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MALTA NURSING AND MIDWIFERY JOURNAL

MALTA UNION OF MIDWIVES AND NURSES

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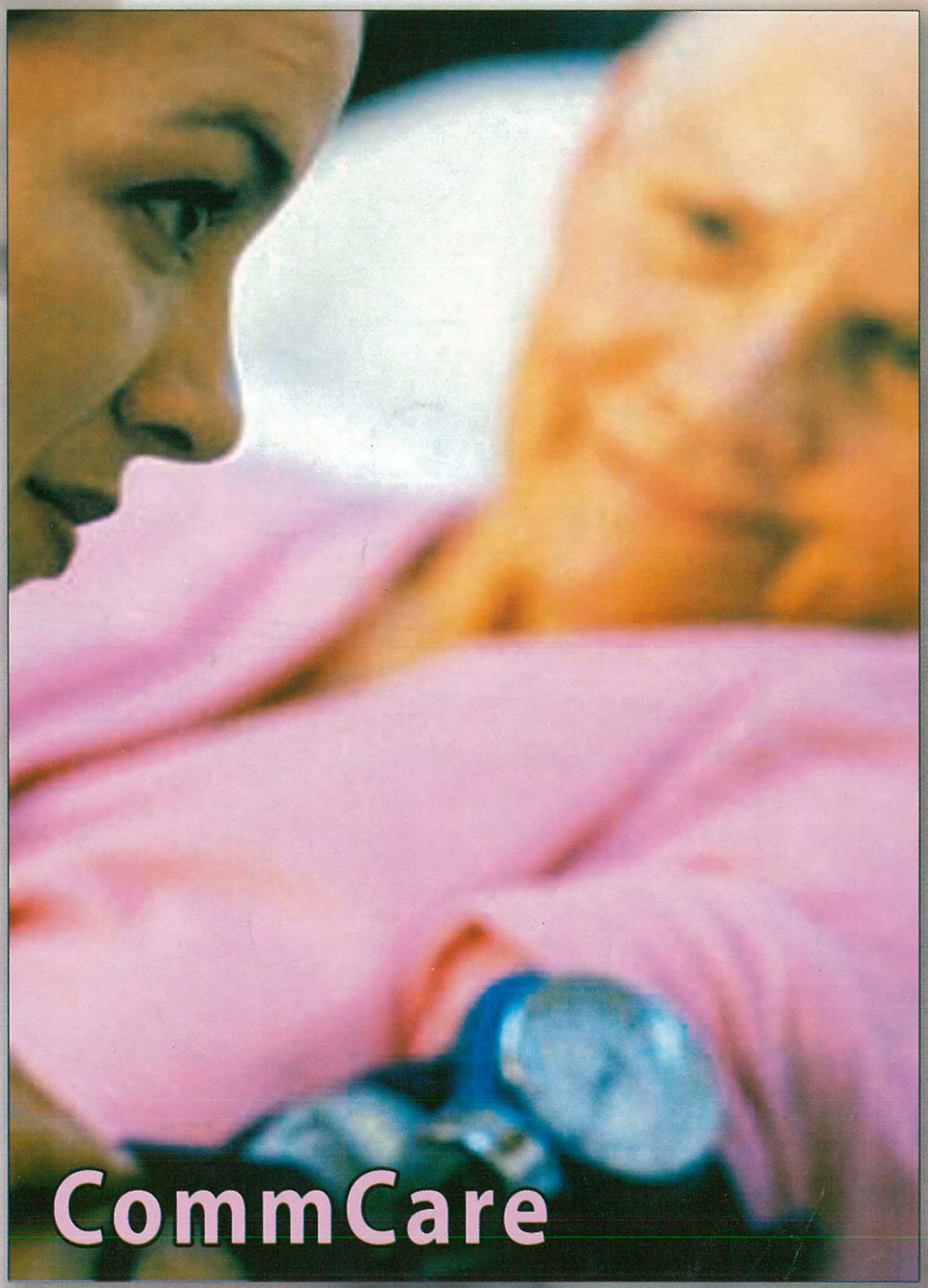

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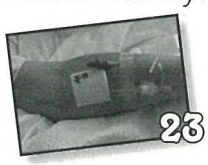
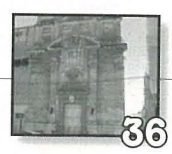
F'Din il-Ħarġa





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editorjal

Ħaddiema Nisa u l-Maternità

Id-drittijiet tal-impjieg dbiddlu mhux ftit mal-medda taż-żmien speċjalment meta kien mistenni b'mod awtomatiku li mara miżżewġa kellha tieqaf taħdem barra mid-dar. Ir-riżenja immedjata mill-impjieg ta' mara li tkun tqila kienet soċjalmet aċċettabbli.

In-normi soċjali u fatturi ekonomiċi biddlu dan kollu b'mod radikali u llum ħafna nisa, kemm jekk miżżewwġa jew ommijiet *single*, ħafna drabi jagħżlu li jibqgħu fl-impjieg matul it-tqala u wara. Mingħajr ma nidħlu fil-mertu ta' jekk dan hux tajjeb jew le, wieħed irid jaċċetta din bħala sitwazzjoni soċjali li qed tikber.

Leġislazzjonijiet differenti trattaw dawn il-bżonnijiet personali u soċjali. Mhux in-nisa kollha huma intiżi fuq das-suġġett u tajjeb infakkru d-drittijiet tal-mara tqila. Per eżempju: *Care responsibilities* m'humiex biss għan-nisa. Il-kura mhux biss immirata lejn trabi u tfal żagħar , iżda anke tfal ikbar li jkunu ma jifilħux, sieħeb jew sieħba ma jifilħux, ġenituri anzjani, eċċ. Din il-kura bażika relatata ma xogħol domestiku trid issir minn kull min hu 'responsabbli' u il-'carer'.

L-ewwel ħaġa mportanti li naċċennaw hi li impjegata tqila hija protetta bil-liġi u waqt li hi tqila ma tistax titkeċċa jew imġegħla tirreżenja. Mara tqila għandha d-dritt li tattendi l-klinika tal-*ante natal* jew appuntamenti mediċi anke waqt il-ħin tax-xogħol u hija intitolata għat-*time off* mingħajr ma jinqata' mil-paga jew jinqata' xi benefiċċju ieħor. Mill-banda l-oħra min iħaddem għandu d-dritt jistaqsi għal-dokumentazzjoni relevanti li juri l-ħinijiet tal-appuntamenti jew dokumentazzjoni oħra li vera attendejt. Huwa neċessarju li kull min qed iġorr tarbija ma jistax jiġi ddiskriminat għax huma bit-tqala, jew għax ma jifilħux waqt it-tqala, għalhekk ma tistax ma tieħux xi promozzjoni u l-anqas ma tista' tiġi irrifjutata li tapplika għal xogħol għax hija tqila. Meta jkun hemm każijiet bħal dawn imsemmija hemm il-Liġi tal-Ugwaljanza tan-Nisa u Rġiel li ilha tipproteġi l-ħaddiema mill-2003 bil-Kummissjoni Nazzjonali għall-Promozzjoni tal-Ugwaljanza bħala entita' li tara li l-liġijiet ma jinkisrux. L-MUMN ukoll, bħal dejjem tista' tgħin f'każijiet bħal dawn.

Meta mara tkun tqila waqt il-*probation*, kull impjegat jista' jitkeċċa mingħajr raġuni mogħtija minn min jimpjega.

Fuq il-post tax-xogħol, min iħaddem huwa marbut bil-liġi biex iqis x'riskji għas-saħħa jista' jaffetwa lill-mara tqila jew mara li qed tredda u jbiddel xogħolha kif hemm bżonn, biex b'hekk jipprotegi lilha u t-tarbija tagħha. Il-miżuri li jittieħdu għandhom ikunu sodisfaċenti skond l-OHSA. Meta r-riskju tas-saħħa ma jkunx jista' jitneħħa kompletament, jeżisti *leave* speċjali tal-maternita' li hu mħallas kompletament għal mhux aktar min tminn ġimgħat.

Mara tqila għandha d-dritt li tattendi l-klinika tal-*ante natal* jew appuntamenti mediċi anke waqt il-ħin tax-xogħol u hija intitolata għat-*time off* mingħajr ma jinqata' mil-paga jew jinqata' xi benefiċċju ieħor

Meta ż-żmien tat-tqala u t-treddieħ jgħaddu u r-riskji tas-saħħa jidhru li spiċċaw, il-mara trid terga' tidħol fil-posizzjoni li kellha qabel mingħajr konsegwenza għall-karriera tagħha.

Jidher li hemm konfuzjoni bejn il-*leave* tal-maternita' u *parental leave*. Kull mara tqila trid titħalla tieħu l-*leave* tal-maternita'. Il-liġi tindika li impjegati li jaħdmu 40 siegħa fil-ġimgħa huma intitolati għall-14-il ġimgħa *leave* tal-maternita', 13 minnhom kollha mħallsa, u ġimgħa mhux imħallsa. Nisa li jaħdmu 20 siegħa u aktar jieħdu *leave* pro-rata. Dawn imsemmija jitbiddlu xi ftit skond kuntratti individwali jew ftehim kollettiv. Biss jistgħu biss jiżdiedu u mhux jitnaqqsu. Dawn id-drittijiet huma għal kulħadd: *Part-timers; full-timers* jew xogħol b'siegħat imnaqqsa.

Il-*leave* tal-maternita' jista' jittieħed għall-perjodu ta' 14-il ġimgħa - erbgħa ġimgħat iridu jittieħdu qabel tixtri, u sitt ġimgħat wara. Il-ġranet li jibqgħu jistgħu jittieħdu għall bżonnijiet speċifiċi. Min iħaddem irid jiġi infurmat b'dawn id-deċiżjonijiet sabiex isiru l-arranġamenti meħtieġa.

Anke rigward il-*parental leave* jidher li hemm min ma jifihmiex biżżejjed. Dan jingħata kemm lin-nisa kif ukoll lill-irġiel. Dal-*leave* huwa *unpaid* u jista' jsir użu minnu sakemm it-tfal ikollhom tminn snin. Il-ġenituri huma intitolati għal sitt xhur bejniethom f'*parental leave* pero' il-*leave* individwali mhux trasferibbli. It-tlett xhur ta' kull ġenitur jistgħu ma jittiħdux f'daqqa imma skond il-bżonnijiet tal-individwu.

Għal meta jkun hemm ħtiġijiet mhux mistennija, hemm ukoll dak li nsejħulu *Urgent Family Leave*, fejn għandek 15-il siegħa ta' *time off* (pro rata) f'każi urgenti tal-familja. Hemm ukoll siegħat imnaqqsa ta' xogħol u *career breaks* bħala għażliet x'jista wieħed jieħu f'kazi bħal dawn.

Għalkemm għandna l-liġijiet, hemm ħafna aktar x'jinħtieġ biex nassistu n-nisa fl-imjieg u fil-ħajja tal-omm. Id-drittijiet tal-ommijiet huma importanti mmems f'dinja li qed tevolvi, speċjalment meta qed inħeġġuhom biex iżommu sod kemm mal-familja u anke f'affarijiet oħra.

message from the president

Dear colleagues,

I am sure that by now most of you know that I shall be stepping down from my role as President of MUMN as from the 29th March 2007. That is after a new Council shall be elected during the General Conference, which I shall have the honour to preside. I must admit that it is difficult to leave MUMN after being 11 years in the helm. I believe deeply in this Organisation of ours and believe in its purpose but I am confident that my timing to step down is right. It has been agreed to introduce a new clause in our constitution that limits the term of office of the President to three Terms. I fulfilled these criteria as I had my share of three terms by the end of March 2007.

Allow me to go back in time and for my last article as President I wish to take you all through the journey of our success. Mind you, the successes we achieved were never given to us on a silver plate, it was a roller coaster ride filled with determination by all to reach our objective. We managed because we believed in ourselves and believed in the potential one can have in being united. We are what and where we are today, with the contribution, minimal as it may seem, of each and every one of you. I could not have succeeded in this venture alone but I needed your support and I was fortunate enough to have for three consecutive terms a good team elected with me to lead you.

Today I am proud to leave a sound Organisation that is well established not only in the local field of trade unionism but also internationally. We made huge strides as from the 19th September 1996, the birthday of MUMN. Nurses and midwives are now united as one big family with a membership of 98.6%. As from day one we never looked back and established ourselves more and more each day. The aim of this Organisation was to represent our professions and doing so by keeping near our members. For this reason we embarked in setting up offices in each hospital around the Islands. These were complimented with a central office, which we rented at Fgura. Being a proactive and ambitious Organisation we did not settle for this and changed our central office after purchasing one of our own just across the road the New Hospital.

During these eleven years, with your support, we have experienced lots of progresses not just from a financial point of view but also professionally. New concepts were achieved that made us be envied by others such as the Continuing Professional Development support. We have witnessed the proliferation of Specialisation in several nursing practices. The office of the Director Nursing Services was restructured and now the process of engaging Nurses and Midwives in the new role of Assistant Directors with the Nursing Directorate is round the corner.

Internationally MUMN is affiliated with five Organisations and I am also one of the 15 elected world wide as Member in the Board of the Directors of the International Council of Nurses (ICN). This proves the level of respect Maltese nurses and midwives enjoy from our colleagues abroad. Such is the esteem that we are given the task and responsibility to host the ICN Conference in 2011 here in Malta.

In conclusion I must say that I look back in pride of what we did together and how much more can we achieve in the future by being united. We had an exciting time but the future is even more, with the opening of the new hospital and conferences as mentioned. I must say that we still need to pursue after two principles that I regret to say did not achieve during my term of office; the granting of a warrant to practice the nursing profession and the never-ending saga to introduce an early retirement scheme.

I take this opportunity to thank, first all those of you, who supported me and gave me the stimulus to go on. I thank all my friends who are leading other Trade Unions in Malta and wish them the best of luck and augur to maintain the great relationship we built together.

I thank all the local media for their assistance, as their coverage was an asset in our plights. I thank the local Health Authorities and Politicians for giving me the opportunity to work together even though there were times that we disagreed, our main objective was common, that to give the best care to our patients.

I thank all my Colleagues abroad with whom I had the opportunity to meet and my colleagues within the Union structure especially the Council. Last but not least I thank you because I could not be the President of MUMN without your presence.

I augur you all the best of times and encourage you to continue to support our Organisation.

Thank you

Rudolph Cini

President

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Entering the Patient's World

My Judeo-Christian faith informs me that God is a good listener. In the book of Exodus, God says to Moses "I have seen the affliction of my people who are in Egypt, and have heard their cry... *(Exod 3, 7)*. If God presents himself as a good listen since he hears the cries of his people, and knows their suffering, how much more the chaplain is to know the cries and the suffering of the patiens whom s/he is ministering to. The key attitude, which gives the chaplain access to the world of the patient, is listening. But how can one listen?

The first challenge that the chaplain undergoes in her/his ministry with patients is how to get out of the saviour complex role. A good chaplain is surely not the one who has a quick fix answer for everything. It is surely not in her/his own competence to give answers, giving advice and wise words, even if they are intended to "lift the spirit" or appear to be the perfect solution for the patients' problems.

During the pastoral conversation, there can be a prolonged moment of silence. What happens is that the patient may need more time to think, continue, change the subject matter of the conversation, express her/his emotions, or simply enjoy the comforting company of the chaplain. It is of paramount importance that the chaplain holds herself/himself back in order to give, respect and protect the patient's sacred space. Hence, waiting is essential.

A good chaplain is surely not the one who has a quick fix answer for everything

A caring chaplain is one who not only listens to the content of what is being said, but ***how*** it is being said. Ears and eyes are to walk hand-in-hand in the art of listening. The patient's nonverbal cues can be of great help in order for the chaplain to better listen what are the patient's major concerns. Sometimes, the patient says one thing and by her/his gestures shows another side of the story. For instance, a patient says that s/he is not angry but her/his flushed face is saying quite another thing. It would be wise for the chaplain to gently confront the patient by saying something like: "I know you say that everything is going fine with you, but your face is red and you do look upset". In this way, the chaplain is kindly challenging the dissonance of the patient.

A pastoral relationship is always a two-way endeavour. Thus, the chaplain needs also to see what nonverbal messages s/he is conveying to the patients under her/his care. Unfortunately it can happen that a chaplain may absolutely forget that the patient is also monitoring the way s/he is behaving with her/him. It is so easy that the chaplain may respond to something which either the patient did not say or else that s/he misunderstood in the first place. Also, the chaplain can be caring by the way s/he responds to the patient but her/his gestures or restlessness is showing to the patient to stop abruptly her/his conversation because the former is tired or needs to visit other patients in the ward. Thus, by monitoring her/his nonverbal communications the chaplain is being more in touch with her/his own feelings, while at the same time s/he is in a better position to listen with openness to the patient's concerns.

Listening is an ongoing complex process. It means being prepared to listen to those things which you like and do not like to listen. If the chaplain is courageous enough to earth herself/himself with the patient's story and befriend it, the latter will have the great benefit of having a faithful companion in her/his own search for meaning. And what a healing experience will it be for the patient when s/he encounters a chaplain who is so empathic and accepting!

Fr. Mario Attard OFM Cap
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kelmtejn mis-segretarju ġenerali

Il-Kunsill tal-Union iddeċieda li fuq l-Isptar Mater Dei jinforma lill-pubbliku bin-nuqqas ta' diskussjonijiet preżenti minn naħa tal-Gvern. Id-diskussjonijiet kellhom isiru fuq żewġ livelli: ma l-*Management* ta' l-Isptar San Luqa u diskussjonijiet oħra fuq livell ieħor, mad-Direttur Generali. l-MUMN fuq dawn ta' l-aħħar, l-aktar li hija prejokkupata u bir-raġun.

Mad-Director Ġenerali iridu jiġu diskussi materji bħall: minn fejn qed jaħseb li ser jiġu n-Nurses nieqsa mill-*compliment*, kif ser jibda' jitħaddem l-Out-Patients Department, in-nuqqas ta' *supporting staff*, in-nuqqas ta' ħruġ għall-sejħiet għall-applikazzjoni ta' *Nursing Officers, Deputy Nursing Officers, Specialist Nurses* eċċ. Dawn huma deċizjonijiet li ma jistax joħodhom il-*Management* ta' l-Isptar San Luqa. Dawn huma l-aktar punti kruċjali. Mhux għax il-parkeġġ, il-*canteen* jew iċ-*childminding* mhumiex, tifmhuniex ħażin, imma dawn bid-diskussjonijiet madwar mejda naslu biex insibu ftehim fuqhom mal-*Management* ta' l-Isptar San Luqa.

L-istess fuq l-Iskema tal-Irtirar Kmieni: Il-Gvern ma jistax jew ma jridx jifhem li din l-iskema, barra li hi għall-benefiċċju tan-Nurses u l-Midwives, li ma jkunux jifilħu aktar jaħdmu minhabba l-età, hija wkoll ta' benefiċċju għal pajjiżna in ġenerali fuq diversi aspetti. L-ewwel nett ser tattira numru konsiderevoli ta' Nurses ġodda, għaliex ngħiduha kif inhi, il-professjoni tagħna mhix daqshekk attrajenti, u b'hekk jibda' jissolva n-nuqqas kbir ta' Nurses, u t-tieni, kemm il-pazjenti kif ukoll in-Nurses kollegi, ħadd ma jkun irid jiġi ttrattat jew jaħdem ma Nurse, li minħabba l-eta' ma tkunx tiflaħ taħdem aktar dan it-tip ta' xogħol. Issa aktar u aktar li l-eta' ta' l-irtirar żdiedet ! Għaldaqstant nistieden lill-Gvern biex impoġġu bis-serjeta' madwar il-mejda biex insibu soluzzjoni u b'hekk jiġi ffrankat bosta tilwim industrijali bla bżonn.

Għaddew erba' snin bħal berqa. Kultant ma nemminx kif erġajna wasalna għall-elezzjoni sabiex jinħatar Kunsill ġdid għal erba' snin li ġejjin. Għamilna ħafna xogħol u mingħajr tlaqliq ngħid li għad baqa' wkoll xi ngiddmu. Nirringrazzja lill-Membri kollha tal-Kunsill għall-ħidma fejjieda li wettqu fl-interess taż-żewġ professjonijiet speċjalment lill-President Rudolph Cini li dejjem kellu viżjoni fejn irid jasal u bil-perswazjoni tiegħu kien ta' stimolu għall-Membri l-oħra tal-Kunsill b'mod speċjali f'sitwazzjonijiet diffiċli.

Impressjonat ħafna bil-hidma li qed iwettqu il-*Group Committees* tal-Union f'kull sptar. Daħlu mill-ewwel fis-sistema u qed jagħmlu d-differenza. Prosit minn qalbi liċ-*Chairpersons* u s-Segretarji li qed imexxu bil-għaqal, kif ukoll lill-Membri tal-Kumitati li kulħadd qed jagħmel il-biċċa tiegħu u aktar. Prosit ukoll imur għall-Florence Nightingale Benevolent Fund li ġie vvutat l-aktar *Group Committee* li stinka u rsista matul is-sena li għaddiet.

Fl-aħħar u mhux l-anqas irrid nagħmel kuraġġ lill-kandidati li ser jikkontestaw l-elezzjoni sabiex ma jaqtgħux qalbhom għaliex meta l-ħidma kienet kollettiva, bi sforz wieħed, is-suċċess fl-MUMN qatt ma naqas, anzi dejjem iffjorixxa f'aktar milli mistenni.

Nieħu l-okkażżjoni sabiex nifraħ lilkom u l-familji tagħkom: Għid ħieni u mimli barka.

Colin Galea
Segretarju Generali
❑ mumn@maltanet.net

Toby Hayes
Director, Fund and Manager Selection
Insight Investment Management Limited

The Success of the La Valette Multi Manager Property Fund

Valletta Fund Management Limited in co-operation with Insight Investment Management Limited launched the La Valette Multi Manager Property Fund in September 2005. The launch was a resounding success with over €10million raised over the launch. Subsequently, asset growth has continued to be strong throughout 2006 and the Fund as at 3 January 2007 was over €60million in size. Performance for the Fund has also mirrored the asset growth as the Fund has generated strong stable returns consistently throughout the year. Total annualised return from launch on the 13 September 2005 to 3 January 2007 was 11.53%*, which was slightly above expectations at the time of launch. The Fund has achieved these returns with very low volatility as well as very low correlation to equity markets. This has primarily been achieved due to the Fund's focus on underlying funds that invest directly into real estate property rather than investing in indirect property funds. Direct property funds give exposure to actual bricks and mortar while indirect property funds give exposure to the equity of property companies and as such, these investments typically show higher levels of volatility and higher correlation with the equity markets. Moving forward, the Fund intends to continue to focus mainly on direct property funds to give investors the most pure exposure to the property asset class. While direct property funds were also a solid contributor to returns over the year, tactical allocations to undervalued markets, such as Asia, also added value. The small allocation to Asian property away from UK property enabled the Fund to capture the yield premium that Asian real estate property has over government securities, as well as benefit from a region that is in early stages of the property cycle. Moving forward, the Fund intends to maintain a small allocation to Asian real estate property markets. The Fund also intends to retain lower exposure in the UK in favour of core Euro zone markets as valuations, as measured by yield levels, have become extremely stretched in the UK, yet still offer significant upside in Europe. German property is a particular case in point, with valuations now at extremely attractive levels versus other European regions. Given the move away from UK property to Euro zone property, the Fund should experience less exchange rate volatility, so the Sub-Investment Manager expects returns moving forward to be at similar levels already experienced.

Past performance is not necessarily a guide to future performance.

Disclaimer

*The Annualised Return is an indication of the average return of the Fund over one year. In view that the Fund distributes income, such Annualised Return is based on the share price prevailing on the 3 January 2007 and the reinvestment of income distribution (net of 15% withholding tax). Any sharp fluctuations in the performance of the Fund over a period of time are not necessarily represented by the Annualised Return indicated.

The value of the investment may fall as well as rise and currency fluctuations may affect the value of the investment. Investors are advised that real estate property is inherently subjective as regards value due to the individual nature of each property. Hence, there is no assurance that the valuations of the Fund's underlying investments will reflect the actual property value. Investment in the real estate property market is, by its nature, relatively illiquid and therefore, redemption requests may be deferred or suspended as more fully described in the Supplementary Prospectus.

Investments should be based on the full details of the Supplementary Prospectus, which may be obtained from Valletta Fund Management Limited ("VFM"), Bank of Valletta Branches and other licensed financial intermediaries. The La Valette Multi Manager Property Fund is licensed by the MFSA as a Professional Investor Fund and may only be promoted to Experienced Investors. Professional Investor Funds ("PIFs") are not subject to the restrictions on their investment or borrowing powers that retail schemes are normally subject to and the degree of risk to which they may be exposed makes them unsuitable for members of the general public. VFM is licensed by the MFSA. Issued by VFM of Level 6, The Mall Offices, The Mall, Floriana, FRN 1470. Tel: 21227311, Fax: 21234565, Email: infovfm@vfm.com.mt, Website: www.vfm.com.mt

My child... A survivor in a world of struggles

On the 3rd of April 2006, I gave birth to a beautiful baby girl by the name of Cheyenne by means of a normal delivery. Like every other mother having her first child, I was overwhelmed with joy and happiness. Everything seemed to be so perfect until when my daughter was 4 months old, when on a monthly routine check up at the paediatrician we were told that our daughter had a heart murmur. According to Brunner & Suddarth (1997) it is an increased turbulent blood flow through the heart. My mind did not rest and the following morning I took my daughter to an echocardiogram; a non-invasive test using ultrasonography to evaluate changes in heart structure and function (Burrell, 2001), where she was diagnosed with Congenital Aortic Stenosis, a narrowing of the orifice between the left ventricle and the aorta which causes an obstruction to the systolic ejection of blood from the left ventricle into the ascending aorta (Gerlock & Pless '97). After being diagnosed with a congenital heart defect, she was constantly being followed up with echocardiograms and ECGs. Her management plan was to be admitted for a valvuloplasty; the repair, rather than the replacement of a cardiac valve, in 2 months time.

Having passed through all this, I began to ask myself; why a child?

This was not all. By the age of 6 months Cheyenne developed focal seizures where later, after several investigations she was diagnosed with congenital right-sided hemiplegia (paralysis of the right side). This was secondary to an antenatal left middle cerebral territory infarct.

Having passed through all this, I began to ask myself; why a child?

Time passed, Chey was readmitted for valvuloplasty where post procedure she developed an absence of pulse in her leg; her right leg was turning cold and was immediately started on Heparin (an anti-coagulant therapy), with no effect. Then Streptokinase was administered, and the pulse could be felt. However, the following morning my daughter was bleeding profusely from the insertion site. This is a vivid picture that will remain in my mind, never to be forgotten. This made my daughter struggle for her life and was transferred to SCBU. Unbelievably enough, Chey recovered well and the following morning she was retransferred to D'Land Ward, and after she recovered she was discharged home.

Having passed through all this, I began to ask myself; why a child? Why my child? Why not me? I often stated that life is unfair. I often became dispassionate about everyday life and wondered what life is all about. I often feel tired, frustrated, angry, heartbroken and in pain. But after passing through this stage somewhere down this journey I realised that this is how it is. It is not an easy life, but I look at it as a challenge. I realised how much love I have to give her, how much joy, happiness, wonder and excitement she brought into my life and how much I am lucky to be a mother of a beautiful girl.

My daughter has struggled to make it this far. Now, she is 9 months old. She is able to vocalise responsively, opens her right hand which used to keep clenched, do passive exercises, is being able to sit and stand up supportively, explores with her food and reaching milestones gradually. She gives me encouragement to continue to struggle with her each day and although in a world of struggles, she is my greatest gift.

I would like to thank God for the ability and strength that he gave me, which I needed most to accept, move on and to continue to struggle every day with my daughter. My profound appreciation is to the Nursing staff at D'Land Ward for their constant support, caring and dedication. I am also grateful to the staff at SCBU and my colleagues at WS1. I am also so thankful to the physiotherapists and OT's at CDAU for their guidance.

Finally special thanks goes to our family for their support, my husband Mark who put up with me during difficult moments, Jackie Rizzo for all she does for my daughter to help her lead an independent life, my best friend Lara at M5 for always being there when I need her mostly, Kevin at S3 and Annise at the Main laboratory for helping me out. All the others too, who gave me strength to go on and to come out of this trauma.

CAROL SPITERI, SN WS 1 SLH

STRESS IN THE NURSING AND MIDWIFERY WORLD

ONE-DAY CONFERENCE

DATE: 20th APRIL 2007

VENUE: NEW DOLMEN HOTEL, QAWRA

The Florence Nightingale (MUMN) Benevolent Fund in collaboration with the Education Committee of the MUMN is holding a one-day Conference regarding *Stress in the Nursing and Midwifery World.*

Nursing was chosen as one of the occupations on which the ILO has commissioned a manual on stress prevention in 1996. Hingley (1994) stated, "Everyday the nurse confronts stark suffering, grief and death as few other people do. Many nursing tasks are mundane and unrewarding. Many are, by normal standards, distasteful and disgusting. Others are often degrading; some are simply frightening."

Job stress is the harmful emotional and physical reactions resulting from the interactions between the worker and her/his work environment where the demands of the job exceed the worker's capabilities and resources. When we are under stress our bodies prepare for a "fight or flight response": adrenaline, cholesterol, and sugar are released into the bloodstream. Some commonly felt experiences are anxiety or panic attacks, migraine headaches, stomach problems, back problems, racing heart beat, dizziness, sweaty hands, and dry mouth. A certain amount of stress is required to live and enjoy life, however, when we are under unremitting stress or if we do not deal with it properly, we cause wear and tear on our bodies leading to physical and psychological problems such as depression and hypertension. Major Sources of Stress for Nurses include:

1. Dealing with death and dying.
2. Conflict with colleagues, including supervisors and other health care professionals.
3. Inadequate preparation to deal with the emotional needs of patients and their families.
4. Lack of staff support.
5. Workload.
6. Uncertainty concerning treatment plans.

These sources will be discussed by different distinguished speakers at this Conference, amongst which are: Mr.Andrew Xuereb, Director H.R SLH/MDH; Dr.Anton Grech, Psychiatrist; Mr.Martin Ward, Mental Health Nursing Consultant; Ms.Tania Farrugia, B.Psy.Hons; Mr. Joe Camilleri N.O., Resuscitation Officer.

The Hon. Mr.Mario Galea MP will open the Conference. Mr.Galea is a colleague staff nurse by profession and a politician who certainly has a good insight of what stress really is! Your attendance will encourage us to continue organising such Conferences that will certainly leave a good effect in our professional and social life.

George Saliba
Chairperson FNBF (MUMN)
❑ mumn@maltanet.net

Xogħol Volontarju ġewwa Lourdes

Minħabba l-fatt li kien hemm ħafna xogħol xi jsir, il-preparamenti bdew ħames xhur qabel

Aħna, **Josette Parnis** u **Lilian Polidano**, żewġ infermiera tar-Renal Unit iddeċidejna li mmorru erbat ijiem Lourdes bħala voluntiera. Konna ser indumu mill-4 sat-8 ta' Settembru 2006 ma' l-għaqda ta' l-AVL li tfisser Assoċjazzjoni Voluntiera Lourdes. Ħames pazjenti mir-Renal Unit iddeċidew li jmorru Lourdes. Kien hemm aktar li kienu imħajrin iżda iċ-ċirkostanzi mhux dejjem ippermettew għax kien hemm min jew minħabba mard jew minħabba biża', qata' qalbu! Minħabba l-fatt li kien hemm ħafna xogħol xi jsir, il-preparamenti bdew ħames xhur qabel. Fost il-ħafna xogħol li ried isir, ridna nibbukjaw magna tal-kliewi għax kif tafu, dawn il-pazjenti ma jistgħux jgħaddu bla magna.

Il-pazjenti kienu lkoll entużjasti li ser jmorru jaraw Santwarju tal-Madonna. Kollha kellhom intenzjoni differenti. Kien hemm min kellu intenzjoni li jrid ifieq jew iħossu aħjar, jew għax ried li jvarja mill-ħajja monotona ta' kuljum!

Minħabba l-fatt li kien hemm ħafna xogħol xi jsir, il-preparamenti bdew ħames xhur qabel

Fl-aħħar il-ġurnata waslet. Tlaqna minn Malta fl-4 ta' Settembru fit-tlieta u nofs ta' fil-għodu. Billi f'dan il-pellegrinaġġ il-maġġoranza kienet morda ma kienitx faċli biex ittellgħa u tniżżel dawk il-pazjenti għax il-maġġor parti kienu f'*wheelchair*. Barra mill-pazjenti tar-Renal Unit kien hemm pazjenti oħra li riedu għajnuna kontinwa. Meta wasalna il-lukanda li kienet qiegħda fi Franza sibna lest għalina l-kolazzjon. Wara, kulħadd mar jistrieħ ġol-kamra tiegħu. Kellna programm mimli daqs bajda. Kont nikkonfondi xi ftit kif ser jagħmlu dak il-ħin kollu barra l-pazjenti. Iżda bl-għajnuna tal-*helpers*, l-infermiera u t-tobba, u tal-Madonna, l-pazjenti xejn ma tilfu mill-attivitajiet. Donnhom kienet ġiethom ċerta saħħa u enerġija. Konna noħorġuhom ukoll fil-għaxija u mmorru nixorbu xi ħaġa. Ħafna drabi konna nġebbdu sa' nofs il-lejl. L-aktar ħaġa intensiva li l-pazjenti esperjenzaw kienet il-ħasil fil-banjijiet mirakoluži u l-grotta talMadonna. Il-paċi u s-sliem li hemm ma tistax tiddiskrivieh. U xi ngħidu għal-purċissjoni tal-Aux Flambeaux?

Mil-pazjenti li kellna ħadd minnhom ma kien siefer qabel jew għamel xi trattament barra minn Malta. Il-ġurnata tas-6 ta' Settembru waslet u f'din il-ġurnata għamlu d-*dialysis*. Morna magħhom bħala *support* u biex inserħulhom rashom li kollox kellhom ippreparat.

Franza il-lingwa hija diffiċli, billi hemm jitkellmu bit-Taljan jew bil-Franċiż u ftit li xejn bl- Ingliż. Din il-ħaġa għall-pazjenti kienet xi ftit jew wisq diffiċli. Erbgħa siegħat għaddew b'wiċċ il-ġid u l-pazjenti ħargu lkoll sodisfatti u kuntenti u komplew mal-programm li kellna. Għalkemm għalina l-infermiera ma kinitx vaganza għax ghajjejna u ħdimna ħafna biex kollox imur b'wiċċ il-ġid, konna sodisfatti bix-xogħol li wettaqna. Aħna tajna

opportunità lil-dawk il-pazjenti li bis-saħħa u l-għajnuna tagħna u tal-Madonna ta' Lourdes irnexxielhom isiefru.

Wara li wasalna Malta dawn il-pazjenti qasmu l-esperjenza tagħhom mal-pazjenti l-oħra u wrewhom ix-xewqa li xtaqu jerggħu jmorru Lourdes.

Il- pazjenti tagħna riedu mbuttatura u kliem ta' kuraġġ biex għamlu din il-mawra. Jien nixtieq minn qalbi nirringrazzja lill-Madonna ta' Lourdes li naf żgur li bis-saħħa tagħha għenitna biex dan kollu kien ta' suċċess!

Josette Parnis SN
Renal Unit-SLH
❑ jparnis@maltanet.net

S. L. H. / M. D. H. Group Committee

Ħidmet il-*Group Committee* S.L.H./K.G.H.

Il-kumitat iltaqgħa darba fix-xahar. Kellna laqgħat ukoll mas-C.E.O Ms M.Rizzo, s-Sur J.Sharples u s-Sur M.Bezzina.

Fost affarijiet diskussi kien hemm:

- Riżorsi umani għad-dipartimenti tal-kirurġija u ortopedija għall-M.D.H.
- Nuqqas ta *Portering System*
- Il-*compliment* tas-sodod
- Id-distribuzzjoni ta mediċini għall-pazjenti
- Id-distribuzzjoni ta' mediċini għall-istaff
- L-ikel ta l-istaff
- Operazzjonijiet li jsiru wara l-ħin u l-listi esaġerati t'operazzjonijiet
- Il-*parking* ta l-istaff
- L-uniformijiet

Apparti dawn l-affarijiet kellna laqgħat b'urġenza dwar id-distribuzzjoni ta' mediċina għall-istaff li wara diskussjoni mal-Union ġew irranġati l-affarijiet.

Dwar il-*Casualty Department* saru laqgħat ukoll u issa bi ftehim mal-Union inħatar *working group* biex l-affarijiet ma jibqgħux sejrin għall-agħar.

Rigward l-*overcrowding* fis-swali tal-mediċina u fi swali oħra ġenerali sar enfasi għal soluzzjoni u sa anke intalab kumpens jekk jibqgħu l-affarijiet kif inhuma.

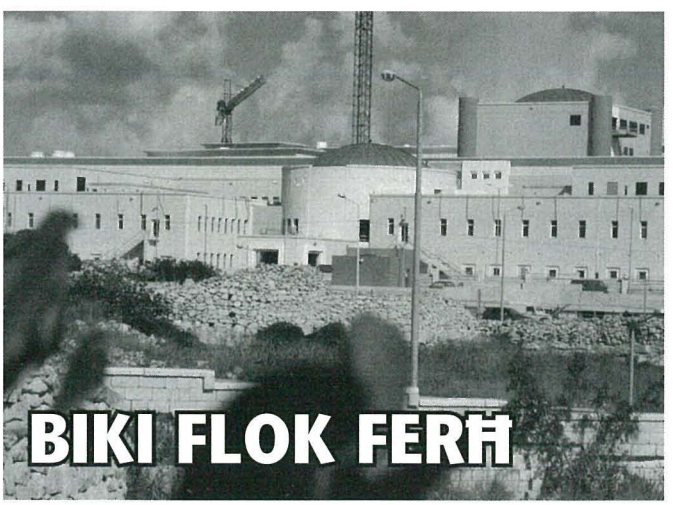
Saret l-ewwel laqgħa mas-C.E.O. dwar il-*migration plan*.

Il-kumitat ħa sehem ukoll fil-konferenza stampa li saret dan l-aħħar ħdejn il-Mater Dei Hospital.

Biex il-membri jkunu nfurmati qed nerġgħu noħorġu n-*newsletter* fuq in-*notice boards*.

Il-kumitat ħeġġeġ lill-membri biex jibqgħu attivi filwaqt li jsostni l-impenn tiegħu għaż-żminijiet futuri.

Thomas Agius
Segretarju *Group Committee* MUMN SLH/MDH



Ritratt: Joe Camilleri

Nies ħosbiena, oħrajn inkwetati, xi wħud qalbhom sewda u ma tista' tkellem lil ħadd għax kważi kulħadd bil-geddum. Hekk tkun ix-xena ta' madwar il-moribond. X'jiswa li jkun hemm min jipprova jsabbar lill-qraba li wara din id-dinja hemm oħra. Xorta jkun hemm min jolfoq bil-biki, allavolja jisma' li l-hekk imsejjaħ moribond, wara li jmut, il-ġenna jisthoqqlu għax veru kien bniedem tajjeb. Meta noqgħod naħseb fuq din ix-xena, ngħid: għala flok nifirħu nagħmlu d-dwejjaq. Għax ngħiduha kif inhi, jekk xi hadd jifhem li min jitlaq minn din-dinja se jkun aħjar, għandu biex jitgħaxxaq. Mela xi ħaga li m'aħniex nagħmlu sew hemm żgur.

Inħoss li min suppost iwassal il-veru messaġġ, mhux jagħmlu fil-ħin u b'hekk tinħoloq l-inċertezza minħabba nuqqas ta' komunikazzjoni kif għandha tkun.

Din l-immaġinazzjoni iġġegħlni nirrifletti xi ħaga li kważi qed ngħixa ta' kuljum. Kulħadd jaf li ser isir trasferiment ta' l-isptar San Luqa għall-Mater Dei. Dan l-isptar ser ikun aħjar, isbaħ u iktar komdu. Mela għala l-impjegati jħossuhom inċerti dwar il-kundizzjonijiet tagħhom ta' meta se jmorru l-M.D.H.? Ejja nkunu iktar ċari u nispjegaw lill-ħaddiema l-affarijiet kollha kif ser ikunu u li ħadd mhu se jnaqqas mill-benefiċċji li jkun akkwista matul iż-żmien. Kulħadd għandu rasu fuq għonqu u min hu responsabbli jaf li ħafna mill-impjegati huma nċerti u li għandhom ħafna dubji jew mistoqsijiet x'jagħmlu. Ejja nneħħu l-ħsibijiet ħżiena. Kollox fuq kollox nafu li kull bidla ġġib rejazzjoni. Dan għandu jsir għall-ġid ta' kulħadd jekk ma rridux li l-affarijiet jiġu mposti kontra x-xewqat tagħna, għax inkella jista' jagħti iċ-ċans li l-impjegati jaħdmu kontra qalbhom u taħt stress. Dan m'għandux ikun.

Għall-grazzja ta l-argument, dan l-aħħar tfaċċa xaqq dawl u bdew isiru xi taħditiet. B'hekk l-impjegat ikun jista' jaħdem kuntent u jgħati l-aħjar servizz li jista'.

Thomas Agius SN
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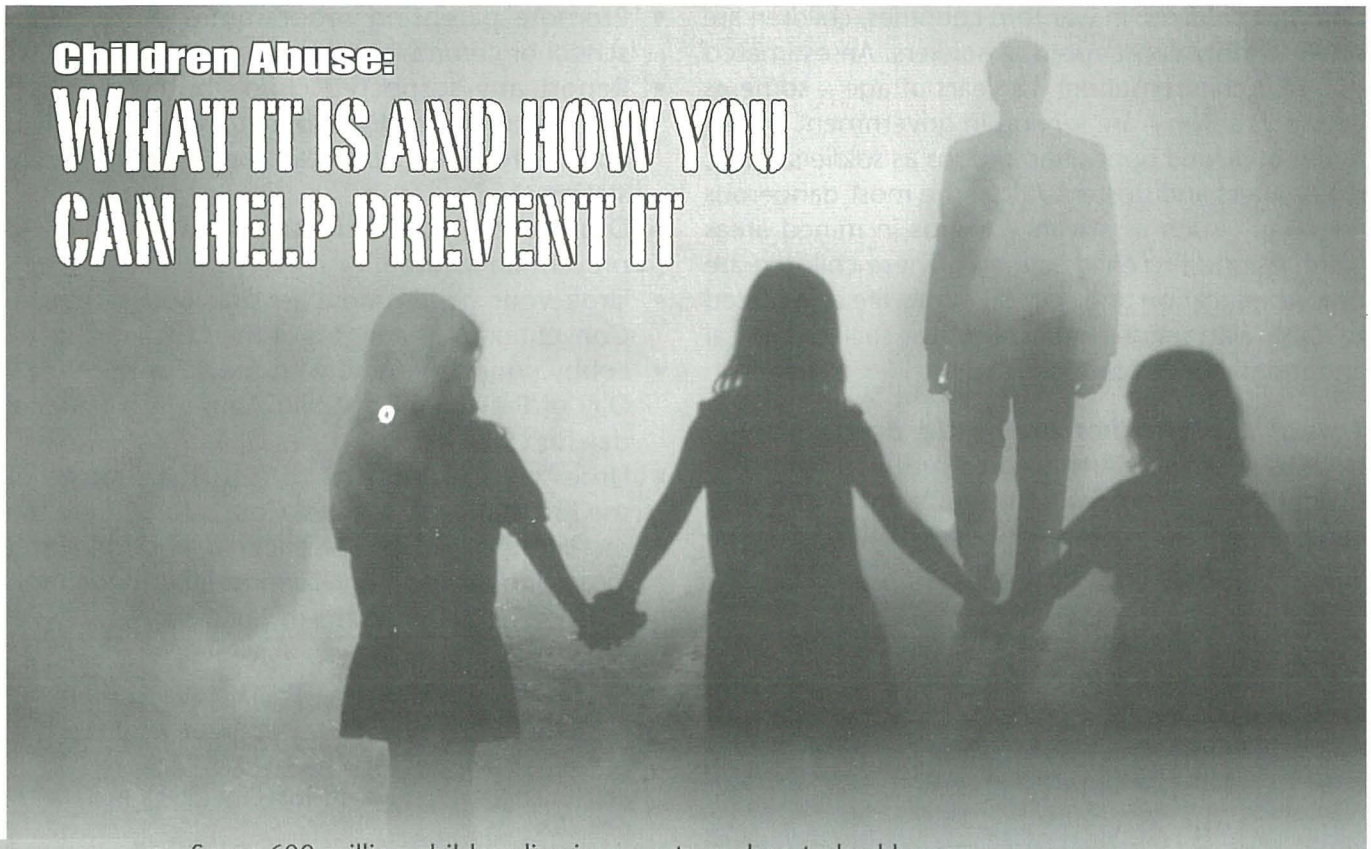
Children Abuse: WHAT IT IS AND HOW YOU CAN HELP PREVENT IT



- Some 600 million children live in poverty and go to bed hungry.
- About one million children, mainly girls, are forced into the multi-billion dollar commercial sex trade every year.
- An estimated 1.4 million children under age of 15 years are living with HIV/AIDS.
- 8.000 to 10.000 children are killed or maimed by landmines each year.
- Approximately 250 million children between the age of 5 and 14 are in the labour market.
- As many as 250,000 children – some as young as seven – are serving in government armed forces or armed opposition groups as soldiers, spies, messengers and porters.
- One third of all the births in the world go unrecorded, and 40 million babies every year join those who will spend the rest of their lives without an official identity or citizenship.

Patient Talk!

What is child abuse?

Child abuse includes physical injury, emotional abuse, child labour, child soldiers and sexual abuse, including use of children for pornography. Children can suffer a single type of abuse or a combination of several forms such that physically abuse children are also often neglected and emotionally abused. All abuse is damaging to children's physical and emotional development.

Physical Abuse: Battering, in which physical injury is inflicted on children, is the most common form of abuse. This can range from single or repeated incidents of inappropriately punishing a child (smacking with a cane or belt, smacking the head or face, or smacking that leaves a mark or bruise) to serious shaking, punching, kicking, strangulation, scalding or burning[1].

Emotion Abuse: Emotional abuse is verbal rather than physical harm. It includes consistent ridiculing, denigrating or scapegoating a child, threatening or scaring; rejecting or ignoring a child; isolating a child from normal social contracts, and involving a child in antisocial or inappropriate behaviour, such as crime violence or substance abuse[2].

Child labour: There are approximately 250 million economically active children between the ages of 5 and 14 worldwide, with 120 million of these children working on a full-time basis[3]. Children are often physically weaker, mentally more vulnerable and their immaturity may leave them incapable of assessing occupational risks or the need for protective measures. Negative effects of child labour on children's healthy include.

- Delayed or stunted growth.
- Hearing and/or sight loss.
- Malnutrition and eating disorders.
- Depression, sleeping disorders.
- Bone malformation.
- Skin infections and allergies.
- Respiratory infections, chemical poisoning.
- Abortion/teenage child birth.

Children soldiers: In war torn countries, children are often forcibly conscripted as soldiers. An estimated 250,000 children under 18 years of age – some as young as seven – are serving in government armed forces or armed opposition groups as soldiers, spies, messengers and posters. Often the most dangerous missions – such as advance troops in mined areas – are assigned to child soldiers[4]. These children are denied education and normal family life and forced to fight, with serious impact on their social, physical and mental development.

Sexual exploitation and child pornography: UNICEF estimates that one million children, mainly girls, are forces into the multi-billion dollar commercial sex trade every year. These children are often lured with promises of an education or a "good job". The exploitation of children through prostitution, pornography and "sex tourism" is a growing form of commercialised violence, with girls as main victims.

What can you do to help prevent child abuse?[5]

- Help out your friends, neighbours or relatives. Being a parent isn't easy. Offer a helping hand to take care of the children and give the parents a break.
- Help yourself. when pressures build up too much, make time for yourself.
- Never shake a baby. Get help if you are hurting your child.
- Promote parenting programmes at you local school or community centre.
- Report any suspected child abuse (physical, emotional and child labour) to your local child abuse prevention programme (179) or police station (112).
- Donate to or join local or national child prevention centre.
- Urge your government to sign and ratify the Convention of the Rights of the Child.
- Lobby your government to proclaim the World Day of Prevention of Child Abuse as a national day for children.
- Urge you government to sing the Statute of the International Criminal Courts to address the recruitment and use of children under 15 and International Labour Organization Convention 182 on the Worst Forms of Child Labour.

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1 NAPCAN Foundation, www.napcan.org.au/what.htm

2 NAPCAN Foundation, www.napcan.org.au/what.htm

3 Grootaert C and Kanbur R (1995). Child Labour: An Economic Perspective. International Labour Review. p89-203.

4 Coalition to Stop the Use of Child Soldiers (1998). Stop Using Child Soldiers.

5 Prevent Child Abuse America, www.preventchildabuse.org

Preventing Heart Disease: Watch Your Cholesterol

Chris Woolston - CONSUMER HEALTH INTERACTIVE

At this very moment, your blood vessels are pulsing with the raw material that can cause a heart attack. Every drop of human blood contains cholesterol, a compound popularly referred to as a fat, which your body needs to form healthy cells and tissues. From birth on, your liver manufactures cholesterol, which is pushed out to the gut and reabsorbed back as part of a system for fat absorption. In addition, cholesterol in the food we eat gets absorbed into the body.

When too much cholesterol accumulates in the bloodstream, it can build up in the coronary arteries and block the flow of blood to the heart. But cholesterol doesn't have to be a threat. With a few healthy lifestyle changes -- and a little help from your doctor -- you can lower your cholesterol levels and slash your risks for heart attack.

What's a "healthy" cholesterol level?

When a doctor checks your cholesterol level, he or she will usually do a test that's called a lipid panel, which includes measuring your total cholesterol and some of the other fats that are in the blood. This test requires a 14-hour fast to get an accurate reading of the blood fats. Unfortunately, there's no sharp cutoff point between healthy and unhealthy levels, but ideally, your total cholesterol should be below 200 milligrams per deciliter. Anything between 200 and 240 mg/dL is considered worrisome, and a level over 240 mg/dL is a serious threat. Check with your doctor about what's right for you.

Looking at a breakdown of your levels of the different types of cholesterol can be even more helpful. The lipid panel can better evaluate your risk for heart disease by measuring your levels of the two major forms of cholesterol, LDL cholesterol and HDL cholesterol. In common lingo, LDL is called the "bad" cholesterol, and HDL is known as the "good" cholesterol. That's because LDL cholesterol is the substance that clogs arteries by delivering cholesterol to the cells and depositing it in the artery wall; HDL cholesterol, on the other hand, actually helps clear LDL cholesterol from the blood by trucking cholesterol back from the cells to the liver for disposal.

The basic goal is simple: You want to keep your LDL within the target level that's right for you. Your target level depends on your situation: If you don't already have coronary heart disease and if you have fewer than two of the major risk factors -- obesity, high blood pressure, or a family history of premature heart trouble -- your LDL cholesterol should be below 130 mg/dL (and preferably under 100). If you already have coronary artery disease or diabetes mellitus and your LDL is over 100, your doctor will probably recommend you take cholesterol-lowering drugs to get your LDL below the 100 mark. If you are at very high risk for a heart attack (you have coronary artery disease or diabetes AND multiple risk factors), doctors may recommend you use drug therapy to bring your LDL readings below 70 mg/dL.

You also want to keep your "good" HDL levels from getting too low. Ideally, your HDL should be at least 40 mg/dL, according to guidelines issued in May 2001 by the National Heart, Lung, and Blood Institute (NHLBI). Since lower levels of "good" cholesterol appear to cause greater risk of heart disease in women, the American Heart Association (AHA) recommends that women's HDL be at least 45 mg/dl.

How can I improve my cholesterol levels?

In many people, cholesterol levels are a reflection of lifestyle. In some cases, however, lifestyle may not account for the level of cholesterol in a person's blood, since that level is often influenced by "internal" factors such as genetics, liver disease or other conditions, or hormones. If you're born with a problem in regulating your internal cholesterol production (which is where most cholesterol comes from), you'll probably need medication to control it.

But in the more common scenario, high cholesterol levels are associated with external factors such as excess weight, lack of exercise, a high-fat diet, and too much alcohol. The good news is that although unhealthy habits can wreak havoc on your cholesterol levels, a few positive changes can help bring them back under control. Here's a look at the best ways to lower cholesterol:

- If you smoke, stop. In addition to directly damaging your heart and arteries, cigarettes deplete your supply of HDL cholesterol.
- Eat a heart-healthy diet. If you're watching your cholesterol levels, you have to lower your intake of fat, especially saturated fat. Your body quickly turns saturated fat into LDL cholesterol. The AHA recommends that the amount of total fat you eat make up no more than 30 percent of your daily calories, and only 7 to 10 percent of your daily calories should be from saturated fat. On a standard 2,000-calorie diet, that means restricting yourself to 67 grams of fat and 22 grams of saturated fat per day. If you already have heart problems, you may need to cut your fat intake even more, but only with your doctor's guidance. Your physician may refer you to a registered dietician to assist you in modifying your diet.

The secret to lowering fat intake is to follow the advice we received from our parents and in turn give our children: watch what you put into your mouth. Before buying those tempting cookies, chips, and crackers in the grocery stories, read the product label: It will tell you many grams of saturated fat the food contains.

Of course, a lot of fast food doesn't come with labels. If you want to find out how much saturated fat is found in a slice of Big Mac, scone, or slice of pizza, check out the online version of Nutrition Action Health Newsletter, which regularly analyzes the content of fast food and restaurant food. The journal reports, for example, that scones, cinnamon rolls, croissants, and other baked goods full of butter and cream often contain more saturated fat than a hamburger with cheese! A simple rule is that in all but a few instances, lowering saturated fat will also lower cholesterol intake (most "sat fats" are found in animal products such as meat, butter, lard, coconut oil, milk, and eggs, which also contain cholesterol).

After saturated fat, the second most dangerous dietary villain is trans unsaturated fat or trans fat. Found in stick margarine, fried fast foods, and some snack foods like cookies, crackers, and donuts, trans fat gives your cholesterol level a double whammy: Not only does it increase your LDL cholesterol, but it also lowers your HDL cholesterol. A recent Harvard University study of more than 80,000 women suggested that replacing just 2 percent of trans fat calories with calories from healthier fats reduced the

risk of heart disease by more than 50 percent. Read all processed food labels and look for "partially hydrogenated oils" -- that's the trans fats that you want to avoid. Look for products that contain olive oil instead.

You should also beware of eating too much dietary cholesterol. This is the type found in most animal products, especially egg yolks, meat, and seafood. Dietary cholesterol isn't quite as dangerous to your heart as saturated fat or trans fat, but you should still be cautious. The AHA recommends you eat no more than 300 mg of cholesterol each day. In practice, that means eating no more than four egg yolks a week and avoiding cholesterol-packed foods such as fried meats. Those with heart disease need to keep cholesterol levels to 200 mg and only two egg yolks a week.

To fill the void left by fatty foods, you should eat plenty of whole grains and at least five to seven servings of fruits and vegetables every day. These foods protect the heart in several ways, including providing soluble fiber, a known cholesterol fighter. The AHA also recommends eating vegetable and fish meals at least three to four times a week -- fatty fish such as salmon contain omega-3 fatty acids, or "good fats," which actually benefit the heart by lowering cholesterol. (If you don't like fish, you may want to take over-the-counter fish oil supplements containing omega-3s -- an option you can talk over with your physician.)

If you're worried that it will be hard or complicated to go low-fat, consider this: Most people can cut their intake of artery-clogging saturated fat in half just by avoiding butter, margarine, fatty meats, and dairy products made from 2 percent or whole milk. (If you have to have margarine on your toast, use the soft kind rather than stick margarine, which is high in trans fats.)

• Get moving. Regular workouts not only strengthen your heart but can also push your cholesterol levels in all the right directions. Your LDL cholesterol will drop, and your HDL cholesterol will rise. (LDL is primarily lowered by diet, and HDL is primarily increased by exercise, but we usually need to do both.) Staying active will also help you take off any extra pounds, an important step towards a healthy heart.

What can my doctor do to help?

Lifestyle changes can make a difference in cholesterol levels, but many people need medications to bring cholesterol completely under control. Drugs are especially important if you have other risk factors for heart disease or if you already have heart trouble.

In fact, NHLBI officials have urged doctors to take a more aggressive stance in treating high cholesterol, including prescribing cholesterol medication even if you've never had a heart attack. In July 2004, the National Cholesterol Education Program released new guidelines advising doctors to prescribe cholesterol drugs for anyone who is at high risk for a heart attack if their LDL is above 100 mg/dL. High risk is defined as anyone who has coronary artery disease or diabetes or multiple risk factors that give them a greater than 20 percent chance of having a heart attack within 10 years. In addition, the new guidelines suggest that people at very high risk for heart disease (those who have coronary artery disease or diabetes AND multiple risk factors) take medication to lower their LDL below 70 mg/dL.

The most effective cholesterol medications available today belong to a group of drugs called statins. These drugs can dramatically lower cholesterol levels and have few side effects, although some patients complain of constipation, stomach pains, and cramps. In rare cases, a patient may develop significant muscle pain and weakness. (Report any unusual symptoms to your doctor; since some of these drugs interact with other medications, always mention any other drugs or herbs you're taking as well.) A recent study of heart patients found that one statin drug cut the risk of heart attacks by more than 60 percent.

Your doctor can also help you track your cholesterol. Starting at age 20, adults should have their lipid panels levels checked at least once every five years. Men over 45 and women over 55 should be checked more often. If you already have high cholesterol or are at risk for heart disease, your doctor may want to measure your cholesterol more often.

What's the right age to start thinking about cholesterol?

Heart attacks usually strike people in their 40s and older, but the clogging process starts decades earlier. Researchers at the University of Texas recently examined the arteries of 300 people aged 15 to 34 who died from an accident, homicide, or suicide. As reported in the November 2000 issue of the American Journal of Clinical Nutrition, many of these people already had clumps of cholesterol in their arteries. Not surprisingly, the victims with the highest cholesterol levels in their blood also had the most serious buildup in their arteries.

The researchers concluded that the teen-age years are an excellent time to start protecting the heart. But don't worry -- even if your teens are a distant memory, it's not too late to make some healthy lifestyle changes to bring your cholesterol count under control. When it comes to preventing heart attacks, a late start is much better than no start at all.

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

Chris Woolston, M.S., is a health and medical writer with a master's degree in biology. He is a contributing editor at Consumer Health Interactive, and was the staff writer at Hippocrates, a magazine for physicians. He has also covered science issues for Time Inc. Health, WebMD, and the Chronicle of Higher Education. His reporting on occupational health earned him an award from the northern California Society of Professional Journalists.

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• First published May 14, 2001
• Last updated July 14, 2004

Mid-djarju tagħna

From our diary...

1. Il-Kunsill tal-MUMN flimkien ma l-Attivisti taw Konferenza Stampa quddiem l-Isptar Mater Dei sabiex juru t-tħassib serju tal-Union rigward in-nuqqas ta' diskussjonijiet fuq kull livell.
2. L-MUMN iffirmat it-tieni Ftehim Kollettiv f'isem in-Nurses ta' l-Isptar Zammit Clapp. Fir-ritratt jidhru l-Uffiċċjali tal-Union flimkien ma l-Management ta' l-Isptar.
3. L-MUMN Florence Nightingale Benevolent Fund ġie vvutat għall-aktar Group Committee li rsista u stinka matul is-sena l-oħra u għalhekk ġie ppremjat bil-Paul Bezzina Shield.
4. Il-Group Committee tal-Pensjonanti reġa' għal darba oħra organizza ħarġa għall-Membri tiegħu. In-Nurses u l-Midwives irtirati mix-xogħol ikunu qed Iħarsu l-quddiem għall-ħarġiet bħal dawn għaliex huwa mezz li jerggħu jiltaqgħu flimkien.
5. Il-Kumitat Eżekuttiv Relazzjonijiet Edukattivi, b'kollaborazzjoni man-Nurses fir-Renal Unit organizzaw Renal Conference li attirat numru sostanzjali ta' delegati.
6. Il-Florence Nightingale Benevolent Fund organizza l-attivita' annwali tiegħu biex jirringrazzja u juri l-apprezzament tiegħu lil Nurses u Midwives, membri tal-Fund, li jkunu irtiraw mix-xogħol is-sena ta' qabel. Din is-sena in-numru ta' dawk li rtiraw kien ta' tmintax.
7. L-MUMN laħqet Ftehim ta' kollaborazzjoni ma' l-Malta Emergency Nurses Association (MENA) u minn naħa tagħha din l-Association issa qegħda fi ħdan l-MUMN. B'hekk it-tlett Assocjazzjonijiet Speċjalizzati fin-Nursing: l-AMON, il-MAPN u l-MENA issa qegħdin taħt il-kappa tat-taqsima edukattiva tal-Union. Prosit lil dawn l-Associations li fhemu li sakemm inkunu magħqudin nistgħu biss nimxu l-quddiem u ngħelbu l-ostakoli.
8. Huwa bix-xieraq li nirringrazzjaw il-Membri kollha tal-Kunsill ta' l-MUMN ta' erba' snin ħidma fejjieda fl-interess tal-Midwives u n-Nurses f'pajjizna.

An Infection Control perspective in preventing intravascular catheter-related infections *(part2)*

Part 1 of this article dealt on the proper use of equipment related to I.V. therapy. It is important that nurses should know what types of devises are at our disposal and the proper use of these devices. Maintaining the sterility of the devices used accompanied with a stringent aseptic technique in all procedures when handling the IVI line is of utmost importance.

Introduction: The basic concept of IVI care lies on the intravenous venous catheter, which is introduced inside the vein. Let us go back to basics – What is a venflon? This has to be clearly understood since we, as nurses tend to forget the basic concept especially in the light that in any acute hospital, 40% of our patients would have a peripheral venous device. A venflon is a simple plastic tube bypassing all body defences (i.e. the skin) and offering a passage into the most sterile area of the body – the blood stream. Whatever we deposit through lack of aseptic technique or through lack of hand washing is flushed into the blood stream of the patient through the cannula. This basic concept should be well understood hopefully making us better nurses to our patients.

The vein

The vein is a living tissue with its own blood supply. It is susceptible to infections and other diseases. That is why prior inserting the intravenous catheter we have to plan ahead as much as possible the likely intended treatment. One has to keep in mind that SMALL IS BEAUTIFUL. The wider the bore of our intravenous catheter, the bigger the risk for phlebitis to occur. Phlebitis is one of the main complications associated with peripheral venous catheters (PVC) and is essentially a result of a chemical (local drug reaction) or mechanical (poor fixation of the catheter to the skin) reaction. According to research studies, 62% of patients with a peripheral I.V. device in situ` will acquire infusion phlebitis. Initially phlebitis will present with pain and/or erythema at the site of cannula insertion. If left unchecked, signs of a palpable venous cord will develop, slowing or halting access to the device and ultimately, thrombus formation occurs.

I. V. Dressings

Purpose of a dressing:

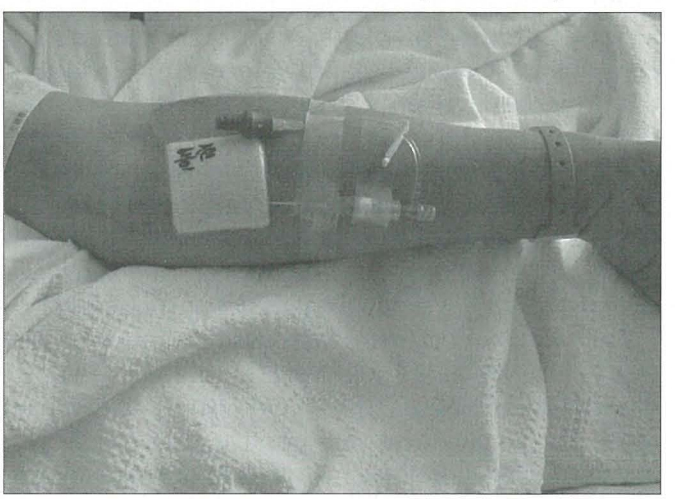
1. Prevent trauma to the wound and the cannulated vessel
2. Secure the catheter
3. Preventing the extrinsic contamination

Whilst insertion of intravenous cannulas is predominately within the doctor's role, both in Britain and in Malta, it is within the nurse's responsibility to assist in the procedure and to care for the intravenous site. This is to ensure that it will remain free of possible complications that are detrimental to the patient's well being. By maintaining sterility in handling the wound site, the nurse would be minimising the likelihood of transmitting infection from her hands or the equipment used to the patient.

Dressing Changes (acc. to ICNA guidelines)
Frequency

- ***Peripheral Vascular catheter*** – polyurethane dressing may remain in place for the life of the device.
- ***Central Venous catheter*** – according to manufactures recommendations

Always change dressing when:
1. soiled - 2. loosened - 3. damp - 4. dirty



Semi-permeable Transparent Dressing
Dressing such as Opsite, Tegaderm and Bioclusive have highly extensible and elastometric properties that contribute to their conformability and resistance to wear and tear. They have adhesive properties, are sterile, and are also permeable to water vapour, oxygen and other gases and impermeable to water and bacteria.

For application to intravenous sites, they have an advantage in stabilising the cannula whilst allowing for easy inspection of the wound site, surrounding

skin and external part of the cannula. Moreover they can be left up to 72 hours without being changed and so they have economical benefits because they save nursing time, allow for easy inspection, and are cheaper in the long run because they do not need frequent changing. They also promote patients' comfort. One disadvantage of these dressing is that accumulation of the skin secretions and sweat may lead to the failure of the adhesive leading to wrinkles through which bacteria may gain access to the wound. It has also been found that there are no clinical in six commercial types of transparent dressings namely Douderm, Vigilon, Tegaderm, Opsite, Bioclusive and Ensure-it in the healing of superficial wounds in traumas. None of the dressings have the ability to resist infection once a pathogen is introduced.

Semi-permeable transparent dressings have also been associated with an increased risk of catheter related sepsis if left on for long periods because of moisture build-up, leading to increased bacterial colonisation brought about by adhesive failure.

The care and the attention of every nurse are important to our patients. Good knowledge and good practices make us safe to work with our patients. None of us Nurses would like to end up with thromphlebitis due to negligence of some health worker. Well, neither do our patients. Work well and try to enjoy your work against all odds.

Paul Pace N.O.
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IVI Lecturer
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The AMON International Orthopaedic Conference

12th and 13th October 2006

The Association of Maltese Orthopaedic Nurses (AMON) was launched in December 2005 and aims to create a professional organization for Maltese orthopaedic nurses. During its first year AMON organised various activities, the most important one being the First International Orthopaedic Conference called 'Knights Hospitalliers'. The conference was held on the 12th and 13th October at the Coastline Hotel and was attended by approximately 160 delegates.

The Directorate Nursing Services as well as MUMN made introductory speeches. 40 speakers and delegates from England, Ireland, Scotland, Wales, USA, Canada, Hong Kong and Turkey were present together with a good number of Maltese speakers including a consultant, a physiotherapist and nurses working in the orthopaedic unit in St. Luke's Hospital. The main themes of the Conference were Practice development and Nurse led clinics, prevention of falls in the elderly and research. A presentation on Leadership was also given and the Honorary Chair of AMON, Ms. Elaine Collins discussed the introduction of an early discharge scheme which has made a difference in their hospital.

International delegates were also invited for a visit to the cities of Birgu and Valletta and a conference dinner was held on the 13th October. The feedback for the conference was very positive having delegates asking AMON committee members to organise another International conference in two years time.

During the conference week AMON was also holding meetings with the International Collaboration of Orthopaedic Nurses (ICON). AMON has been an active member of this collaboration since it was founded in 2005. These 7 associations work together with a common vision and mission in order to advance the practice of orthopaedic nursing globally. Member associations of ICON include:

- Asian Association for Dynamic Osteosynthesis (AADO) – Hong Kong
- Canadian Orthopaedic Nurses Association (CONA)
- National Association of Orthopaedic Nurses (NAON) – USA
- RCN Society of Orthopaedic and Trauma Nursing (SOTN) – UK
- Association of Maltese Orthopaedic Nurses (AMON)
- Australia and New Zealand Orthopaedic Nurses Association (ANZONA)
- Irish Orthopaedic Nurses Section (IONS)

I would like to conclude by thanking all the AMON members who gave us support during the last year and all the AMON committee members who worked really hard during the past year in order to achieve the goals desired.

More information of the AMON International Conference and Activities together with other educational material is available on the AMON website at www.amon-nurse.com

Alistair Chetcuti
Vice-Chairperson AMON

CommCare
Assessment Unit

Bridging Health & Social Care: coordinating community nursing

One year on since CommCare Assessment Unit (previously known as 'Community Care Vetting Office') started to operate, and the growing needs to respond to the challenges of bridging health and social care is continuously running parallel to the demands within the community.

The European population's age structure is older than that of any other world region and it is set to age further during the next few decades (Grundy, 2006). Between 1995 and 2015 the evolution is forecast to be greater. Malta is among the 10 countries in Europe with the highest anticipated rate of growth in the proportion of elderly persons, (+7 percentage points), Mette (2006). Although CommCare Assessment Unit provides services across the lifespan, the majority come from the 60+ age cohort. Additionally, the shift from secondary to primary care, increased day surgery and earlier discharge, diverse family structures, decreasing numbers of hospital beds, and higher patient and carer expectations have all added to further pressure leading to significant changes to the community nurses' role and the way the service is delivered.

It is the coordinator's responsibility to perform the initial assessment, and then to regularly evaluate and coordinate care.

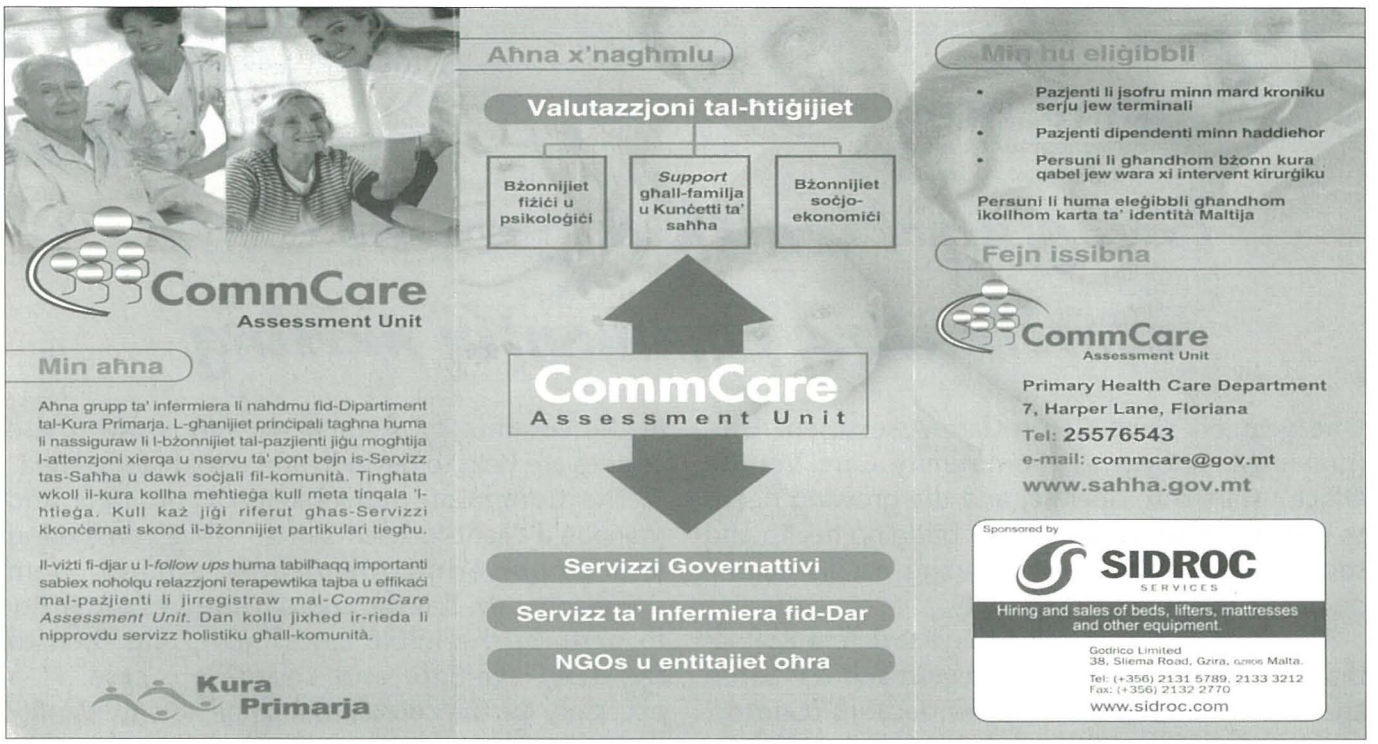
As community nursing coordinators we work hand-in-hand with other health professionals including community nurses (MMDNA), government services (all hospitals, Tissue Viability Unit, Occupational therapists, Physiotherapists, social workers, Health Centres, the Ministry for the Elderly and Community Care the Ministry for the Family and Social Solidarity, etc) and NGO's (Appo[[, Richmond's foundation, Hospice movement, etc). Clients are normally referred to the CommCare Assessment Unit from all departments within the Health Division, private GP's, private hospitals and other health and social care entities professionals who are discharging patients/clients in the community. Regular meetings with these entities are held to develop and update as needed.

The CommCare nurses team coordinate and manage a client-focused system while considering and empowering the people around them simultaneously. It is the coordinator's responsibility to perform the initial assessment, and then to regularly evaluate and coordinate care. It is necessary for the coordinator to be able to identify and prioritise the needs of patients, to negotiate with patients an appropriate care plan, and to improve patients' ability to cope with problems. This entails being in close contact with clients by visiting them in their own environment and through periodical reviews by telephone.

Home visits serve to assess the needs in the client's own dwelling where his/her age, family composition, culture, lifestyle, social networks, environmental factors and the choices and obligations of the individual are considered. Together with the client a plan is developed, and according to the needs and choices of the client a referral is made to the appropriate entity. Moreover the CommCare nurse seeks to promote healthy lifestyles and encourages self-care wherever possible. Community-nursing assessments need to be ongoing (that is the opportunity for reassessment should be undertaken at each visit) if the changing needs of these patients are to be met. This requires thinking beyond the reason for referral.

The expansion of community nursing faces up to a number of challenges, which range from the prevention of abuse of service, to making people aware of the services that exist and to help them cope better and remain in the community as much as possible. Another challenge we are often confronted with, which poses considerable ethical dilemmas, is that of providing palliative care to young adults and middle-aged individuals with life-limiting illnesses. At the heart of such dilemmas are the issues of what services are available, whether the services are appropriate and where they are provided.

Our aim is to wrap all the services available around clients who need them, keeping the elderly



out in the community and preventing admissions to tertiary care. Moreover, we construct our role identity around person-centred care and direct health promoting activities at individuals.

By recognising and addressing the needs of thea informal carer as well as the patient/client, nurses can protect the physical and mental health of both.

CommCare coordinators have first-hand knowledge, experience and understanding. This is displayed through probing into the client's anxieties, triggering their needs to surface. Following this, the coordinator makes a considered judgement about which services might best bring about change for the individual. This demands effective working relationships with other health and social care professionals in order to ensure effective transition to other services.

Furthermore, CommCare coordinators appreciate and value the contribution of informal carers – a very valid economic resource. From our experiences when visiting clients we often find that some carers are children or young people and another substantial number are already old when they take on this role. In spite of these risks, the health needs of family carers may easily be overlooked (Lundh, 1999). Health professionals may focus on their client and their condition but fail to ask how this is affecting the carer's health. At the same time informal carers find it difficult to assert their own needs when time is short and they are worried about a sick relative. By recognizing and addressing the needs of the carer as well as the patient/client, nurses can protect the physical and mental health of both.

As a final point, we would like to inform our colleagues that the referral criteria must be adhered to by all health professionals to ensure inappropriate referrals are kept to a minimum. Communication and collaboration between members of the multidisciplinary team are the cornerstone of effective discharge planning and the provision of a successful seamless service (Bowler, 1993). Recently, a leaflet about the purpose and the services of the CommCare Assessment Unit has been issued and distributed to all hospitals, Health Centres, District Clinics, Local Councils, Day-centres and NGO's. Anyone needing further information may contact us on:

Tel: 25576543 • E-mail: commcare@gov.mt

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Is the Food at Your Child's School Healthy?

By **Diane Griffith**, HealthAtoZ writer
Prevention Minnesota, Blue Cross Foundation: Blueprint for Health Wellness Centre

Have you taken a good look inside the vending machines at your child's school lately? Depending on where you live, you may be unhappy with what you see.

Some school vending machines are filled with potato chips, chocolate bars and baked goods, as well as colas and sugary fruit drinks. In many school districts, though, milk, water, dried fruits and nuts are offered instead.

Some states have laws - or are working on them - that will keep children from buying unhealthy snacks and drinks during the school day. Instead, kids will be offered bottled water, 100 percent fruit juice, milk, yogurt, cheese, fruit, nuts, seeds and trail mix.

The cola wars

Many school districts have signed contracts with soft drink dealers, agreeing to sell a certain brand of soft drink - and only that brand - in exchange for money. Signing these agreements has earned school districts across the country hundreds of millions of dollars, but may not be in your child's best interest.

Dairy products encouraged

Students are now being offered "dairy-only" vending machines in some schools. Here children find plain, strawberry, chocolate and even banana milk, as well as cheese and yogurt. Studies show that kids will drink milk if it's served cold, offered in different flavors and displayed attractively. Kids who drink milk have better diets and healthier weights than those who prefer sweetened drinks. Teen girls who drink milk gain less weight than those who don't. On the other hand, the more soda a teenage girl drinks, the more her weight increases.

Organisations against soft drinks in schools

The American Beverage Association recently asked school districts to buy only water and 100 percent fruit juice to serve to elementary school children. Middle school children would receive the same beverages, as well as sports drinks, calorie-free soft drinks and low-calorie juice drinks.

Many organisations believe soft drinks cause cavities, aren't nutritious and are bad for children's overall health. According to the American Academy of Pediatric Dentistry (AAPD) and the American Pediatric Association (APA):

- The acids in sodas can eat away at tooth enamel.
- The more soft drinks children have, the less milk they drink.
- Drinking sweetened beverages can lead to weight problems.

Obesity

Nearly one in every three children is at risk for becoming overweight, and one in six children actually is overweight. Obesity can lead to high cholesterol, high blood pressure, type 2 diabetes and other diseases. Each year, these types of diseases in children and adults cause more than 300,000 deaths.

Calcium

Nearly 40 percent of our bone mass is gathered during adolescence. Lost bone mass -resulting from a lack of calcium - can lead to a future of osteoporosis and fractures.

Between 56 percent and 85 percent of school children drink at least one soft drink daily. Twenty percent of those children drink four or more servings daily. When children replace milk with soda, calcium isn't the only nutrient they lose. Milk also gives them phosphorus, riboflavin, vitamin B12, protein and vitamin A.

What can parents do?

If you're concerned about the junk food showing up in your school's vending machines, let your voice be heard. Encourage school officials (e.g. the principal, your child's teacher, the school gym/health teacher) and parent groups to push for nutritious snacks and beverages. Also, talk to your child and get them to ask for changes. Regardless, talk to your children about why you feel the choices in their cafeteria are unhealthy. Then pack nutritious snacks and beverages for them to take along each day.

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

Snippets

Public Services International

FOCUS on Public Services 1/2006 PSI
in brief... Page 14

Don't Privatise Oxygen!

A woman has died, allegedly following the breakdown of a newly privatised system to provide oxygen supplies to patients at home in England and Wales, the BBC reported on 17th February. An estimated 60,000 people require oxygen at home for heart, pulmonary and cancer problems, according to the National Health Service. Four companies took control of this former NHS service just two weeks before; two of them have suffered supply problems. Now the blame is laid at the door of doctors. "It was the GP's responsibility to fill out the order form but the company should have ensured that they had checked all of the people who needed oxygen before taking over the service," a relative said. "It seems nobody had bothered to add up the GP's and match them against patients and the forms the company had received."

NEW WEBSITE ON HEALTH

PSI has developed new pages on its website devoted to health issues. They cover HIV/Aids, safety at work, health reform and nursing. There is a link to the page on migration and women health workers. See www.world-psi.org/health.

MIGRANT HEALTH WORKERS...

MINUS 400 NURSES A YEAR

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The Caribbean is losing 400 nurses annually through migration to the US, Canada and the UK. Officials say that it is hard to give an accurate figure, since many nurses leave without ever resigning: some simply apply for their annual leave and never return.

Nurses are recruited through placement agencies or advertisements in local newspapers. Recruiters-from the US in particular - visit the Caribbean to sign up nurses. One incentive offered by overseas health institutions includes a payment of between US $2,000 and 3,000 to any nurse who recruits another. It is mainly those who are trained in theatre, trauma and intensive care who migrate.

While the numbers for the Caribbean are small compared with the global figure, they are nevertheless significant. Many countries find themselves in apposition where they can hardly improve or even sustain the quantity and quality of public health services.

> "The recruitment is a real threat to the survival of our healthcare delivery system (and the region) cannot underestimate the severe consequences, should mass migration of nurses continue unabated."
>
> **Dr. Earl Asim Martin**,
> Minister of Health, St Kitts and Nevis

Towards privatisation

The situation is grave: approximately 35 percent of posts for registered nurses are vacant. The nurses graduating are not enough to replace the haemorrhage.

For years, nurses, doctors and patients at the Queen Elizabeth Hospital (QEH) in Barbados have been complaining of deteriorating facilities and buildings, shortages in supplies, poor working conditions and management, and low salaries. Government's response has been to conduct a study, funded by the InterAmerican Development Bank (IDB), and recommend reform. The first part was realized in late 2005 when the management of the QEH was taken over by a Board of Directors seen as the first step in privatisation. In Trinidad and Tobago, another reform project has been pushed by the IDB.

With these moves toward privatisation and no improvement in working conditions or salaries, even more nurses and other health care workers have migrated. The result: the governments are now actively recruiting nurses, pharmacists and doctors from the Philippines, Cuba, Jamaica, Nigeria and Guyana. The staff that remain are overworked, their levels of frustration increase and their morale gets lower and lower. The quality of care is jeopardised.

The immigrants join

As part PSI's Migration and Women Health Workers Project, the NUPW Barbados met with immigrant nurses. The union assisted them in settling complaints about discrimination in pay, lack of uniforms and delays in refund of expenses. These nurses have since oined the union.

Text: **Sandra Massiah** and **Ann-Marie Lorde**

DONAZZJONI

Joe Camilleri, bħala rappreżentant tal-ex Staff Support Group tal-Isptar San Luqa, li għadu kif ġie xolt, ta donazzjoni ta' Lm120 lit-Transplant Support Group. Dan sar waqt il-Konferenza 'Therapies and Management of Chronic Kidney Disease' organizata mill-Educational Executive Committee fi ħdan l-MUMN fl-ewwel ta' Diċembru 2006, ġewwa r-Radisson SAS Golden Sands, Golden Bay. Il-flus kienu qliegħ li kien sar minn Seminar ta' nofs ta' nhar dwar l-i*Stress*. Is-Sur Alfred Debattista flimkien ma s-Sur Joseph Bonello laqgħu dan il-ġest u rringrazzjaw lil kull minn jagħti donazzjonijiet simili.

Rehabilitation in the context of long-term care in the elderly

'The aim of rehabilitation is either to restore individuals to their former level of functioning or to maintain or maximize remaining function.' (William, 1984, Brummel-Smith, 1993). Rehabilitation is of significant importance because it may prevent muscle contractures, ulcers, disuse atrophy and psychological problems. The multidisciplinary team with the active involvement of the patients and their families should carry out rehabilitation. The type of rehabilitation environment depends on the patients' needs and their support systems.

Rehabilitation includes the involvement of the patient, family, nurse, doctor, occupational therapist, speech therapist, social worker, physiotherapist etc. Teamwork is of vital importance and it should be directed towards every patient's specific needs and the availability of health care professionals and other services. The nurse is often in the best position to observe changes in function. Therefore it is his/her role to coordinate care, teach both the patient and the family, and promote functional independence of the elder as much as possible.

People who form part of the aging population are active members of the society and they deserve the best holistic care in whatever clinical setting they form part of.

The **HOME** environment is often the very best setting for rehabilitation of the elderly because they have all the emotional security and their family and personal possession with fewer distractions. But difficulties with rehabilitation in the home environment may arise. So it is the nurse's responsibility to assess them. These may include overprotection and overindulgence from family members (though this is often well-meant), tendency not to comply with prescribed regime, unavailability of special devices and physical obstacles, and alterations in the family's life. Therefore the nurse should assess appropriate rehabilitation and also include emotional support to the elderly and their families, and giving the right answers to the questions they ask.

Some old people may be best rehabilitated in a **HOSPITAL** setting, as sometimes they lack support, motivation and independence in a home. Advantages include the availability of the multidisciplinary team and the necessary treatments and facilities to care for their elderly problems. Family members may feel afraid, alone and guilty. In the hospital setting they can find the nurse to rely on for emotional support and for feeling a part of the care given to enhance rehabilitation. Some elderly may not adjust to the hospital, but others may adapt to the hospital environment and do not want to leave as they find enough security in the support system of the hospital.

A **RESIDENTIAL** home may offer a good rehabilitative programme for patients who need it after hospitalisation. Some elderly dread the idea of going to a residential home and this may induce relocation stress. The nurse's role is to work with the patients and families to know their fears and concerns, and emphasise the rehabilitation potential and returning home, if there is a possibility. Special environment design can enhance physical mobility and social interaction. Speaking from the little experience I have, the majority residents state that they experience strengthening of family ties and discover new love, affection and trust with the nurses in residential homes. Surprisingly enough I have found that this truly helps the patients for quicker rehabilitation in the course of their recovery.

People who form part of the aging population are active members of the society and they deserve the best holistic care in whatever clinical setting they form part of. The nurse is in the ideal situation to give this type of care by building a therapeutic and supportive relationship whilst at the same time preserving the patient's rights and dignity.

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Position Statement

Occupational Health and Safety for Nurses

ICN Position:

ICN is clear that a safe work environment in the health sector significantly contributes to patient safety and supports positive patient outcomes. To that end ICN promotes the development and application of international, national and local policies or instruments that will safeguard the nurses' right to a safe work environment, including continuing education, immunisation and protective clothing/equipment. ICN reconfirms its mandate to encourage research in this area and to circulate relevant information on a regular basis to appropriate stakeholders.

CN deplores the lack of appropriate national occupational health and safety legislation covering nurses in their place of employment, the often inadequate mechanisms for workers' participation in the monitoring/elimination of professional hazards, and the insufficient resources allocated to ensure optimal occupational health and safety services and labour inspection.

ICN strongly supports the various ILO Conventions relating to occupational health and safety and believes that national nurses' associations should:

- Urge their respective governments to ensure that all health agencies fall within the provision of occupational health and safety legislation. This can be done through lobbying, individual and/or collective political action.
- Initiate and/or support research in their countries into the safety and suitability of the work environment of nurses as well as risk behaviours, attitudes, procedures and activities.
- Sensitise nursing personnel, employers and the public to occupational hazards in the health sector, including violence or abuse.
- Raise nurses' awareness of their rights (as workers) to a safe environment and of their obligations to protect their safety and promote the safety of others.
- Convince governments and employers to adopt and implement all necessary measures to safeguard the health and well-being of nurses at risk in the course of their work, including vaccination when appropriate.
- Urge governments/employers to ensure the access of nursing personnel to protective measures (e.g. clothing) and equipment at no extra cost to staff;
- Encourage nurses to undergo vaccinations relevant to their health and safety in the workplace.
- Cooperate with the competent authorities to ensure the accuracy of the List of Occupational Diseases and periodically evaluate its relevance to nursing personnel.
- Support nurses' claims for compensation in relation to occupational disease and/or injury.
- Obtain and disseminate information on the incidence of work-related accidents, injuries and illnesses of nurses.
- Cooperate with other organisations supporting the worker's right to a safe work environment.
- Recognise the important relationships between workers and their families in the development of culturally appropriate occupational health and safety policies and treatment plans.
- Support nurses' freedom from being intimidated in their role of patient advocate.
- Call for adequate monitoring systems at all levels that will ensure appropriate implementation of policies.
- Disseminate information on the introduction of new hazards in the workplace.
- Disseminate information on non-compliance by employers of occupational health and safety legislation, including reporting mechanisms for such violations.

ICN supports the expanding role of the occupational

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Position Statement

health nurse in meeting workers' primary health care needs, and demands fair remuneration and adequate career structures that support professional development. ICN calls for the recognition of occupational health and safety as a professional nursing role with the appropriate remuneration that corresponds to the level of expertise and incentives to attract/retain nurses in this area of practice.

Background:

ICN recognises the major role occupational health and safety plays in health promotion. Furthermore, ICN acknowledges the growing expertise nurses have gained in the area of occupational health and safety and the cost-effectiveness of the services provided for workers.

Patient care benefits from a safe work environment for health personnel. The work environment of the nurse is frequently unsafe, however, as a result of:

- Environmental contamination by waste products resulting from human and industrial activity.
- Risks (e.g. chemical, biological, physical, noise, radiation, repetitive work)
- Medical technology – lack of maintenance, insufficient training in the use of technology.
- Inadequate access to protective clothing and safe equipment.
- The disturbance of everyday life patterns associated with shift work.
- The increasing demands made upon the emotional, social, psychological and spiritual resources of the nurse working in complex political, social, cultural, economic and clinical settings.
- Incidents of violence, including sexual harassment.
- Poor ergonomics (engineering and design of medical related equipment, materials and facilities).
- Inadequate allocation of resources, e.g. human, financial.
- Isolation.

ICN notes that most governments fail to collect current accurate information on the incidence of accidents, injuries and illness of nursing personnel as the basis for sound policy formulation. The lack of relevant data is a matter of great concern.

In certain countries, there is no occupational health and safety legislation. In others, the means to monitor its implementation and the machinery to discipline the offending employers is ineffective or non-existent. Yet other countries have adopted legislation that excludes hospitals and other health agencies.

Convention 149 of the International Labour Organization (ILO) concerning Employment and Conditions of Work and Life of Nursing Personnel [1] calls on member states to "improve existing laws and regulations on occupational health and safety by adapting them to the special nature of nursing work and of the environment in which it is carried out". Section IX of the accompanying *Recommendation (157)*[1] further develops the measures considered necessary to guarantee the health and safety of nurses in the workplace.

Related ICN Positions:

- Abuse and violence against nurses
- Shift work

ICN Publications:

- Guidelines on Coping with Violence
- Framework Guidelines Addressing Workplace Violence in the Health Sector

[1] International Labour Organization, **Convention 149 and Recommendation 157 concerning the Employment and Conditions of Work and Life of Nursing Personnel**, Geneva, ILO, 1977.

Adopted in 1987

Revised and updated in 2006

Ejjew Nieqfu ftit STUPIDITY

Spotted in a toilet of a London Office:
TOILET OUT OF ORDER - PLEASE USE FLOOR BELOW

In a Laundromat:
AUTOMATIC WASHING MACHINES: PLEASE REMOVE ALL YOUR CLOTHES WHEN THE LIGHT GOES OUT.

In a London Department store:
BARGAIN BASEMENT UPSTAIRS.

In an Office:
WOULD THE PERSON WHO TOOK THE STEP LADDER YSTERDAY PLEASE BRING IT BACK OR FURTHER STEPS WILL BE TAKEN.

In an Office:
AFTER TEA BREAK STAFF SHOULD EMPTY THE TEAPOT AND STAND UPSIDE DOWN ON THE FRAINING BOARD.

Outside a second-hand shop:
WE EXCHANGE ANYTHING-BICYCLES, WASHING MACHINES, ETC. WHY NOT BRING YOUR WIFE ALONG AND GET A WONDERFUL BARGAIN?

Notice in health food shop window:
CLOSED DUE TO ILLNESS.

Spotted in a safari park:
ELEPHANTS PLEASE STAY IN YOUR CAR

Seen during a conference:
FOR ANYONE WHO HAS CHILDREN AND DOESN'T KNOW IT, THERE IS A DAY CARE ON THE 1ST FLOOR.

Notice in a field:
THE FARMER ALLOWS WALKERS TO CROSS THE FIELD FOR FREE, BUT THE BULL CHARGES.

Message on a leaflet:
IF YOU CANNOT READ, THIS LEAFLET WILL TELL YOU HOW TO GET LESSONS.

On a repair shop door:
WE CAN RFEPAIR ANYTHING, (PLEASE KNOCK HARD ON THE DOOR – THE BELL DOESN'T WORK)

Always keep smiling!

Rapport Grupp Pensjonanti

Il-*Group Committee* tagħna organizza ħarġa oħra soċjo-kulturali f'Ħaż -Żabbar nhar l-Erbgħa 29 ta' Novembru 2006, b'dan il-programm: Bdejna b'quddiesa b'suffraġju għall-ex kollegi. Wara dorna l-mużew ta' Ħaż-Żabbar u hawnekk il-gwida tatna ħafna informazzjoni nteressanti. Wara morna għall-ikla ġewwa *restaurant* f'Marsascala.

Matul ix-xahar ta' Novembru il-kunsill tal-Union inkarigana bl-elezzjonijiet tal-gruppi ġewwa l-isptarijiet u ċentri tas-saħħa.

Bagħtna wkoll kwestjonarju lil kull membru u kellna rispons tajjeb (kwestjonarju megħmuż).

Il-*grupp committee* matul din is-sena beħsiebu jorganizza aktar ħarġiet, bl-ewwel waħda aktarx tkun ġol-Mater Dei Hospital, u wara se nippruvaw nagħmlu laqgħa mal-Arċisqof Pawlu Cremona. Nappellalkom tieħdu sehem fil-ħarġiet li nagħmlu għax b'hekk tagħmlulna aktar kuraġġ.

Inselli għalikom u nixtiqilkom is-saħħa.

Paul Bezzina
Chairperson

GROUP COMMITTEE PENSJONANTI

QUESTIONNAIRE

	IVA	LE
1. Inti gejt biex tivvota fil-Laqgha Generali? Jekk le ghaliex?_____ _____	___	___
2. Tattendi ghall-attivitajiet li jsiru mill-Grupp?	___	___
3. Tissuggerixxi xi forma ta' attivitajiet ohra? Ezempju:_____ _____	___	___
4. Tixtieq li jekk tkun rekoverat (dar/home), ssirlek xi zjara mill-Kumitat?	___	___
5. Jekk inti membru fil-Benevolent Fund:		
a) Konxju mill-beneficcji li joffri?	___	___
b) Taf li tista' tibbenefika mill-fondazzjoni Richmond Foundation?	___	___

Kummenti ohra:_____
_____
_____

Jekk joghgbok, imla din il-questionnaire u ibaghta l-ufficju ta' l MUMN fis-self addressed envelope li ssib. Grazzi hafna.

L-ISTORJA TAL-ISPTARIJIET ĊIVILI U ĠENERALI MALTIN

Sensiela ta' artikli li jeħduna mal-medda tas-snin fl-iżvilupp tal-isptarijiet ċivili u ġenerali ta' Malta. Storja glorjuża u li għandha taghmilna kburin bis-serviżż tal-isptarijiet Maltin għall-ġid tal-pazjenti

JOSEPH CAMILLERI N.O, Resuscitation Nurse Specialist-SLH - ❑ joseph.f.camilleri@gov.mt

L-ISPTAR TAS-SACRA INFERMERIA TAL-BIRGU (VICTORIOSA) *L-EWWEL SPTAR TA' L-ORDNI (1532)*

L-ewwel ħsieb tagħhom, b'fedeltà mal-voti li jħaddnu kien: li jduru bil-morda

Bini massiv maġenb il-Knisja ta' Sant'Anna fil-Birgu kien l-ewwel Sptar mibni mill-Ordni Sovrana ta' San Ġwann f'dawn il-Gżejjer.

Meta l-Kavallieri ta' San Ġwann rifsu Malta u wara li damu seba' snin jiġġerrew fil-belt il-qadima tal-Birgu, u għalkemm dil-Belt kienet magħżula bħala s-sede ta' l-Ordni, dawn bilkemm setgħu isibu post biex jibnu s-"Sacro Convento" li kien iħaddan fih il-Kavallieri tal-Gran Croce, Balliji, Prijuri, Kmandanti, Kavallieri, Kappillani u ħafna aktar membri oħra.

Fuq kollox, ħafna familji li kienu joqgħodu Rodi waqt li l-Ordni kienet hemm, segwew l-Ordni meta ġiet Malta. Kienet problema biex issib post fejn takkomoda d-dinjitari kollha ta' l-Ordni.

F'daqqa waħda inqala ġenn sħiħ biex tiġi solvuta dil-problema. Ħafna djar kellhom jiġu mkabbra u oħrajn mibnija biex ikun hemm postijiet għal kulħadd f'post ristrett li ġie msejjaħ "Collachio".

L-Infermeria tlestiet f'sena

Biex iżommu ma' waħda mil-wegħdiet, dik li jieħdu ħsieb il-morda, l-Ordni għaġġlet tibni s-Sacra Infermeria, kif kien magħruf l-isptar mill-Ordni. Għalkemm il-post kien żgħir, ġie magħżul sit li kien diġa żviluppat. Numru ta' djar kellhom jiġu rekwiżizzjonati mill-Ordni li mbgħad ġew imwaqqa' biex jinħoloq l-ispazju neċessarju għall-Infermerija. Il-post fejn inbena l-isptar kien l-aħjar parti tal-belt-eżatt faċċata ta' l-entratura tal-port.

L-ewwel ġebla tas-Sacra Infermeria ġiet impoġġija fil-Festa tal-Qaddisin Kollha nhar l-1 ta' Novembru tal-1532, sentejn wara li waslu l-Kavallieri. Dak inhar, wara l-quddiesa fil-Knisja ta' san Lawrenz, il-GranMastru L'Isle Adam, akkumpanjat mill-Gran Prijur, il-Gran Croce u l-Kavallieri, imxew sas-sit fejn kellu jsir il-bini u fin-nofs, poġġew salib u hemmhekk sar it-tberik ta' l-art. Il-GranMastru ddekika s-sit lill-isptar: id-dar sagra għall-marid-la sacra casa degli infermi. L-għada. tpoġġiet l-ewwel ġebla ta' l-isptar mill-GranMastru L'Isle Adam u minn hemm il-quddiem ħa nteress attiv biex jara li dan l-isptar jitlesta u fil-fatt, dan tlesta u beda jopera fl-1533.

L-Uffiċji ta' l-Infermerija ta' l-Ordni, is-Swali, il-kwartieri amministrattivi u mediċi, Spiżerija, Kappella (għall-użu tal-pazjenti u impjegati), rifettorju u l-kċejjen huma mqassmin madwar il-kwadrangolu tal-kunvent fuq in-naħa ta' Triq Santa Skolastika.

Simili għal dak ta' Rodi, il-pjan terran serva għall-ħażna ta' proviżjonijiet, apparat u l-ħasil tal-ħwejjeġ. Dawn wara, ġew separata mill-bini ewlieni mis-sidien u mikrijin lill-pubbliku.

Il-ġiebja u l-ġnien

Loġġa kbira tagħti għall-entratura prinċipali u minn taraġ, wieħed jista' jasal għas-swali fis-sular ta' fuq. F'nofs il-'cortile grande'- il-bitħa l-kbira, hemm ġiebja għall-ilma tax-xita, minn fejn jittella' l-ilma bħal żmien il-bibbja. Dan il-bir huwa l-istess barriera minn fejn ġew maqtugħa l-ġebel għall-bini ta' dan l-isptar.

Xena sabiħa u trankwilla hija offruta mis-siġar tal-laringì li hemm mad-dawra kif ukoll bil-ħdura tal-weraq li hemm telgħin mal-kolonni ta' dal-Kunvent sieket.

Sala rettangolari, bil-ħnejjiet kienet isservi ta' refettorju. Din ġiet mibdula mis-sorijiet u qed isservi ta' kċina. Minnha wieħed jista' jinżel għal 'cortile basso' il-bitħa t'isfel. Maġenba hemm żewġ kmamar żgħar magħrufin bħala 'I Carceri'- il-ħabs li kienu jintużaw fejn jaqflu n-nies. Lejn it-tramunana ta' dal-bini kien hemm il-Kappella li ġiet mibdula f'Sala ta' l-ikel (Refettorju). Dis-sala jgħidu li kienet magħrufa għall-eleganza tagħha arkitettonika b'numru kbir ta' kaptellli skolpiti b'disinji distinti u ornamenti.

"Ir-raġuni għala dawk li kienu jiddefendu mill-Gwarniġjuni mfarrka tagħhom, ma sofrewx daqs l-għadu, jista' propabbilment imur lura għall-prinċipju kardinali tal-Kavallieri, dak ta' Ospedallieri...Fl-Isptar, fejn taħt kundizzjonijiet normali, kemm l-għani kif ukoll il-fqir, kavallier u bniedem komuni, kienu jiġu servuti l-ikel minn platti tal-fidda-biex iżid

mad-dekor tal-Isptar..." Ernle Bradford, "The Great Siege", paġna 208-209.

Il-bini tal-Knisja

Il-kwadrangolu tal-Kunvent, sofra sfreġu u n-naħa tal-punent tiegħu ġiet imwaqqa' fl-1901. Il-bieb prinċipali u l-fetħa fejn jilqgħu in-nies ukoll ġew imwaqqgħin biex jinbnew is-sitt idjar żgħar li hemm fi Triq Santa Skolastika. Dawn kienu ġew mibnija apposta biex jgħattu l-appartamenti fejn kienu joqgħodu s-sorijiet mill-abitanti ta' faċċata tagħhom.

Il-fetħa tal-bieb, skond ritratt qadim, kellu fuqu basso riljef fin-nofs bl-ittri I.H.S miktubin b'karattri antiki u kien ta' Arkitettura Lombarda. Dan kien eżempju tajjeb ta' l-influwenza gotika fuq stil klassiku. Dan kien fuq is-sit li bħal issa hemm id-dar numru 15 fl-istess triq.

Ħafna tibdil strutturali kien sar qabel l-1652 biex jaqdi l-bżonnijiet tas-sorijiet, l-akbar tibdil kien it-twaqqih ta' numru ta' kmamar biex tinbena l-knisja tagħhom. Erba' mis-swali prinċipali, li kellhom it-twieqi jħarsu fuq it-terrazzini, ġew maqsuma fi kmamar żgħar.

Kif intqal diġa', il-binja nnifisha hija moħbija bi knisja li nbniet aktar tard u bi djar bi tlitt sulari fi triq Santa Skolastika. Minn barra kważi ma jidher xejn, bħal per eżempju l-ġenb tal-kappella l-qadima. Faċċata tal-baħar, il-binja maqsuma f'parti ċentrali u żewġ sezzjonijiet fil-ġnub, u l-ispazju bejn dawn iż-żewġ sezzjonijiet jifforma żewġ galleriji.

Dan l-isptar ġie msemmi fil-Kapitlu ta' l-Ordni li kien sar fl-1538 meta l-GranMastru D'Omedes iddeċieda li jkabbru. Dan irriżulta fiż-żieda ta' sular ieħor fuq il-binja kollha li għadha ġġib l-isem ta' l-istess GranMastru.

Waqt il-ħakma ta' La Valette (1560), l-Ordni ħasset il-bżonn li tirranġa l-akkomodazzjoni għax is-sitwazzjoni kienet saret tant gravi li wħud mill-abitanti kellhom bilfors joħorġu minn djarhom u minn soddithom.

Ħafna xogħol ġie rrapurtat li sar b'ordni tal-Kunsill. Ħafna minn dawk li ndarbu waqt il-gwerer feroċi ta' l-Assedju l-Kbir ta' l-1565 ġew ikkurati f'dan l-isptar. La Vallette innifsu kien żar il-midruba fis-swali kbar immens tal-Isptar.

L-istoriku ta' l-Ordni Bosio isemmi l-proviżjonijiet sanitari u iġeniċi li saru fl-1538 biex l-isptar seta' jitmexxa tajjeb. Fl-1569, inħarġu ordnijiet biex jirregolaw l-infieq u biex ikun hemm aktar indafa.

Jidħlu s-Sorijiet

Għalkemm il-bini ta' Sptar kbir beda fil-Belt Valletta fl-1571, l-Infermeria tal-Birgu baqgħet tiffunzjona. Ħafna utensili u għodod li kienu jintużaw fis-Swali ta' dan l-isptar wieħed għadu jista' jarhom fil-Mużew

Nazzjonali tal-Belt. Dan juri li l-isptar ma kien jonqsu xejn.

Meta l-Infermeria tal-Birgu ma baqgħetx tiffunzjona fi żmien il-ħakma tal-GranMastru Lascaris (1635-1657), is-sorijiet Benedittini malajr bagħtu petizzjoni biex jiġu trasferiti mill-Palazz Maġisterjali għall-isptar, li issa kien ġie vojt. Dawn ingħataw il-permess u l-kuntratt ġie ffirmat fl-1643. Meta tlestew l-alterazzjonijiet li kien hemm bżonn, fl-1652, is-sorijiet għamlu d-dħul tagħhom solenni f'dan il-bini li ismu inbidel għal Kunvent ta' Santa Skolastika. Minn dak Iż-żmien, tnaqqas żewġ perjodi żgħar, il-bini dejjem kien okkupat mis-sorijiet Benedittini.

Id-dar b'numru 19 Triq l-Osservatur, kienet ir-residenza uffiċjali tas-Supretendent ta' l-isptar, li kien ukoll il-Gran Prijur tal-Lingwa Franċiża. Għalhekk waqt l-okkupazzjoni Franċiża (1798-1800), is-sorijiet ħallew il-Kunvent tagħhom u kienu rifuġjati l-Imdina, fil-Kunvent tal-Benedettini ta' San Pietru u San Benedettu. Fl-1940-43, fl-aqwa tal-Gwerra Dinjija, is-sorijiet, għal darb'oħra, fittxew rifuġju fl-Imdina.
Il-knisja ta' Sant'Anna l-ewwel inbniet fl-1652, meta parti mill-Infermeria twaqqgħet. Grazzi għall-għotja ta' flus li ġiet mogħtija minn Lady Dorell, din kienet mibnija mill-ġdid fl-1679 b'xi tibdiliet. Il-bieb ta' biswit, il-"Parlatorio" jipprovdi bħal issa l-entratura għall-Infermeria.

L-istil arkitettoniku ta' dil-Knisja huwa Korintu. Ringiela t'anġli skolpiti fil-għoli minn Gafa' iżejjnu l-faċċata minn ġewwa. Pittura ta' Preti għadha hemm issebbaħ il-post minflok oħra antika li kienu ġabu

magħhom is-sorijiet mill-Imdina fl-1604 u li għadha miżmuma ġewwa l-Kunvent.

Fuq kull naħa ta' l-artal prinċipali, wieħed jista' jara twieqi bil-persjani li jgħaqqdu l-kor tas-sorijiet mal-knisja. L-artal magħmul minn irħam rikk, huwa xogħol Gafa' u jġib l-arma ta' l-Isqof Alpheran.

L-artali taż-żewġ naħat huma ddedikati lill-Immakulata Kunċizzjoni u lil San Mikiel u l-pitturi ta' fuqhom huma xogħol ta' l-artisti famużi R. Buhagiar u F. Zahra rispettivament.

Gallerija spazjuża li tissejjaħ il-Kor ta' fuq tħares lejn il-knisja u tintuża biss mis-sorijiet.

Hemm ukoll relikwarju ta' Santa Veneranda ġo kaxxa tal-ħġieġ, rigal mogħti lill-knisja mill-Inkwiżitur Antonio Ruffo fl-1728. Plakka ta' l-irħam li tikkomemora il-konsagrazzjoni tal-knisja fl-1787 tinsab fuqha.

Iskrizzjoni oħra ta' tifkira li tikkomemora għal min hija ddedikata l-knisja u il-bini tagħha mill-benefattriċi Lady Dorell tinsab fuq il-bieb prinċipali bħala ringrazzjament talli kienet meħlusa minn epidemija tal-mewt fl-1675.

Il-knisja għandha bħala teżori tapezzeriji rikki paramenti antiki, kif ukoll għadd ta' oġġetti antiki tal-fidda li ta' kull sena jiġu murija waqt iċ-ċelebrazzjoni tal-Festa ta' San Benedittu fil-21 ta' Marzu.

Għalkemm dan l-Isptar kien mibni viċin il-port, dan ġie meħlus minn kull ħsara waqt l-aħħar gwerra dinjija. Din fortuna kbira ghax-dal-bini huwa storikament konness ma' l-Assedju l-Kbir-wirt Malta, minħabba li huwa wieħed mill-eqdem bini tal-Kavallieri li għadu ppreservat. Bini li serva ta' Sptar taħt l-awspiċi tal-Ordni u li kompla jiffunzjona sakemm inbniet is-Sacra Infermeria tal-Belt Valletta.

Referenzi:

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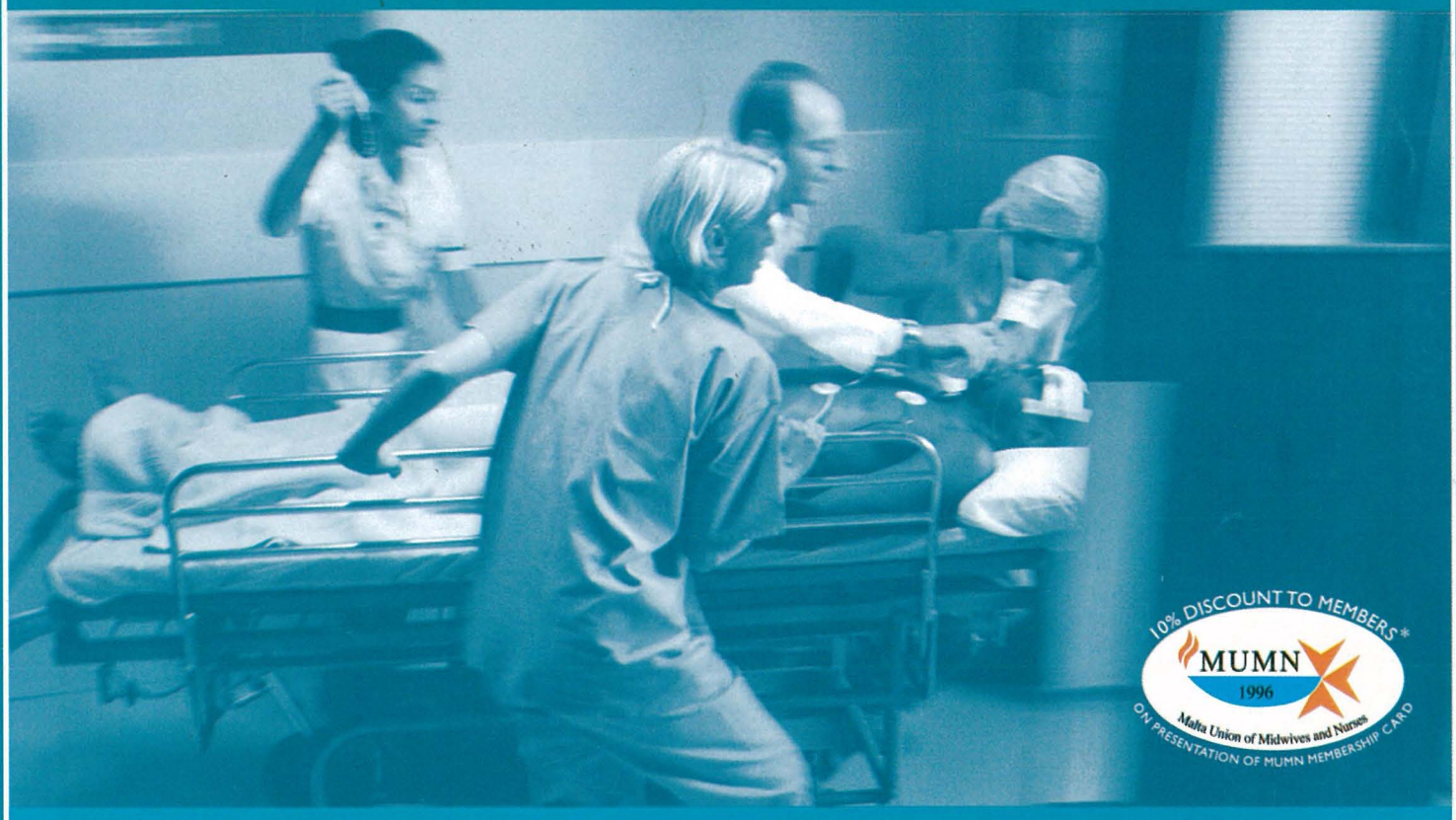
• E.R.Leopardi, First Hospital Of The Knights, Malta's Heritage: Times of Malta, November 6. 1965. Maqlub għall-Malti.

L-E.T.MONSINJUR ARĊISQOF PAWLU CREMONA SER JINDIRIZZA L-KONFERENZA ĠENERALI TA' L-MUMN NHAR ID-29 TA' MARZU 2007 FIS-7.30PM ĠEWWA L-LUKANDA PHOENICIA. DIN HIJA ĠURNATA STORIKA GĦAN-NURSES U L-MIDWIVES.

ATTENDU BI ĦĠARKOM GĦAL DIN IL-LAQGĦA MA L-ARĊISQOF

PROFESSIONAL FOOTWEAR



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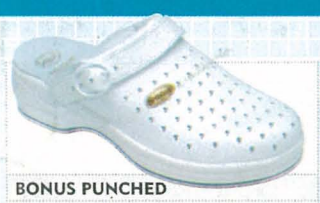
Working with your body all day long



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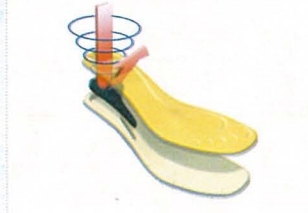
COLOUR: White / Navy
TECHNOLOGY: Professional
PRICE: Lm22.90 80400010 - 80400021

VERVE
SIZES: 35 - 42 Leather
COLOUR: White / Black
TECHNOLOGY: Professional
PRICE: Lm23.90 80470010 - 80470013

VIGOUR
SIZES: 35 - 42 Leather
COLOUR: White / Black
TECHNOLOGY: Professional
PRICE: Lm23.90 80490010 - 80490013

ENERGY
SIZES: 35 - 42 Leather
COLOUR: White / Black
TECHNOLOGY: Professional
PRICE: Lm23.90 80510010 - 80510013



BACKGUARD TECHNOLOGY
Protects the feet and spine from walking impact, helping prevent back pain.

Scholl

AVAILABLE FROM:
Scholl Foothealth Centre, Valletta, The Scholl Centre, 67, The Strand, Sliema • Norman's Pharmacy, Tower Road, Sliema • Suffolk, 13, Merchant's Street, Valletta • Abela's Health and Beauty Centre, Victoria, Gozo,
*discount redeemable only at: The Scholl Centre, the Strand, Sliema and Scholl Foothealth Centre, South Street, Valletta