good health is the best gift you can give yourself - and your family. Wellness should not just mean the absence of disease.

Sure, change is difficult. But for new habits to set in, change must come slowly. Take small steps and set mini-goals for yourself.

Setting goals: easier than you think

One secret to changing your life is to set goals -- big one and little ones. Tell yourself, "I'm going to walk one block today." This is a mini-goal. "When I feel stronger and less winded, I'll walk two blocks." Another mini-goal. "Eventually I'll be walking a mile." The big goal.

Months or even a year later, you'll be doing your ultimate goal of walking two miles every day. Realistic goals mean gradual goals. You have to be patient. Listen to your body. When it tells you it's tired, take it easy. Never force yourself because that could mean injury or frustration.

Make a pact or contract with yourself. Decide what you want to do and how you plan to get there. Write it all down and include the reasons why you are making this change - to look better, to lose weight, to feel better, to help with your present conditions or to prevent disease.

Here's a sample contract:

Goal: I'm going to eat less fat.

The first step: I'll have yogurt instead of ice cream after dinner.

Goal: I want to exercise for 30 minutes most days of the week.



The first step: I will walk around the block.

Keeping tabs

Keeping track of your progress can be a great motivator. Use a journal, a log sheet or some other way to record your successes and how you want to improve your routine. Note the changes. Are you losing weight? Do you feel better about yourself?

Celebrate everyday victories

Go ahead and pat yourself on the back every time you do something good for yourself and reach one of your mini-goals. Did you eat two servings of vegetables today instead of one? Did you walk a mile instead of a half mile? Did you drop a pound? Yes, these are small accomplishments, but small accomplishments eventually lead to big ones. These are all stepping stones on your path to wellness.

Celebrate each little victory. Get a pedicure. Take a bubble bath. Buy a new CD. Go dancing with your loved one. Your victories are unique and so too are your rewards. Remember; don't celebrate with a chunk of cake or a cigarette. Your celebrations should reinforce your new habits.

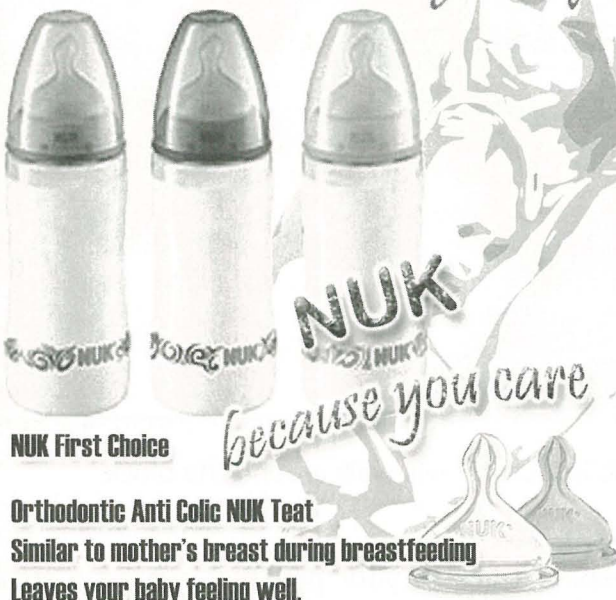
Make it your strategy to get healthier and improve your life.

If you think you may have a medical emergency, call your doctor or 112 immediately.

This article was reviewed June 2006, by John Acquaviva, Ph.D., Associate Professor, Health and Human Performance, Roanoke College, Salem, VA.

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Understanding Life



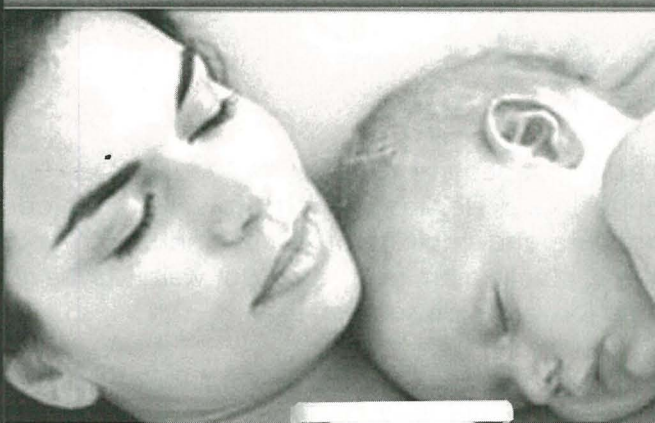
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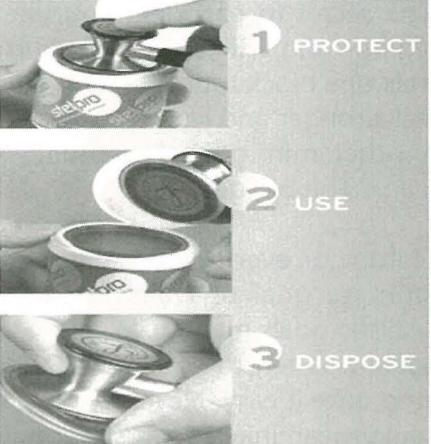
DOES YOUR STETHOSCOPE CARRY BACTERIA?

FACT: The stethoscope is the most widely used medical instrument.

FACT: Studies show stethoscope heads can harbour pathogenic bacteria e.g. MRSA, yeasts, fungi, gram-positive cocci.

Very little attention is paid to the stethoscope as a vector for harbouring infection.

Protect your patients from stethoscope head transmitted infections



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European Federation of Nurses Associations

PRESS RELEASE

Protect Europe's nurses from contaminated needles!

On the event of International Nurses Day, May 12, the European Federation of Nurses Associations (EFN) is taking the opportunity to focus on the life-threatening risks faced by nurses and other healthcare workers across Europe, on a daily basis, due to injuries with contaminated needles. It is estimated that there are more than one million needlestick injuries suffered by healthcare workers in Europe each year, with the associated risk of HIV, hepatitis B, hepatitis C, and other dangerous blood borne viruses. Even where an infection is not acquired many healthcare workers who suffer a needlestick injury face months of uncertainty and emotional stress not knowing if they will contract a life-threatening infection or not.

The majority of these injuries are avoidable,

with the implementation of safer working practices and the use of medical technology that incorporates needle protection, but most healthcare employers are very slow to implement. Yet in any other work situation such risks would be unthinkable.

The EFN congratulates the European Parliament on their recent initiative to improve the directive on the protection of workers from risks related to exposure to biological agents at work (2000/54/EC), to include specific provisions concerning the prevention of needlestick injuries. Paul de Rave, Secretary General of EFN, adds that if properly implemented this will serve as an excellent example of the positive value of the European Union at a very practical level. Nurses Europe-wide will appreciate it.

More information is available on EFN website

EFN PRESS RELEASE BOLOGNA

On 14th October 2005 EFN sent a letter to Mr. Vladimir Špidla, the European Commissioner for Employment and Social Affairs, presenting EFN input to the Commission Green Paper "Faced with Demographic Change, a new Solidarity between the Generations" COM (2005) 94.

As part of that input, EFN sent to the Commissioner the recently endorsed EFN position statement on 'EU challenges for long-term care', and called on the Commission "to undertake the necessary reforms in order to ensure that adequate financing is provided for older people care and active ageing, and to develop EU legislation that ensure appropriate nurse/patient ratios in nursing homes and other health services for older people". As nurses provide 80% of direct patient care it is essential, when designing new policy in the social and health area, to include nurses and nursing vision to obtain a full picture of care.

In general terms, EFN is calling for more discussion on the key principles and strategies needed in long term care and the nursing issues to support them, convinced of the fact that addressing

nursing issues in relation to long term care will improve the quality of life for long term care patients.

The new EFN position statement approaches elderly care focusing on accessibility, quality & workforce, and sustainability. It is a step forward towards a paradigm shift in long-term care.

Editor's Note:

The European Federation of Nurses Associations (EFN), former Standing Committee of Nurses of the EU (PCN) was established in 1971 (PCN). EFN represents over one million nurses and is the independent voice of the profession. The mission of EFN is to safeguard the status and practice of the profession of nursing and the interests of nurses in the EU and Europe.

EFN Press Release – 14 10 2005

The European Federation of Nurses Associations (EFN)
Registration Number 476.356.013

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Count your Blessings

If you woke up this morning with more health than illness... you are more blessed than the million who will not survive this week.

If you have never experienced the danger of battle, the loneliness of imprisonment, the agony of torture, or the pangs of starvation... you are ahead of 500 million people in the world.

If you can attend a church meeting without fear of harassment, arrest, torture, or death ... you are more blessed than three billion people in the world.

If you have food in the refrigerator, clothes on your back, a roof overhead and a place to sleep... you are richer than 75% of this world.

If you have money in the bank, in your wallet, and spare change in a dish someplace... you are among the top 8% of the world's wealthy.

If you hold up your head with a smile on your face and are truly thankful... you are blessed because the majority can, but most do not.

If you can hold someone's hand, hug them or even touch them on the shoulder... you are blessed because you can offer God's healing touch.

If you can read this message, you just received a double blessing in that, someone was thinking of you, and furthermore, you are more blessed than over two billion people in the world who cannot read at all.

Have a good day, count your blessings and remind everyone else how blessed we all are.

LIVE ONCE, BE REMEMBERED WELL ALWAYS.

IL-MUSBIEH
MALTA NURSING AND MIDWIFERY JOURNAL

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Tel: 21 44 85 42
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Snippets

WANTED: FOUR MILLION HEALTH WORKERS!

The World Health Organisation's World Health Report 2006 reveals a shortage of more than four million doctors, midwives, nurses and support workers worldwide, and contains ambitious proposals to tackle the problem over the next ten years, starting immediately. At least 1.3 billion people worldwide lack access to the most basic healthcare. The burden is greatest in countries overwhelmed by poverty and disease. For instance sub-Saharan Africa has 11% of the world's population and 24% of the global burden of disease, but only 3% of the world's health workers. The report has led to calls for Western countries to stop "poaching" healthcare staff from these countries. It is available for download in six languages from <http://www.who.int/whr/2006/en/>.

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PSI World News

REGIONAL NEWS from: PSI WOMEN No 26 January 2006

INDIA: Night shift nurses not entitled to rest facilities

The All Indian Cantonment Board Employees Federation, together with the PSI South Asia Sub-Regional Office, sponsored a quality health services workshop in Pune, India, in September. A report concerning the occupational health conditions of nurses at the government Medical College at Chandigarh, Haryana, one of the major medical establishments in the region, was presented to the workshop. The report revealed the extent of backache and inflammation of the vertebrae among 437 nurses. Three hundred reported suffering from mild to acute backache. During the night shift nurses can only rest by sitting on plastic or metal chairs, which do not relieve pains in the back. Junior doctors, however, are permitted to take rests on beds provided for them. The nurses took this issue up with hospital authorities only to be told that Indian nursing council regulations do not make any provision for rest facilities for nurses during working hours.

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Individual patient medication tests can help reduce risks of pain medication

A tailored, patient-centric approach to chronic pain management shows how physicians could better manage the risks associated with use of pain medication, according to a research published in the *American Journal of Therapeutics* (AJT)^{1,2}.

Researchers in Australia used individualised medication effectiveness tests (IMETs), which involve double-blind assessments of analgesic efficacy, to identify which patients obtain a satisfactory response from paracetamol, and who might get additional benefit from NSAIDs. A total of 71 IMETs were undertaken in patients with osteoarthritis, which is the most common chronic painful condition presenting in general practice^{1,2}.

Patients involved in the trial underwent three consecutive treatment periods lasting 4 weeks each, testing either paracetamol or ibuprofen against placebo, a paracetamol-ibuprofen combination against either ibuprofen or paracetamol and paracetamol directly against ibuprofen. Results were measured by assessing pain and stiffness, the use of escape analgesia (paracetamol), and side effects^{1,2}.

The results demonstrated that the number of patients achieving adequate pain control on paracetamol alone rose by over 20% (from 41% to 63%), and 38% (eight out of 21) of patients previously on taking NSAIDs and 25% (four out of 16) previously taking COX-2 inhibitors stopped taking these classes of medication after the trial¹. The most common treatment change at the end of the trial was to either add paracetamol or substitute existing treatment with paracetamol^{1,2}.

Dr Nikles, Senior Research Officer, The University of Queensland, Australia and the research lead said: "Using the IMETs approach can help strike a balance between efficacy, safety and cost for individual patients. Results support paracetamol as first-line treatment for chronic pain, which is appropriate in conditions, such as OA, that need long-term treatment. This approach allows NSAIDs to be restricted to those patients in whom there is clear evidence of improved efficacy over paracetamol."

The researchers have also been looking at the COX-2 group where such an approach may be beneficial.

Additional caution urged for analgesics when purchased OTC.

Other papers published in this issue of the AJT called for caution with the use of OTC analgesics^{3,4}. While pain remains the most commonly self-treated symptom, concerns have been raised over the inappropriate choice of certain OTC analgesics in the absence of healthcare professional advice.

Patients should be made aware of the possible side effects, contraindications and drug interactions associated with common OTC pain relievers, such as ibuprofen.

In Malta many pain relief tablets are sold without prescription each year. Safe use of these medications relies upon appropriate use and dosing³. However many people may be simply unaware of the risks associated with inappropriate use, and more than 60% of people cannot identify the active ingredient in their brand of pain reliever⁴.

Research conducted in the UK and Australia has suggested that ibuprofen could be contraindicated in up to 1 in 5 people, compared to less than 1 in 50 people for paracetamol³. Self-medicators are also likely to be unaware of the potential risks associated with the long-term or inappropriate use of OTC pain relievers, particularly if they are also taking medications prescribed by their doctor. Authors writing in the AJT cited the example of the use of ibuprofen in combination with an ACE inhibitor and diuretic medication as increasing the risk of acute renal failure⁵.

Dr Jawad, Consultant Rheumatologist at the Royal London Hospital, United Kingdom and author in the AJT commented "Paracetamol should be used as the cornerstone of pharmacological pain management, both as a first-line analgesic and as a foundation to which additional treatments, including NSAIDs, can be added when necessary. Paracetamol has a long history of use and therefore has a well known safety profile, it also has no major drug interactions, and is suitable for use by the majority of people as it has few contraindications with other medical conditions."

This positioning as the cornerstone analgesic is supported by authors in the AJT and a number of treatment guidelines published by a variety of health professional bodies across the world, including European League Against Rheumatism (EULAR), American College of Rheumatology (ACR), National Institute of Health's asthma guidelines and the World Health Organization's (WHO) cancer pain ladder⁶⁻⁹.

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Article provided by GlaxoSmithKline Consumer Healthcare.

Spirituality within a clinical setting

My pastoral experience as a hospital chaplain keeps informing me of the reality that a human being cannot live by bread alone. Besides the physical, social and psychological needs, every human being has also spiritual needs.

It is almost impossible to give a clear cut definition of the notion of spirituality. Thus, it would be more appropriate to speak about characteristics of spirituality. In this short article I envisage four characteristics which tend to give an exhaustive idea of spirituality and its connectedness with the clinical setting.

The first characteristic projects spirituality as a deeply personal endeavour. In fact, spirituality is essentially personal. Every patient has got her/his own way of expressing it. What sounds important is that the patient finds the most comfortable manner through which s/he can get in touch with everything that can enlighten her/his understanding of the present moment.

The second feature that comes into play in spirituality is the relationship of the patients with the "Being-greater-than-themselves". This "Being" can be God, Yahweh (Yhwh), Allah, Jehovah, Brahma, Shekinah, Sophia, Vashti, Gaia, the Great Spirit and so forth. Meeting such an all-embracing Being makes the patient realize her/his own limitations as well as serves as a splendid prelude to a faith community. It is amazing how patients can better face whatever prospects may come on their way, had they been supported by a caring community of faith.

The third element of spirituality explains that having a relationship with the Being, inculcates within the patient a sense of meaning in life. Vital expressions of such a relationship, like prayer or reading from the "holy book", can prove to be decisive factors in one's way of conceiving and interpreting the chain of events that one goes through. Such spiritual experiences tend to broaden the patient's concept of life, especially by enriching it through the inclusion of other crucial issues such as death and life after death.

The ultimate characteristic of spirituality within a hospital setting is one that often equips the patients with existential criteria to understand themselves, other people and the world around them. For Wesley L. Brun this implies a "relational" dimension to a patient's spirituality that changes how one feels/thinks about oneself, and as a result, how one also feels/think about others and this world. Thus, one's spiritual experience has the power to enlighten, alter and renew a



patient's being with the entire cosmos.

As it stands, the patient cannot be ostracized from her/his inner world. Regardless of her/his religious or nonreligious beliefs, practices and spirituality, the mere fact of being human implies also being spiritual. It is the paramount duty and expertise of hospital chaplains to respect, nurture, encourage, help and safeguard a patient's spirituality. Hence, the chaplain is in an ideal position to make a patient at home with her/his spirituality. After all, is not total respect and promotion of religious freedom; still is, as one of the most basic rights of the

patient and every human person on earth?

Fr Mario Attard OFM Cap

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PROSIT M'hix bi hsiebni noqghod niftaħar bil-professjoni li għandna n-Nurses u l-Midwives, għalkemm żgur jimmerithom. Huwa fatt magħruf li dawn l-impegati għandhom xogħol delikat u bilfors iris isir bil-galbu għax fin-nofs hemm persuna u mhux oġġett. Però nixtieq nemfasizza fuq attivitajiet li jsiru minn xi wħud minn dawn il-professjonisti li tista' tgħid li m'għandu x'jaqşam xejn max-xogħol propju tagħhom.

Fost dawn insemmi li hawn min jagħti sehmu fil-qasam kulturali bħal per eżempju surmast ta' banda, bandisti u anke tenuri. Oħrajn jagħmlu xogħol fil-volontarjat jew f'xi sport b'risq xi għaqda filantropika. Xi wħud jagħmlu parti minn xi għaqda bħall-union u oħrajn f'xi partit politiku u sa anke hawn min sar membru parlamentari, sindku u kunsilliera.

Niftakar anke meta xi wħud b'riskji għalihom ħadu sehem f'traġedji ta' *hijacks*, u oħrajn li marru bħala voluntieri, jaħdmu fid-diżgrazzja taz-tsunami. Haġa oħra ta' min isemmi hi li hawn min jagħti sehemu fil-*management*, u dan b'dedikazzjoni u li jagħmel unur lil din il-professjoni.

Dawn huma xi ftit mill-affarijiet li ġewni f' moħħi u ma semmejtx ismijiet apposta, għax il-lista hija twila u ma rrid ninsa' lil hadd. Għalhekk filwaqt li nifrah lil dawn involuti f'xi hidma jew oħra, nawgura biex aktar membri ta' din il-professjoni jagħtu sehemhom f'xi volontarjat għall-ġid tal-Komunità.

Thomas Aguis
SN DSU SLH

The Truth About Cancer

By **Diane Griffith**, HealthAtoZ writer

According to a recent survey by the American Cancer Society, a large number of Americans believe some common cancer myths are true. Several of these myths result in unnecessary fears, leading people to question the safety of such items as cell phones or antiperspirants. Others can be dangerous, causing people to avoid cancer treatment itself.

Take a look at these commonly believed cancer myths:

Myth 1: Treating cancer with surgery can disturb cancer cells, causing them to spread.

Highly trained specialists perform cancer surgery, taking precautions to prevent the spread of cancer to other parts of the body. These doctors can take safe biopsies and remove tumours without allowing the cancer to spread.

Myth 2: Cell phones cause cancer.

Although studies suggested a link between a rare type of brain tumour and cell phones, a consistent relationship between the two has not been found.



Myth 3: There is a cure for cancer, but the medical industry is hiding it from the public. It would hurt the industry financially to stop treating cancer.

The medical profession has quickly shared past breakthroughs (e.g., the polio vaccine) with the public. Also, doctors, scientists and their families develop cancer as often as the rest of the world - and want a cure just as badly.

There isn't one disease called "cancer." There are many different types requiring many different cures. Each day, advances are made in cancer research. A few decades ago, the number of children still alive 10 years after a diagnosis of leukemia was less than 10 percent. Today, nearly 80 percent of children with leukaemia are cured with chemotherapy. These increased cure rates apply to other types of cancer as well.

Myth 4: Cancer is always painful.

Some cancers don't cause any pain, while others cause pain only in the late stages. Newer medications have been developed that can keep patients comfortable.

Myth 5: Antiperspirants can cause breast cancer.

Studies performed in 2002 and 2004 revealed no clear link between antiperspirants and breast cancer.

Myth 6: Microwaving plastic containers and wraps release cancer-causing substances into food.

According to the FDA, any plastics released into microwaved foods are at very low, unharmed levels.

Myth 7: If you have a strong risk factor for breast cancer, you are likely to get the disease.

Even if you've inherited the breast cancer gene, your chances are between 20 percent and 60 percent that you will not develop breast cancer. For people with other risks factors, the chances are even lower.

Myth 8: Radiation and chemotherapy make you feel sick.



Some people experience nausea and vomiting; others do not. For those who do, medications are now available that are much more effective than those previously available. Many of them have no side effects.

Myth 9: You can become addicted or build up a tolerance to morphine.

Addiction to morphine is rare in someone with chronic cancer pain. If a patient does build up a tolerance, doctors can change dosage levels or switch medications to provide the patient relief.

Myth 10: Birth control pills cause breast cancer.

Birth control pills used to have high doses of hormones and were associated with a small risk for breast cancer. Today's birth control pills contain low doses of these hormones and aren't linked to breast cancer. In fact, they can provide protection against ovarian cancer.

This article was published on 21/07/2005. If you think you may have a medical emergency, call your doctor or 112 immediately.

Is-Suwiċidju: Veritajiet U Hrejjef

Ħadd m'għandu jiġġudika lil ħadd, speċjalment lill-vittmi tas-suwiċidju. Alla biss jaf it-tbatija li jkun għaddej minnha qabel ma jaslu li jieħdu dan il-pass. Rolheiser (2002) għamel analogija bejn il-marda tal-kanċer u s-suwiċidju. Hu qal illi: "Is-suwiċidju huwa marda, u bħal kanċer, tkun kemm tkun l-imħabba u l-kura tagħna, xorta waħda ma jistax jitfejjaq". Però, il-problema ta' dan ir-raġunament tinsab fil-fatt illi s-soċjeta faċli tħossha mpotenti quddiem il-problema, meta fil-fatt dan m'għandux ikun.

Biex nuża l-istess analogija li ntużat fl-artiklu, nixtieq ngħid illi bħall-marda tal-kanċer, jekk wieħed jinduna bil-marda minn kmieni, hemm il-possibilita li dan ikun imwaqqaf u f'ħafna każi ikun imfejjaq. Huwa għalhekk, illi bħala infermiera u edukatriċi fil-qasam tas-saħħa mentali, nħossni fid-dmir li niġbed l-attenzjoni dwar ċerti twemmin fuq is-suġġett.

Ħrafa: Is-suwiċidju jista dejjem ikun prevedut.

Verità: Sfortunatament, għalkemm ħafna drabi dan huwa veru, hemm drabi oħra fejn dan ma jistax isir, minkejja l-isforzi kollha li jsiru u minkejja l-attenzjoni u mħabba kollha li tingħata lill-individwu.

IMMA:

Ħrafa: Min jitkellem dwar il-ħsieb li jagħmel suwiċidju, ma jasal qatt li jagħmlu.

Verità: Ħafna minn dawk li jagħmlu suwiċidju jikkellmu dwar dan qabel ma jwettquh. Min jitkellem dwar il-ħsieb li jagħmel suwiċidju, jista' jkun qed jagħmel dan biex jitlob l-għajnuna. Fil-fatt, il-maġġor parti ta' dawk li jikkontemplaw li jwettqu suwiċidju jgħatu sinjali li jkun ser jagħmluh. Fost dawn is-sinjali hemm:

- Il-persuna tibda tinqata' għalija waħedha u tista' twaqqaf ir-relazzjonijiet tagħha mall-ħbieb u ma' kull min iħobbha.

- Ikun hemm bidla fil-personalita u fil-mod ta' kif iġġib ruhha l-persuna.
- Il-persuna tkun għaddejja minn dipressjoni jew xi marda mentali oħra.
- Il-persuna tkun tabbuża mid-drogi jew alkoħol.
- Il-persuna tista' tkun osservata li qed tgħati xi affarijiet li tant tħobb (*prized possessions*) lil xi ħadd ieħor. Eż: Annimali (pets) jingħataw lil xi ħadd ieħor biex jieħu ħsiebhom.
- Il-persuna tnaqqas jew iżżid fl-irqad.
- Il-persuna tibda ssibha diffiċli biex tikkonċentra u ma tibqax tieħu pjaċir b'attivitajiet li qabel kienet tieħu gost tagħmel.
- Il-persuna tibda taħseb repetutament dwar il-mewt u tesprimi speċifikament ix-xewqa li tmut.

Diskors dwar suwiċidju għandu dejjem jittieħed bis-serjeta. **DEJJEM.**

Ħrafa: Min jitkellem dwar is-suwiċidju huwa manipulattiv u jrid jiġbed l-attenzjoni.

Verità: Le, min jitkellem dwar is-suwiċidju m'huwiex manipulattiv, imma bniedem għaddej minn problemi serji f'ħajtu. Għaldaqstant, għandu bżonn min jifmhu u jgħadru. Jekk tghid lil xi ħadd li qed jaħseb dwar suwiċidju li hu jrid biss jiġbed l-attenzjoni, tkun qed turi kemm inti insensittiv u njoant. Min imut b'suwiċidju ħafna drabi jitkellem dwaru qabel ma jwettqu. Hu jagħmel dan b'tentattiv li jsib l-għajnuna.

Ħrafa: Meta persuna tiddeċiedi li tmut b'suwiċidju ħadd u xejn ma jista' jwaqqafha.

Verità: Wieħed jista' jipprevjeni s-suwiċidju. Ir-riċerka turi li huma biss 3% ta' dawk kollha li jikkommettu suwiċidju, li verament ikunu jridu jmutu. Normalment, min jagħmel



suwiċidju jkun irid BISS iwaqqaf it-tbatija u l-uġigh li jkun għaddej minnu. Għal din il-persuna, il-mewt biss tkun l-unika soluzzjoni.

Ħrafa: Min jipprova jew jirnexxilu jwettaq suwiċidju, huwa miġnun.

Verità: Kulħadd jista' jgħaddi minn mumentu ta' tbatija fiżika u/jew psikoloġika li tpoġġieħ f'pużizzjoni li jikkontempla s-suwiċidju. Dawk li jwettquh huma għaddej minn żmenijiet diffiċli ħafna f'ħajjithom.

Ħrafa: Is-suwiċidju jagħmluh biss ċerti nies, u mhux kulħadd.

Verità: Kulħadd jista' jkun vittma tas-suwiċidju.

Ħrafa: Meta titkellem ma' xi ħadd dwar il-ħsieb li jagħmel suwiċidju, tkun qed idahħalu l-idea f'moħħu.

Verità: Tista' ssalva ħajja ta' persuna billi tistaqsiha jekk tkunx qed taħseb biex tagħmel suwiċidju. Il-persuna li jkollha dan il-ħsieb f'moħħha tkun għaddejja minn tbatija kbira, u għalhekk huwa mportanti li wieħed jitkellem mall-persuna dwar din it-tbatija. B'hekk ikun qed juriha li hemm xi ħadd interessat li jgħinna u li hemm tama għaliha minbarra l-mewt.

Ħrafa: Min jipprova jagħmel suwiċidju u ma jirnexxielux, m'hemmx ċans li jerga jipprova darb'oħra.

Verità: Min jipprova jagħmel suwiċidju u ma jirnexxielux, qieghed

f'riskju li xi darba jew oħra jerga jipprova jagħmlu.

Ħrafa: Meta xi ħadd li jkollu l-intenzjoni li jagħmel suwiċidju jidher li jkun qaleb għall-aħjar, ifisser li m'għadux jaħseb dwar is-suwiċidju.

Verità: Ħafna drabi, meta l-persuna tiddeċiedi li trid tmut b'suwiċidju ser tkun tidher li qed tħossha aħjar. Dan għaliex f'moħħha jkun hemm il-ħsieb li t-tbatija dalwaqt tispicċa.

Ħrafa: Iz-żagħżagħ ma jikkomettux suwiċidju.

Verità: Is-suwiċidju huwa t-tielet kawża ta' mewt fost persuni ta' bejn il-15 u l-24 sena.

Ħrafa: L-Anzjani ma jwettqux suwiċidju.

Verità: L-ogħla rata ta' suwiċidju fl-Amerika hija fost il-persuni ta' l-fuq minn 65 sena.

Kif nistgħu ngħinu lil min qed jaħseb dwar is-suwiċidju?

Fid-dawl ta' dawn il-fatti, nistħajjel lil qarreja jistaqsu: Allura x'nistgħu nagħmlu biex ngħinu lil xi ħadd li qed jikkellem magħna dwar il-ħsieb li jwettaq suwiċidju?

Hemm ħafna x'jista' jsir:

1. Kun af il-fatti.
2. Kun attent għas-sinjali li jistgħu jingħataw mill-individwu li jkun qed jaħseb li jwettaq suwiċidju.
3. Tkellem fil-beraħ u bla biża dwar is-suwiċidju mall-persuna kkonċernata. Toqgħodx tibza

ssemmi l-kelma "suwiċidju". Ara xi pjan għandha f'moħħha l-persuna. Dan iservi biex inti tifhem aktar lill-persuna u tkun tista' tgħinna.

4. Kun sensitiv u pprova ifhem l-uġigh u t-tbatija li jkun għaddej minnhom l-persuna.
5. Qatt m'għandek tgħid lil dak li jkun: "Hu ejja. Inti m'intix it-tip li tagħmel suwiċidju!" jew "Hu ejja. Qum minn hemm u tghaġġibix" jew "Għandek ħafna għal x'hiex tgħix" jew "Hemm min hu aghar minnek". Dawn il-kummenti u oħrajn simili juru nuqqas ta' sensitivita lejn il-persuna li qiegħda tbat.
6. Isma' dak li l-persuna tkun qed tgħid. Tagħtix pariri. Jekk ma ssibx xi tgħid, tgħid xejn. Pero' ibqa' mall-persuna u ssapportjaha.
7. Tiġġudikax. Evita li toqgħod "tghati lezzjoni" lill-persuna dwar is-sbuhija tal-ħajja.
8. Għalkemm il-kunfidenzjalita hija mportanti, twiegħedx lill-persuna li m'intix ser tikxef il-pjanijiet tagħha. Fil-każ li l-persuna tafda l-ħsieb tagħha miegħek, għidilha li biex tgħinna inti wkoll ser ikollok bżonn l-għajnuna. Ċempel lit-tabib mmedjatament u tħallix lill-persuna waħedha.
9. Spjegalha li dan qed tagħmlu għall-gid tagħha u mhux għax ma tafdahix. Uri lill-persuna li inti interessat fiha u li għalik din il-persuna hija mportanti.

10. Offri tama lill-persuna kkonċernata, billi tgħidilha li hemm alternattivi oħra li għandhom jiġu kkunsidrati.

11. Toffrix tama falza. Eż: "Issa tara kif kollox imur sew". Dan biss juri li inti m'intix qed tifhem lil dak li jkun.

12. **HU AZZJONI. NEĦHI L-MEŻZI MINN IDEJN IL-PERSUNA. DAWN JISTGħU JKUNU ĊINTORIŊI, ĦBULA, SKIEKEN, VELENU, EĊĊ. GħALHEKK PUNT NUMRU 3 HUWA TA' MPORTANZA ENORMI.**

13. Fl-aħħar nett, fittex għajnuna għalik innifsek – Tkellem ma' xi ħadd li jifmhek u li jista' jgħinek.

Filwaqt illi napprezza l-artiklu ta' Rolheiser u l-messaġġ li jrid iwassal – dak li m'għandniex niġġudikaw lill-persuna u lil min jiġi minnha, ma nħossx illi għandna nieqfu hawn.

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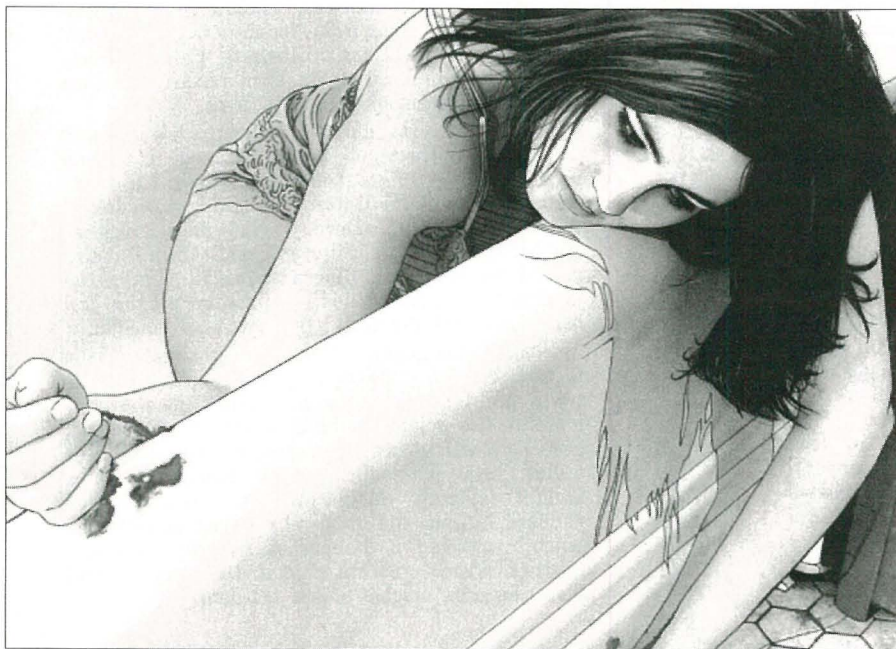
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Xi grajt...

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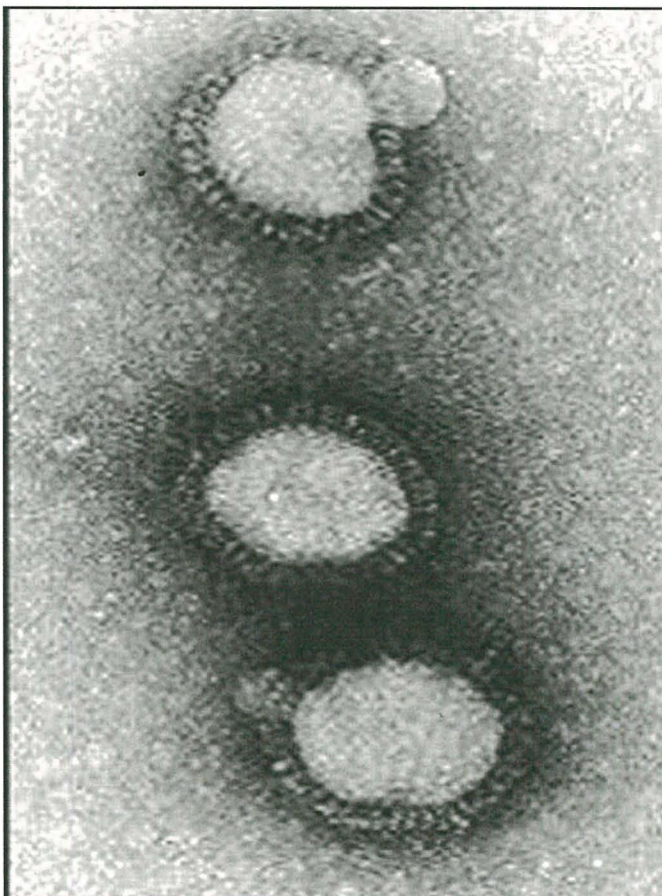
**"History of the Royal Malta Artillery"
ta' Brigadier A. Sammut Tagliaferro**

L-ISPANJOLA

L-Influenza Spanjola kienet il-kaġun ta' mhux anqas minn 651 mewt f'sitt xhur. Dan kien bejn l-1 ta' Settembru, 1918 u l-1 ta' Marzu, 1919.

Fil-ktieb tiegħu, il-Brigadier jagħmel riferenza speċjali għal din il-marda li hu jsemmi, li hi ġrajja li ma tistax tintesa u li s-sena 1919 tibqa' tissemma' għaliha għar-raġuni li l-RMA kienet affetwata biha.

Nikkwota mill-ktieb tiegħu: "L-influenza Spanjola ġiet fuqna mill-ewwel wara l-herba li ħalliet warajha l-Gwerra l-Kbira u malajr xterrdet mad-dinja kollha bla ma ħafritha la liż-żgħażaġh u lanqas lix-xjuħ, toqtol bla ħniena miljuni ta' nies, aktar milli kienu mietu aktar qabel jew waqt azzjoni, jew bil-mard fuq l-għelieqi maħsulin bid-demem waqt l-akbar Gwerra li qatt kienet saret sa dak iż-żmien fl-istorja. Il-pandemika waslet Malta tard fl-1918 u bejn l-1 ta' Settembru ta' dik is-sena u l-1 ta' Marzu tas-sena ta' wara kienu mietu mhux anqas minn 651 ruħ."



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SPONZATURI

Li sponzatura hi haġa tant lixxa u li tati r-ruħ lill marid li cull infermier għandu iċun jaf jagħmilha tajjeb. L-effett ta' li-sponzatura jidher hecc li l-marid li forsi iċun ilu granet ma jagħlak għaineih, wara sponzatura jorkod u jistrieħ, u hecc dawn li sponzaturi inakksu d-deni u jiccalmaw lill marid.

Li-sponzatura tista' ssir bżewġ modi: 1. Titkiegħed incirata fuk is-sodda u fuk l-incirata tinfirex cutra shuna. Fuk din jintedd il-marid imnażza', għarwien laham, u jitgħadda bi sponza mxarrba fil-mishun fietel (li miegħu jista' icollu f'it hall aromatieu). Din l-operazjoni għanda ssir malair u li-sponza għandha titgħadda minn nahha tas-sakain. Meta l-gisem iċun sponzat collu, l-gnieb tal-cutra li l-marid icollu tahtu jirtiegħu u jintnew fuk il-marid mingħajr ma wiehed jixxuttah; fuk il-cutra mitnija jitlegħed mil-gdid il-friex, u il-marid jithalla ewiet għal nofs siegħa jew għal siegħa u ma għandu wiehed jissiccah b-xejn hliet biex itih xi sustanzi. Wara li jgħaddi dan iż-żmien, tista' targa' tiltibes il-kmis ta' bil-lejl, u is-sodda tinfirex bhas-soltu.

(2). Meta d-deni hu kawwi u iċun jinhtieg li tibaxxa t-temperatura, l-isbah maniera hi chif sejrin ngħidu: - Il-marid jitlegħed fuk is-sodda għarwien bħal l-ewwel cas u li sponza titgħadda li-stess ucoll fuk il-gisem; imma floc li l-marid jitgħadda bil-cverta, jithalla jinxfel fl-aria u sa chemm die l-indewa, li teun halliet li-sponza fuku tinxfel, t-temperatura tinzel: dan jigi bis-sahlha ta' l-evaporazzjoni li tbaxxi t-temperatura. F'cas gravi jista' jitgħadda il gisem bl-ilma chiesah jew bis-silc.

Meta l-marid hu debbuli wisk floc ma jitgħadda l-gisem collu f-dakka, jista' jinchixef bičca bičca, u

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cull parti hecc miexufa titgħadda bli sponza għaliha sachemm hecc jitgħadda f'it f'it il-gisem collu.

PACC UMIDU CHIESAH

Dan hu mezz tajjeb hafna biex tbaxxi t-temperatura fid-deni u fxi mard iehor kawwi; u isir hecc: - Il-mitrah jitgħadda l-ewwelnett b-folia incirata u fuk din jitpoggeu żewġ faxex wisghin, mal wisa' tas-sodda, wahda in-nahha tar-ras, u l-ohra in-nahha tas-sakain: dawn il-faxex iridu iċunu itwal mil wisa' tas-sodda. Fuk il-faxex u l-incirata tinfirex cverta tas-suf hoxna, u fuk il-cverta liżar imxarrab fl-ilma chiesah u magħsur chemm jista' iċun.

Il-marid, mnażza' għarwien, jitpogga fuk il-liżar li wiehed idawwarlu tajjeb miegħu b-mod li l-marid iċun imgheżwer minn ghonku sa sakaih. Il-cverta tintafa' mbagħad fuk il-liżar u il-marid, u tiddahhal tajjeb taht genbein il-marid. L-infermier imbagħad idahhal ideih minn taht il-cverta taht sakain il-marid jarfa' l-gverta u jitwilu l-bičca taht sakaih, u mbagħad jirtabtu l-faxex fuk collox, u jixtehtu erbgha jew hames cutri fuk il-marid, li jirtassu wcoll miegħu.

Bħala regola generali l-marid ma għandux jithalla fil-pacc chiesah actar minn nofs-sigħa, u jecc f-dattul ta' hin, il-marid ma jibdiex jiccalma, jista' wiehed idewmu f'it actar; imma katt actar minn siegħa, għax jista' tih għaxwa. Sa chemm il-marid hu hecc milful, jista' jehu cull tant f'it ilma chiesah biex ighinlu l-gharak. Meta jitnehha l-pacc, wiehed jisponza l-gisem bl-ilma fietel; imbagħad jixxuttah tajjeb b-xugaman, u fl-ahharnett ighezwru mil-gdid f'cutra msahhna għal f'it siegħat. Dan jista' isir cull tlieta jew erba' siegħat fil-casi tad-deni.

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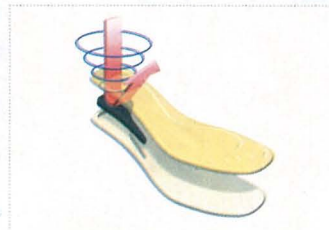
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