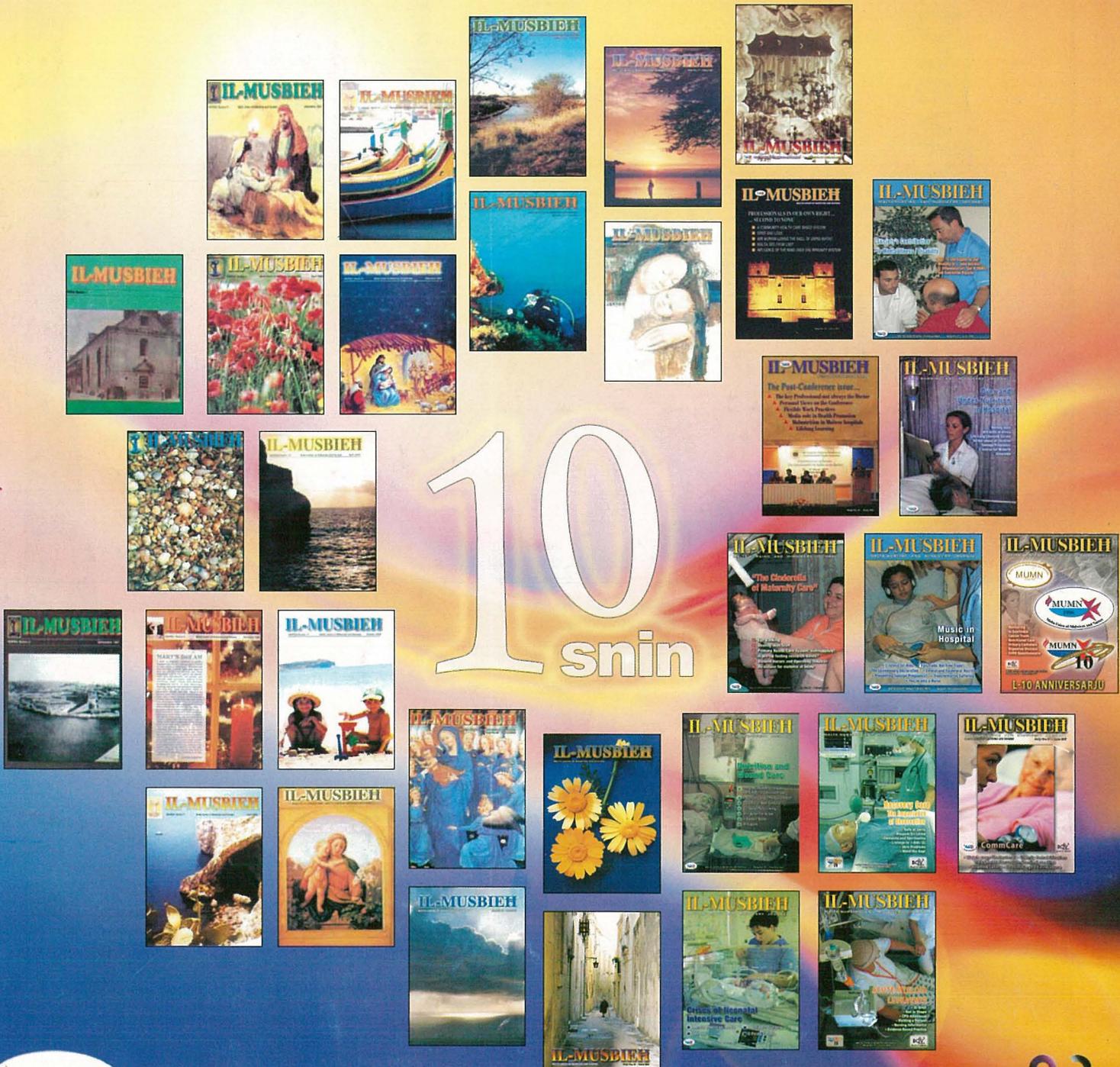


IL-MUSBIEH

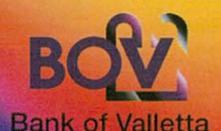
MALTA NURSING AND MIDWIFERY JOURNAL
MALTA UNION OF MIDWIVES AND NURSES

Ħarġa Nru. 35 - Ġunju 2007



• Il-Musbieh jagħlaq 10 snin

- Psychiatric Nursing in Malta • Kolera tal-1837 •
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Editorjal	4	The journey of psychiatric nursing in Malta	23
Message from the President	5	Targeting Mental Health	27
In the Hospital Chaplain's Shoes	6	What is a safe toy?	28
Kelmtejn mis-Segretarju Ġenerali	7	Consultative Measures	30
Malta Emergency Nurses' Association	8	Xi Qrajt...	33
Childhood Nutrition	11	Ejjew nieqfu ftit	35
Induction of New Operating Theatre Nurses	13	L-Istorja tal-Isptarijiet civili u ġenerali Maltin	36
Mid-Djarju Tagħna - From Our Diary	20		



PUBBLIKAT: Malta Union of Midwives and Nurses

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

L-MUMN ma tistax tinżamm responsabbli għal xi hsara jew konsegwenzi oħra li jiġu kkawżati meta tintuża nformazzjoni minn dan il-ġurnal.

L-ebda parti mill-ġurnal ma tista' tiġi riprodotta mingħajr il-permess bil-miktub ta' l-MUMN.

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

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Il-Musbieh jiġi ppublikat 4 darbiet f'sena.

Minhabba kuxjenza ambjentali li thaddan l-MUMN, il-ġurnal jitwassal għand il-membri tiegħu f'boroż tal-karta u mhux tal-plastik.



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E ditorjal

Il-Musbieĥ

jagħlaq għaxar snin ukoll

Flamsa w tletin ħarg'ilu, jiġifieri għall-ħabta ta' Ġunju tal-1997, il-bord editorjali ta' **Il-Musbieĥ**, illum imsejjah **Il-Musbieĥ Group Committee** fi ħdan I-MUMN, kien konsistenti f'suċċess wara l-ieħor biex jippublika l-uniku ġurnal tan-Nursing u l-Midwifery f'Malta. Grupp dinamiku fejn il-membri tiegħu jikkontribwixxu regolarment biex il-kontenut tal-Ġurnal jitjeb minn ħarga għal oħra.

Mil-2004 **Il-Musbieĥ** beda' joħrog kull tlett xhur u mhux erbgha. Dan ifisser li d-domanda ta' xogħol minn membri volontarji, biex ilaħħqu fil-ħin, żdiedet mhux ħazin, u ta' min jieħu l-opportunità biex jirringrazzja mill-qalb lil kulhadd tax-xogħol siewi kollu li jsir mingħajr ħafna xinxilli. Rigward in-numru ta' pagni fil-Ġurnal: F'Marzu 2004 tela' għal-32 pagna; f'Settembru 2004 tela' għal-36; u baqa' b'40 pagna minn Diċembru 2004 'l hawn. Lċ-ċirkolazzjoni hija ta' 2200 kopja. **Il-Musbieĥ** jitqassam b'xejn lill-membri kollha u anke lil-dipartimenti tal-gvern, rappreżentanti tal-poplu, entitajiet importanti, organizzazzjonijiet u anke barra minn Malta.

Minn 35 ħarga, wahda minnhom kienet speċjali fejn trattat il-5 Konferenza Reġjonali Ewropea tas-CNF.

Happy Birthday **Il-Musbieĥ**

Jidher li l-ħarġiet kollha kienu u għadhom qed jintlaqgħu tajjeb b'diversi kummenti pożittivi dwar kwalità, kontenut eċċ. Hemm minn saħansitra jirreferi għal xi artikli f'xi *assignment* jew *paper* li jkun ipprepara u hemm qarreja li dejjem iżommu l-ħarga bħala kollezzjoni ta' xi tip ta' artiklu jew ieħor. Dejjem qed ikun hemm storja/artiklu li jkun prinċipali u li jkollu t-tema tiegħu permezz ta' l-istampa fuq il-qoxra.

Għalhekk żammejna b'mod konsistenti ritratti fil-qoxra ta' barra ta' **Il-Musbieĥ** meħuda fl-ambjent tagħna stess li b'xi mod jew ieħor juri n-Nursing/Midwifery f'Malta. Ir-ritratti ta' ġewwa huma kważi kollha lokali. Wara analiżi ta *survey* li konna għamilna, il-bilanċ bejn l-użu tal-lingwa Maltija u dik Ingliża ħallejnief kif inhu, iżda dejjem qed jinħass li biex żgur jinqara' minn kulhadd f'Malta u barra minn xtutna, inżidu d-doża tal-lingwa Ingliża. Ankè rigward l-użu tal-kelma Nurse/Midwife jew Nursing/Midwifery, inħass li dawn jintużaw bla mittiefa u mhux jieħdu xi kelma oħra Maltija li mhix propju dik li rridu nfissru, jew ħafna drabi ma nsibux kelma għaliha. Kemm jista' jkun qed niżguraw li nipublikaw artikli minn kittieba lokali u naraw ukoll li jkun hemm bilanċ f'dak li hu kontenut ta' suġġetti varji.

Mhux l-ewwel darba li xi editorjal jew artiklista ta' xi Ġurnal lokali jikkwota mill-editorjal ta' **Il-Musbieĥ** speċjalment meta jkun ta' natura kontroversjali jew b'*news value*. Nafu wkoll li dak li ġie ppublikat jiġi wkoll kkwotat minn Diretturi f'laqgħat, u entitatijiet ta' ċertu mportanza. Nafu anke b'*memos* interdipartimentali li ħarġu apposta biex jikkjarifikaw xi *issues* li kien hemm.

Ma nistgħux ma niringrazzjawx lill-isponsors tagħna li jirreklamaw ma **Il-Musbieĥ**.

Il-Musbieĥ mhux biss Ġurnal tan-Nursing u l-Midwifery f'Malta biss, iżda l-*mouthpiece* jew vetrina tal-MUMN ukoll. **Il-Musbieĥ** huwa sinonomu mal-MUMN u għalhekk irid jiġi zgurat li mhux biss nibqgħu nipublikawh b'mod regolari iżda nipprogettawh f'ambitu akbar ta' professjonalità kullimkien. Għalhekk l-impenn ta' dan il-*Group Committee* ser ikompli għaddej b'ċertu ritmu biex jiżgura l-kontinwità, l-kwalità u l-konsistenza ta' **Il-Musbieĥ**. *Happy Birthday Il-Musbieĥ*.

M

essage from the President

This is my first contribution to our Nursing Journal as President of MUMN. Being President of our Union at the moment is very challenging and requires great commitments from all those involved. Issues which have been pending during these last few years, pinnacle all at the same time. Being a member on the previous Council, we had envisaged that this time, particular prior the migration to the new hospital, would be a challenging period. But as a Union we could not allow any obstacles to hinder us from addressing issues which have been having a negative toll on our Nurses and Midwives. The positive aspect of all this is, that the newly elected Council members are all enthusiastic to contribute to the tasks delegated to them from the Council whilst the experienced veterans are all using our experiences to achieve our targets and demands. In short – we all make a great team.

One of my first duties I committed myself to, was to meet all Chairpersons and their respective Committees. There are fourteen of them in MUMN. During such meetings we discussed all the current issues and was glad to discover a common consensus was attained in all the Committees.

But what are the goals of our Union for the next four years?

The challenges vary: The migration to Mater Dei Hospital and the working conditions of our Nurses and Midwives are at the moment one of our top priorities; Lack of supporting staff; Nurse's shortages and child care facilities are issues we are also tackling with the authorities. The list could be endless. Another important issue that affects us all is the one about the new packet of incentives we are discussing with the Government.

We are also handling tribulations in SVPR. Problems regarding staff shortages and overcrowding are causing burnout. This could easily be seen in the female wards. Hopefully in the coming months new Nurses and carers would be placed in these wards.

Other issues which need to be addressed are:

- The migration of Zammit Clapp Hospital and Boffa Hospital;
- The Community Care;
- Reviewing the Nursing Compliment in Mount Carmel Hospital;
- Equality of opportunities for Nurses in the Gozo General Hospital;
- Collective agreements in these four years;
- Warrant, Bridging, Students, etc.

As the President I do feel that I have to pass this message. Work should not only be done by the few whilst others just watch and comment. I do believe that first and foremost all Nurses and Midwives should be members of the MUMN and secondly, all Nurses and Midwives should participate fully, if not in the Group Committees, at least attend activities organised by our Committee within MUMN. Nurses and Midwives should feel proud of their profession and their Union. If we expect our patients and the general public to treat us with respect, we should first make sure to treat with respect one another and ourselves.

Paul Pace

President

□ mumn@maltanet.net



In the Hospital Chaplain's Shoes



Pastoral ministry is an art that needs to be learned, reflected upon and continually supervised. Being a hospital chaplain is really a privilege and a humble service. It all boils down to how the chaplain is deeply and genuinely concerned about the uniqueness and sacredness of the person s/he is ministering to.

The first step that the chaplain needs to take in order to be a truly and an infectious compassionate presence within the clinical setting is precisely that of transcending into the world of the other to experience her/his feelings with her/him. S/he needs to assess the present emotional state of the person/s s/he is encountering with and respond appropriately to feelings that are being communicated to her/him. By listening and responding empathically to the emotional content of the conversation, the chaplain is encouraging the person/s to explore and communicate what is particularly important and pertinent for the individual/s involved.

From my hospital ministry experience I came to realize the importance and awareness of body language. Many well hidden words can easily be communicated by instant gestures. It is essentially paramount for the chaplain to thoroughly observe the other person/s as well as her/his nonverbal behaviour. From it s/he will have enough information on how the person and her/himself is feeling about the issue involved as well as on the required dosage which is needed for a valid pastoral intervention.

It is fundamentally wrong to assume that the hospital chaplain is a problem solver. In fact, the basic role of the chaplain is that of journeying with people. This eloquent metaphor suggests perseverance and risk. A journey is long and can take different directions. A basic attitude that any hospital chaplain must endorse is that of staying with the people s/he is accompanying. Even if staying with them proves uncomfortable. May be it would be the time where the chaplain can ask herself/himself why s/he is being confronted by these scary emotions. It could be that the chaplain is being taken over by the grief or the emotions of the person/s s/he is journeying or projecting her/his personal issues on others. Such situations call for and justify constant vigilance in ministry.

An effective chaplain is imbued with humility. S/he knows that s/he does not know it all. Like anyone involved within the caring professions, from time to time the chaplain needs to go to pastoral supervision. With the help of the pastoral supervisor, s/he can reflect on her/his ministry and find new ways of making it more available and effective to alleviate the great spiritual and emotional distress people undergo within the hospital environment. The more a chaplain is versed in the skills of

the Clinical Pastoral Education the better s/he can serve her/his singular mission of compassion and healing.

A basic attitude which nicely couches the comforting and healing role of the chaplain is kindness. When openness, validation of feelings, and a being there spirit are minced with kindness, those who approach the chaplain feel they are welcomed, respected and unconditionally accepted. Such unconditionality is also visible in the flexibility with which the chaplain exercises her/his ministry. Within the hospital domain situations can dictate how the caring approach ministry can best respond to the circumstances at hand. Obviously the more a chaplain is capable to work hand in hand with the members of other professions the more the patient, the family and the staff will greatly benefit from her/his ministry.

A responsible chaplain not only knows how to care for others but also how to care for her/himself. Self-care is a necessity. Refreshed by a balanced life of service, study, personal reflection and supervision, prayer, non-hospital interests and leisure time a chaplain is likely to be in the best position to respond creatively, professionally and compassionately to the never ending demands of her/his mission. Hospital chaplaincy is essential as the soul is to the body. May we as hospital chaplains continue to enrich our work, spirituality and professionalism so that the entire healing of the people we serve as well as our own, is promoted, safeguarded and deepened as much as possible.

Fr Mario Attard OFM Cap

☐ koinonia@waldonet.net.mt



**Fl-Okkażjoni
storika tal-
Kanonizzazzjoni
tal-ewwel
Qaddis Malti,
San Ġorġ Preca
nhar it-3 ta'
Ġunju, 2007.**

*"Grazzi Sinjur
Alla u Aħfirli
Sinjur Alla"*

K

kelmtejn mis-Segretarju Ġenerali

Kunsill ġdid veru, però l-prinċipji u l-oġġettivi jibqgħu l-istess... li nħarsu u nġibu l-quddiem l-interessi tal-membri tagħna. Il-mod u l-manjieri kif nilhqu dawn l-oġġettivi żgur li nbidel għaliex nies differenti tfigħer mentalità diversa. Is-sitt membri godda diġa' qabdu ritmu sew u daħlu fil-magna tal-Union qishom ilhom hemm is-snin. Barra minn hekk issa ġew iffurmati wkoll dawk il-Kumitati kollha li ma jkunx jinhtieg elezzjoni sabiex jiġu fformati.

Sodisfatti mmens bir-rispons qawwi li bagħtulna dwar l-ittra tal-pakkett ta' incentivi u l-iskema ta' rtirar kmieni. Issa l-Kunsill il-ġdid għandu mandat ċar sabiex ikompli jinnegozja mal-Gvern il-pakkett ta' incentivi u twegiba oħra daqstant ċara kienet: li jekk ma naslux fuq il-mejda, 96% tal-membri lesti li jobdu azzjonijiet industrijali horox. Grazzi mill-qalb. Konxji li intom apprezzajtu dan il-mod ta' konsultazzjoni. Inwegħdu li kif ikkonsultajna magħkom, hekk ukoll se nkomplu nżommukom infurmati bl-iżviluppi li jseħħu.

Il-proċess tal-*migration* ser jaffettwa tlett sptarjiet direttament, l-Isptar San Luqa, Boffa u Zammit Clapp. Din il-Union hija nvoluta f'diversi laqgħat sabiex tkun infurmata dwar jekk il-kundizzjonijiet tan-Nurses u l-Midwives humiex ser jiġu mittiefsa b'xi mod. Għadna kemm ilhaqna ftehim mad-Direttur tan-Nurses fl-Isptar San Luqa dwar in-numru ta' Nurses li ser ikun hemm f'kull sala fl-Isptar Mater Dei. Diġa' għamilniha ċara li jekk dan in-numru ma jiġix rispettati, l-MUMN tagħti d-direttivi neċessarji sabiex dawk in-Nurses li jkun jaqdu d-doveri tagħhom f'dik is-sala partikolari jibqaw fl-Isptar San Luqa u ma jtilgħux lejn Mater Dei. Għaddejnin ukoll negożjati mal-*Manager* li hija responsabbli mis-swali tal-Maternità. Hawn ukoll qed naraw xi diffikultajiet però nemmen li b'rieda tajba bejn iż-żewġ partijiet naslu għall-ftehim aħhari.

Żewġ diffikultajiet li jolqtu lill-membri tagħna li jaħdmu fl-Isptar San Luqa b'mod ġenerali huma n-nuqqas adegwat ta' *showers*, li jista' jirriżulta li tispicċa titlaq mill-Isptar siegħa wara li jkun intemm il-hin tax-xogħol, u n-nuqqas ta' servizz fl-Isptar Mater Dei taċ-*Child Minding Facility*. Dawn iż-żewġ problemi qegħdin jiġu trattati ma' l-awtoritajiet konċernati u nżommukom ukoll infurmati b'dak kollu li jkun qed isehħ.

Dwar in-Nurses li jaħdmu fl-Isptar Zammit Clapp u f' sala partikolari fl-Isptar Boffa, din il-Union wkoll għaddejja b' trattattivi sabiex inserrħu moħħa li l-kundizzjonijiet tax-xogħol mhux ser jiġu effettwati.

Dwar ir-Residenza San Vincenz de Pauli, l-MUMN hija kkommessa li s-sitwazzjoni tal-*vacation leave* tinbidel u ma tibqax fis-sitwazzjoni miskina li għandna llum. Għadna kemm ilhaqna ftehim sabiex fl-1 t'Awissu li ġej ser jintbagħtu 20 Nurse mara fl-għaxar t' iswali l-kbar tan-nisa bir-roster DDO. B' hekk in-numru ta' Nurses mal-ġurnata ser ikun 3 u barra li li r-residenti ser noffrullhom servizz aħjar, il-*vacation leave* ta' Nurse waħda kulljum ser ikun garantit. Barra minn hekk, din il-Union qed tinsisti li kull *shift* fir-Residenza ikollu żewġ *nursing aids/carers* u jekk din it-talba ma tintlaqax ser induru fuq in-Nurses ta' l-SVPR għas-sapport tagħkom.

Kif qed taraw ix-xogħol tagħna ma jiqafx. Dan huwa biss ftit minn dak li qed isir għaliex laqgħat oħra u korrispondenza fuq iċ-Ċentri tas-Saħħa, fuq l-Isptar Monte Carmeli u dak Ġenerali f' Għawdex huma ta' sikwit. Dan biex ma nsemmux in-numru ta' każijiet individwali li kull rappreżentant tal-Union ikollu. Imma dan kollu konna nafuh qabel dhalna għal din il-biċċa xogħol, ħidma li tħallilek sodisfazzjon kbir speċjalment meta tara li s-sapport tan-Nurses u l-Midwives huwa wieħed kontinwu u shiħ.

Nispicċa dawn il-kelmtejn billi niringrazzja b'mod personali li dawk kollha li vvutawli fl-elezzjoni. Inwiegħed li nkompli nagħti dak kollu li nista sabiex inkun ta' servizz għalikom. Grazzi mill-qalb.

Colin Galea

Segretarju Ġenerali

✉ mumn@maltanet.net

MUMN Courses

organised by the Educational Committee

New courses starting in October organised by the MUMN Educational Committee

- Neonatal Intensive Care • Communication Skills • Leadership in Management •
- Management in the Healthcare setting • Handling Interpersonal skills •
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Limited places available. Applicants are to be chosen on first-come-first-served basis. Special Discount for MUMN Members. For further details contact MUMN Office on 21448542 and the Education Committee Chairperson Rowland Bezzina on 79233314.



Malta Emergency Nurses' Association



Emergency nursing is a specialised area of nursing practice. It includes a defined and evolving body of knowledge, based on research, which is independent from, yet collaborative with other fields of nursing practice and with that of other professions.

The Malta Emergency Nurses' Association was established with the aim to promote excellence in emergency nursing practice, in view of the professional code of ethics for nursing practice, upon which the association's mission statement is founded.

MENA was founded by a group of nurses working in an Accident and Emergency setting, and the first meeting was held on the 13th July 2004. The first meeting of the permanent committee was held on the 4th October 2005.

Since then much work has been done and after calling the first official meeting, the members approved unanimously the association statute which is fundamental in having good pediments for a successful mission.

After that, the executive committee identified various areas of focus with the aim of moving emergency nurses forward, and as one may expect the issues are many and much needs to be done! To achieve such goals it was decided to involve MENA members more directly, thus work will be distributed better and goals can be achieved in the least time possible.

With this in mind, working groups have been set up. These working groups are already working very hard and we now host our own official website on the portal, www.enamalta.org and last month we launched the first Maltese nursing forum www.enamalta.org/forums where everyone can join and have his/her say.

This portal is a mean by which interested persons in emergency get to know what MENA can offer to them. It is also intended to deliver recent news to MENA members and keep them up to date about any activities MENA will be organising.

The Association is currently working on other two



Photo: MENA

main projects. The first one is the organisation of short courses and lectures which are now becoming very popular with the nursing staff and secondly to organise together with MUMN the first MENA conference about emergency care which is going to be held in October 2008.

MENA also signed a 2 year deal with the MUMN educational section and a 4 yr deal with the CENA (College of Emergency Nursing Australasia), which such deals can help us to promote emergency nursing even more. Moreover we are also very near to sign another affiliation deal with the Italian Emergency nurses' association (AISACE) and having their President with us during our Annual General Meeting was a great honour.

More information about MENA and how to become a member can be obtained from www.enamalta.org or else by sending an email on info@enamalta.org.

Finally I want to thank MUMN especially Mr. Colin Galea, Mr. Rudolph Cini (Ex-President MUMN) & Mr. Joseph Camilleri for giving us this space and for supporting us all the way.

Moreover I would like to take this opportunity to wish MUMN new executive committee all the best wishes for their future work.

Mario Fleri Soler SN
General Secretary MENA
□ info@enamalta.org

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Patient Talk!



The International Council of Nurses
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The Preschool Years

Preschoolers often insist on a certain food one day and reject it the next. Despite these ups and downs, they do look for security and structure. Steps that you can take to improve your child's nutrition and encourage smart eating habits include:

- Having regular family meals
- Serving a variety of healthy foods and snacks
- Being a role model by eating healthy yourself
- Avoiding battles over food
- Involving children in the preparation of meals

Source: www.kidshealth.org

Energy and nutrient requirements

Preschool children have high-energy requirements for their size because they are growing and active. To meet this demand, your child should eat small and frequent meals of foods high in energy and rich in nutrients. Protein, calcium, iron and vitamins A and D are necessary. Choose a wide assortment of foods from the main food groups, and let your child experiment with different textures and flavours. Skimmed milk is usually not suitable for children under five. If you are planning a vegetarian diet, talk to your health care professional.

What about vitamin and mineral supplements?

Studies have found that a lack of zinc, iron, vitamin B and protein in the first three years can cause behavioural problems in later years. An early start in proper nutrition can help with longlasting wellness and vitality. In some circumstances, supplements, particularly of vitamins A, C and D, may be prescribed. Your dietician or doctor can provide guidance on the type, amount and duration. Like medications, supplements should be kept out of your children's reach.

Common diet-related concerns

Constipation can be dealt with by gradually increasing the amount of fibre and liquids in your child's diet. Vegetables, fruits and wholemeal bread are high-fibre foods popular among children. Encourage your child to drink water.

Toddler diarrhoea may be linked to low fat diets, high fibre diets and/or excessive sweet drinks. Give small frequent meals and snacks from the main food groups. Most children grow out of the problem between two and four years of age.

Choking is the greatest risk in children under three. Sausages, grapes, hard pieces of candy and vegetables, and very sticky foods can cause choking. Foods should be cut in narrow, length-wise pieces. Supervising your children and encouraging them to sit quietly when eating can prevent choking.

Tooth cavities are caused by a steady food supply of acid-producing bacteria in mouth. Sugars found in sweets and starches feed the bacteria. Limiting sweet sticky foods and ensuring children brush their teeth regularly can promote dental health.

School-Aged Children

At this stage your child is on the go! Meals are often eaten away from home and snacks become an important part of your child's diet. Although your child thrives on accomplishment, you might notice that he or she also enjoys less active pursuits, like watching television or playing video games. Balancing your child's activities with his or her food needs can be challenging.

Energy and nutrient requirements

Children grow according to their own patterns. Typically, they have high-energy requirements for their size. They often have growth spurts during which they get thinner even though their appetite increases. Regular meals and healthy snacks should include carbohydrate-rich foods, fruits and vegetables, dairy products, lean meats, fish, eggs, legumes and nuts. Children under 16 should avoid eating shark, marlin and swordfish because of the relatively high levels of mercury that these fish contain.

Iron deficiency

The rapid growth periods of children place them at high risk for iron-deficiency anaemia. If left untreated, iron-deficiency may lead to behavioural or learning problems. If you recognise the symptoms listed below in your child, talk to your medical doctor. He or she can diagnose whether your child is at risk or already has an iron deficiency.

- Fatigue and weakness
- Pale skin and mucous membranes
- Irritability
- Decreased appetite
- Dizziness or a feeling of being lightheaded

Source: www.kidshealth.org

Overweight or obesity

The number of overweight and obese children is increasing. Evidence shows that irregular family eating patterns, high intakes of fat and processed foods and little physical activity lead to overweight and obesity in childhood. If your child is overweight, he or she should not be on a restrictive diet. Rather, a lifestyle of healthy eating and activity

is most successful. Include the whole family in healthy lifestyle changes. Public health authorities recommend that children have at least 60 minutes of moderate physical activity every day. Being overweight because of a medical condition is rare, but check with your health care professional if concerned.

There is no relationship between snacking and being overweight in childhood. The important factor is to make sensible choices in the context of a healthy, active lifestyle. For more information on childhood nutrition, consult the following sites:

- The European Food Information Council. www.eufic.org
- Health Canada. Office of Nutrition Policy and Promotion. Nutrition for Preschoolers: www.hc-sc.gc.ca/hpfb-dgpsa/onppbppn/food_guide_preschoolers_e.html. Nutrition for Children 6-12 years: http://www.hc-sc.gc.ca/hpfb-dgpsa/onppbppn/focus_child_e.html
- British Nutrition Foundation. www.nutrition.org.uk
- American Dietetic Association. Healthy Habits for Healthy Kids. www.eatright.org/Public/index_16684.cfm
- Scottish Executive. Scottish Nutrient Standards for School Lunches. www.scotland.gov.uk/library5/education/niss-00.asp

AWGURI!

Issa ilu għaxar snin. Dak inhar twieldet il-Union tal-Infermiera u l-Qwiebel: l-MUMN. Is-Sur Rudolph Cini kien inħatar l-ewwel president tagħha. Matul dan iż-żmien saru żviluppi ta' gwadann, sew għall-membri u anke għall-isptarijiet. Ġara li dan l-aħħar is-Sur Cini ddecieda li ma jergax jikkuntesta għall-kariga. B'elezzjoni li saret ġie maħtur is-Sur Paul Pace bħala president. Filwaqt li nirringrazzja lis-Sur Cini għall-ħidma siewja li ta matul dawn is-snin, nifraħ u nawgura lis-Sur Pace u l-Kunsill il-ġdid għall-karigi tagħhom.

Wara xi sitt snin ma joħroġux promozzjonijiet f'SLH għall-Midwives u n-Nurses, dan l-aħħar ħarġu l-promozzjonijiet għall-kullimkien u għall-kulhadd. Prosit ta' din l-inizjattiva għax aħjar tard minn xejn. Għalhekk filwaqt li nifraħ lill-awtorità tal-pass li ħadet, nawgura lil dawk li ser jieħdu l-promozzjoni u forsi anke jkunu xi wħud li għamlu l-conversion course.

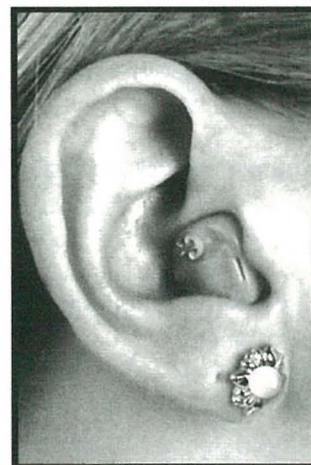
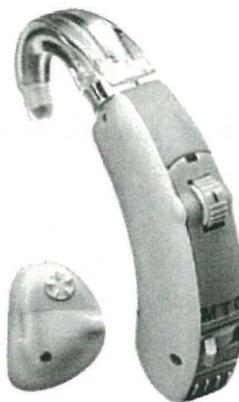


...hemm bżonn li jinstab mezz ħalli dan il-post jerga' jkun użat u jkun ta' kontribut.

Żmien twil ilu beda' l-bini ta' sptar ġenerali ġdid biex jieħu post l-Isptar San Luqa. Matul is-snin saru xi deċizjonijiet ta' kontroversja li ħolqu firda. L-isptar San Luqa għal xi sebgħin sena kien ta' għajjnuna għall-marid u l-batut. Issa waslet is-siegha tiegħu li jieħu l-pensjoni u jirtira wkoll. Però xorta naħseb li hemm bżonn li jinstab mezz ħalli dan il-post jerga' jkun użat u jkun ta' kontribut. Fl-aħħar nawgura li l-Isptar Mater Dei iżid is-servizz ta' kura u jkun ta' fejda għal ħutna l-batuti Maltin u Għawdxin u 'l kull min jiġi bżonn xi forma ta' fejqan.

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Induction of New Operating Theatre Nurses

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PART 1: Introduction

It is today acknowledged that education and training is a continuing and lifelong process. The pace of scientific, technological, social and economic change is so rapid and intense that an initial period of professional or occupational training can only provide the foundations of knowledge, skills and attitudes on which further self and continuous professional development must take place if professionals are to remain current and competent.

During the last twenty years, there has been a growing recognition of the role of mentoring as an important contributor to the professional and personal development of individuals (Gibbons, 2002). It has been related to professional development as mentoring is aimed at transferring the required knowledge and skill and also providing psychological support and assisting in personal development (Clutterbuck, 1998).

While mentoring is integrated within professional development, it is increasingly realised that it is critically necessary at the beginning of someone's career (Lorriman, 1997) and an integral element in successful recruitment and development of human resource potential within learning organisations.

As part fulfillment for a Master Degree in Business Administration (MBA), the researcher conducted a study in 2005 whereby he could evaluate the process by which new operating theatre nurses were induced into their new professional duties.

This study was conducted at the Main Operating Theatre, St. Luke's Hospital, which is a 24-hour service unit made up of five operating rooms in which approximately 8000 operations are performed annually (Data Management Unit, 2004). These figures represent 31% of all operations performed at St. Luke's Hospital making it the busiest of the eight operating departments within the hospital. The Main Operating Theatre accommodates various areas of surgery and can facilitate the attainment of different surgical specialities.

Every day, various members of different health professionals unite efforts to produce one, strong multi-disciplinary quality service by which surgery can be successfully performed. Amongst such professionals, the Main Operating Theatres host, to date, sixty-six nursing staff. Most nurses arrive on the unit soon after they graduate and are then allocated specific tasks and roles to form part of the large framework making up the Main Operating Theatre.

Aims and objectives of the study

This study set out to satisfy three different aims. It aimed to identify the extent to which mentoring prepares new operating theatre nurses for education and training. It aimed to assess the extent to which the programme assists new nurses in the transition from students to qualified staff. Thirdly, this study highlighted the constitution and duration of the mentoring programme.

To reach these aims, the study strived to satisfy the following objectives:

- ❖ To identify current policies and practices.
- ❖ To gauge the effect of the programme for new nurses in transition from student to qualified nurses.
- ❖ To determine the time frame for the programme.
- ❖ To determine the traits, roles and responsibilities of mentors.
- ❖ To identify core issues to be addressed during the programme.

Selection of Topic: The problem researched

Induction through mentoring was introduced to new scrub nurses at the Main Operating Theatre in 1995 (Departmental Nurse Manager, personal communication, 2005) and for the following 9 years and to date, it was the tool through which new scrub nurses were taught the required knowledge and skill necessary to function safely. The system or technique did not vary much over the years. Mentors, most often highly experienced theatre nurses, have no other or additional academic qualification in theatre nursing or how to transfer the necessary information. Tuition and training are mostly based on mentors' experience (Senior Supervisory Nurse, personal communication, 2005). Since, mentors may differ in levels of experience, perceptions, knowledge and ability to transfer information to recruits, the present way of facilitation may have been liable to subjectivity.

The operating theatre is an area where only zero tolerance, optimal standards and highest quality care are considered as acceptable. Mentoring new operating nurses is perceived as the best and quickest alternative through which nurses are successfully and safely integrated into the new environment, contributing to overcome the initial problems of transition from student to professional life and, enhancing the quality of nursing services. Since the start of the programme at the Main Operating Theatre, no formal evaluation has ever been performed so as to see the relevance of this method, how it can be improved or, with what other method of development can it be enhanced or substituted to reach the learning objectives.

Systematic evaluation is a crucial part of an effective mentoring programme (Mertinko et al., 2000). A systematic evaluation documents what a programme is doing most effectively and enables one to continually improve it. A self-evaluation allows appraisers to evaluate and support what one intuitively knows about the programme. Statements based on a sound, systematic evaluation are more likely to be accepted and believed than those based on casual observation or intuition. Recognition of processes and events will subsequently translate into more service quality through which patients may reap the benefits of optimal nursing standards and service.

Defining mentors and mentoring

As described by O'Shea (1994), mentoring is an advisory process in which an experienced, highly regarded, collegial person guides another individual in the development and examination of their own ideas, learning and, personal and professional development. Their relationship is dynamic and reciprocal while the main reason for mentoring is to help the mentee to increase in effectiveness and productivity (O'Shea, 1994). Mentors are chosen persons that, together with their assigned mentee/s, are to analyse, plan, implement and evaluate the mentoring process (Anforth, 1992). Sweeney (2001) argues that mentoring is the complex and development process which mentors use to support and guide the protégé through the necessary early career transition which are part of learning how to be effective, reflective educator and a career-long learner.

The concept of mentoring seems to have generated considerable discussion and debate in nursing. One thing about which there is considerable consensus seems to be that there is lack of agreement and consistency in the definition of 'mentor' (Anforth, 1992). Haggerty (1986) refers to this as a 'definition quagmire' as definitions of mentor's roles and functions are inconsistent. Oxford's Dictionary (1990) defined mentors as experienced and trusted advisers, while Conway

(1997) described them as wise counsellors. Darling (1984) described mentoring as a close relationship between mentor and mentees in which attraction, action and emotion meet. However, as Morle (1990) claims, many health care institutions have opted to use mentorship to comply with the English National Board for Nursing, Midwifery and Health Visiting. This professional board, in 1988, (Circular No. 39), defined mentors as appropriately qualified and experienced first level practitioners who by example and facilitation guide, assist and support students in learning new skills, adopt new behaviours and acquiring new attitudes.

Mentoring Approaches

There are two common approaches for mentoring being:

- ❖ Informal, Classical Mentoring (Primary Mentoring)
- ❖ Formal, Contract Mentoring (Secondary Mentoring)

In Classical mentoring, the nature and terms of the relations are set informally by the people involved in that, mentors and mentees are free to develop the relationship in the manner of their choosing. The emphasis is on informality (Morton and Palmer, 1993). The processes that evolve are mutually formulated by both parties, naturally occurring and informal within the specific organisational culture. The expectation that arise will relate to what the mentor and mentee may deem as important in gaining the 'tribal wisdom' of the organisation (Darling, 1984) or obtaining the 'DNA of the profession' (Palmer, 1992).

In Contract mentoring, mentor terminology and helper functions are determined by the organisational culture (Murrey and Owen, 1991). It is concerned with the adaptation of classical mentoring and its resulting applications within structured programmes. The people involved are obliged to achieve the identified aim, purposes and outcomes of a recognised programme of development or support. Most often, individuals can be assigned to each other through what is termed as 'forced matching'. According to Morton and Palmer (1993), both mentoring approaches contain vital elements essential to mentoring including:

- ❖ Helper functions
- ❖ Mutuality and sharing
- ❖ Identified stages and duration

At any stage of a mentoring programme, one can and should find a mix of both approaches as they are recognised to compliment each other in particular to organisational situations. This permit for organic, dynamic approach to changing scenarios that may arise in the hectic and changing work environment. The following figure summarises and compares features for each mentoring approach.

Informal/Classical Approach

- ❖ Self-selection of individuals, attracted by shared wish to work together.
- ❖ No defined programme.
- ❖ Less specific purposes and functions set by the individuals, circumstance and context.
- ❖ No explicit formal reward for mentor.
- ❖ Length duration, 2 - 15 years.

Formal/Contract Approach

- ❖ Clear purposes, functions, defined aims and outcomes.
- ❖ Selected individuals with assigned mentors, forced matching.
- ❖ Explicit material rewards for mentors.
- ❖ Shorter duration, 1 - 2 years.

Furlong and Maynard's model

There are many theoretical models for mentoring. A popular one, Furlong and Maynard's (1995) mentoring model is empirically based. Being a differentiated model, it grew not from a survey of literature but from field studies, particularly of student teachers.

Furlong and Maynard's is a staged model which depicts learning to teach a series of overlapping phases in which mentoring strategies need to be carefully matched to novices'

development needs. Accepting the fact that individuals' personality, perceptions, attitudes and needs differ, the stages in this model need to be interpreted 'flexibly and with sensitivity' (Furlong and Maynard, 1995 p.181).

This model is dynamic in nature where different mentors and mentees may be at different stages of training and development. This may be due to the educational and training background of mentees, the mentoring approach or, to implications caused by personal factors of both mentors and mentees. Factors may include the level of motivation and commitment to teach and to learn as well as to the identification of roles that mentors and mentees should play within the organisational framework. As Furlong and Maynard (1995) state, implications support the idea that mentoring cannot be developed in a vacuum and stages within the programme should serve and be built on an informal understanding of what students need and how they develop.

This staged and developmental model consists of 4 different stages:

Beginning Stage	Supervision Stage	Conceptualising Stage	Reflection Stage
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For each separate stage of the model, as can be seen in the table below, Furlong and Maynard go on to define three critical concepts that they identified through studies undertaken from which the model has emerged.

Dimension	Beginning	Supervision	Conceptualising	Reflection
Stage of novice development	Survival	Recognising difficulties	Hitting the plateau	Moving on
Focus of novice learning	Rules, rituals, routings and authority	Competencies development	Understand learning and competency development	Take control and develop professionalism
Role of mentor	Providing models of effective practice	Advice and instruction	Friend, constructive critique	Co-quirer
Key mentoring strategies	Observation techniques	Observation, feedback	Re-assessment of need	Partnership and supervision

Theory Practice Gap

The Theory Practice Gap, as defined by Armitage and Burnard (1991), is the discrepancy between what students are taught and what they practice in the clinical setting. This gap has long been considered as problematic, even an embarrassing sign of failure within education, research and practice (Rafferty et al., 1996). Scott (1994) argues that it has long been recognised that theory-practice gap in nursing does exist. While several authors have pointed out potential causative factors for the occurrence of this gap (Cook 1991, Scott 1994), however, few solutions seem to emerge (Lomax, 2000). On the other hand, Burnard (1990) states that mentors are the ones who are going to bridge the theory-practice gap. They are the ones who are going to help to develop the next generation of nurses (p.4).

While Lindsay (1990) also agreed that theory-practice gap exists, he also argued that a gap between theory and practice in modern nursing will never be sealed completely. Although it is unavoidable, he continued that it should not be considered as undesirable. Rafferty et al. (1996) note that theory and practice are always in dynamic tension with each other and this same tension is essential for the development of new concepts and ideas that may serve to improve clinical practice for the patient's benefit. During the highly stressful period of transition from students to nurses, Stanulis (1994) found that most students during this period saw supporting role of mentor as highly significant. While students continued to argue that support in itself does not directly help in bridging the theory-practice gap the fact that their stress was reduced facilitated the successful shift from theory to practice. The same concept was confirmed

by Anforth (1992) and Stanulis (1994) who found that trainees considered mentors as reducers of stress, helped with orientation and setting in, great emotional support and assistance in technical competence development.

Time and learning

Critical to the success for mentors to bridge the gap is the fact that they should and need to be provided with the appropriate preparation to fulfil their role. As described by Stanulis (1994), this requires two factors namely learning and, adequate time. Conway (1997) argued that short concise courses are not enough to transfer the right ingredients for a successful mentoring. Longer-term courses, as shown by Wilson-Bennett et al. (1995) and Ferguson and Jinks (1994), confirmed the effectiveness of such tuition.

For the theory-practice gap to be effectively surpassed or alleviated, and as previously mentioned, there should be adequate time for an effective mentoring programme to take place. From studies performed world-wide (Davies et al. 1999, Luker and Carlisle 1995) and Bezzina (1996) in Malta, together with and through observational assessment of various hospital units at St. Luke's Hospital in Malta by the author of this study, there seems to be a constant, persistent problem of work overload in clinical settings. In such case, the attention of mentors would be shifted towards patients and away from their mentees. Corlett (2000) suggested that mentors should be an 'extra' individual on such units or else that mentees should be allocated more time for the necessary tuition to be given.

Clinical and academic relationship

Mentoring goes beyond one-to-one mentor-mentee relationship. The success of partnership may receive a positive push forward if mentors can extend relationships with academic bodies (Vaughan, 1999). Clinical, academic relationship can and should further bridge the theory-practice gap (Butterworth et al., 1998). One fundamental role that a mentor should serve is that of co-operation, giving feedback and receiving relevant information upon the mentee's nursing curriculum. Davies et al. (1999) found that as mentors lacked knowledge about what students learnt during their learning days within nursing schools, they found that it was either difficult to teach or that they were repeating already taught subjects. As Scott (1994) argues, the task for mentors to bridge the theory-practice gap should be aided with constant, mutual effective information sharing between clinician and academics. Both should structure programmes with the intent to enhance mentees' chances of learning effectively.

Links between the academic body of training and clinical staff can be created through faculty-organised mentor preparation. The success of such preparation has, according to Ferguson and Jinks (1994) contributed to the smooth choice and recruitment of good mentors. This further improved the mentoring system since, as found by Gardner (1992), motivated and satisfied mentors were those holding formal education in mentoring.

Retention of nurses

Systematic induction can be the possible solution for many new nurses (Burnard, 1990). As Grindel and Roman (2002) highlight, in a report commissioned by the state of Florida's nursing services in United States, over 50% of new graduate nurses leave their first professional nursing job in less than one year whenever mentoring programmes were not conducted. Similar results were experienced in the United Kingdom after the adoption in 1986 of a newly set plan named Project 2000. This project reduced drastically students' clinical commitment from 60% to 40% of common foundation programmes (Castledine, 1993). This considerably reduced the time of mentorship relations between clinical staff, students and new recruits.

In support of such provisions, the United Kingdom Central Council launched another project in 1990 focusing on Post-Registration Education and Practice. Amongst the

recommendations of this project, it included for a 3 to 6 month induction period in support of the new recruit. This period of support was aimed for new nurses to ease their transition from student to qualified nurses. Such support, as recommended by the project, was to be delivered by a mentor. The rationale behind this was the philosophy that mentoring is most useful during the novice stage in the course of an individual's self and professional development.

The looming crisis of staff retention has been compounded in the operating rooms of various Canadian hospitals. Retention of staff and nursing shortage crisis, in particular operating room nurses, has been precipitated by the choice of several schools of nurses to provide for only basic operating room nursing at an undergraduate level.

Research design

This study was conducted via a mixed-method approach by combining qualitative and quantitative methods, in order to increase the scope, depth and power of research (Punch, 1998). Moreover, as the scope of the researcher is an evaluation of the current models and practical concepts used for the current mentoring programme, mixed research combines theoretical and/or technical aspects of qualitative and quantitative research within a particular study (Creswell, 1994).

As Punch (1998) shows, the methodological justification for bringing qualitative and quantitative methods together is primarily addressed to capitalise on the strength of the two approaches and to compensate for the weakness of each approach. At the same time however, the specific reasons for combining approaches should be considered in particular situations in the light of the practical circumstance and context of the research. Many writers, amongst whom Bell (1996) and Creswell (1994) have discussed the concept of combining approaches. From these studies, several criteria amongst which the following have been laid for research to justify the use of both methods.

- ❖ *Logic of triangulation:* - Triangulation is characterised by having both quantitative and qualitative approaches (Patton, 1990). Its origin was intended to add a measurement of psychological traits in addition to quantitative research. This concept was further expanded by Denzin to ensure that variance was reflected in traits and not in methods of collecting data. Patton (2002) clarified the notion that the purpose of triangulation is to test for consistency rather than to achieve the same result using different data sources or inquiry approaches. Triangulation, over the years, increased in popularity as researchers needed to know and use a variety of methods to be responsive to the nuances of particular empirical questions (Patton, 2002). Thus, triangulation is perceived to be able to cut across qualitative-quantitative divide. Therefore, researchers are turning to mixed methods to conduct stronger research (Rocco, 2003).
- ❖ *Provision of general picture:* - Not all issues under investigation are amenable solely to a qualitative or quantitative investigation. Thus, one method of data collection may be employed to plug the gap prescribed by the other.
- ❖ *Facilitate interpretation:* - As the researcher's intention was to bring out possible relationship/conflicts among programme variables, quantitative data readily allows this to be achieved. However, this data collection method is weak when it comes to explore the reasons for such relationship or response. Thus, to compliment the study, the element of qualitative research was perceived to provide the missing link for interpretation and analysis of findings.
- ❖ *Macro and micro levels:* - An effective evaluation of a programme implies for an in-depth analysis of both 'large-scale' structural features of the programme and also, the 'small-scale' behavioural aspects of such. Combining quantitative and qualitative research ensures that all aspects are collected.

Target population and sampling techniques

The target population was that of individuals that in some way or another had connections with the mentoring programme at the Main Operating Theatre.

As for qualitative research, interviews were conducted with two sets of people:

1. *Administration*: All managerial persons involved in the running of the Main Operating Theatre were interviewed. This included two Nursing Officers and three Deputy Nursing Officers.

2. *Senior Scrub Nurses*: Amongst the thirty-seven scrub nurses working at the Main Operating Theatre, ten of them have been working on the unit for more than 9 years. Thus, they were not trained through the current mentoring programme, however may have served on more than one occasion as mentors for new nursing recruits. A judgmental sampling approach was used where the researcher, being himself an experienced operating theatre nurse, selected the sample on judgement whereby samples were selected to suit their specific purpose.

For quantitative data collection, questionnaires were distributed to a total of forty-five nurses who have served as scrub nurses during the last nine years. All these nurses arrived at the Main Operating Theatre since 1995, some of which have moved to other areas of work. To eliminate or reduce non-response error to this survey, reminders were sent to participants, particularly to those who are now working away from the research site. The questionnaire was made up of thirty-seven item questionnaire that investigated all the aims that this study set out to achieve. It consisted of a mix of structured and unstructured questions. A variety of structured questions were used including: -

- ❖ *Simple dichotomy*: The answer to mutually exclusive questions, usually a 'yes' or a 'no' answer.
- ❖ *Checklist type questions*: Respondents indicate an opinion or position from a given list. More than one answer can be given and the option 'other' is included.
- ❖ *Determinant type question*: Respondents are to take one position from a set of alternatives. No opt out option is given and only one answer is expected.
- ❖ *Category scales*: Respondents indicate a position on a continuum.

The use of open-ended, unstructured questions, most often a follow up question to one or a set of structured questions, enabled respondents to generate and broaden their line of thought, thus facilitating more in-depth opinions and responses. Objective measures further enhanced the reliability and accuracy of results.

Data Analysis

Adopting a mixed method approach, two separate sets of data collection tools were used, each of which was analysed separately using different approaches. Quantitative data was analysed using descriptive and analytical statistics using the Statistical Package for the Social Sciences (SPSS) package. Demographic information was used facilitating the analysis of possible variations, namely because of three variables being gender, age, and level of academic training. Qualitative data was thematically analysed as part of content analysis. Data was coded by themes or categories, facilitating analysis and presentation of data. Thematic coding was performed after that the interviews were systematically assembled, read and sorted. The sample size (n=15) was small enough to allow manual thematic analysis. Effort was made to ensure objectivity and eliminate any researcher's subjectivity in the attempt to maintain actual opinions, perceptions, and experiences of respondents.

Results

Demographic data for quantitative analysis

The sample chosen was that of 45 nurses, 12 males and 33 females. Their age ranged between 20 and 53. 32 nurses, representing 71% of the sample, were immediately allocated at the Main Operating Theatre after graduation. The other 13

nurses (29%) were transferred from other hospital units. 62% of the respondents (28 nurses) asked to be transferred on the unit while for the other 17 nurses (38%), the Main Operating Theatre was not their ideal or prime destination of work.

Time Frame

Amongst the aims of this evaluative study, the ideal time frame for the programme was expected to be determined. With a mean of 3.82 months and a standard deviation of 1.267, respondents confirmed that the present duration for the programme of 3 months is satisfactory and acceptable.

The hypothesis question

The hypothesis for this study stated that the induction programme positively affects newly recruited nurses in their duties at the Main Operating Theatre. To answer and satisfy this question, respondents were asked about their level of abilities in operating theatre nursing before and after the mentoring programme. The difference of such questions determined whether the null hypothesis had to be rejected by the researcher. The difference was tested using the Wilcoxin Signed Ranks Test to check the degree and significance of the differences between pre-and-post training periods. The difference found showed that there was considerable statistically significant shift towards a positive response from the pre to post training period.

	Mean	St.Deviation	95% Con. Interval		Asymp. Sig
Q11 less Q4	0.444	0.867	Lower 0.184	Upper 0.705	0.0002

This lead the researcher to reject the null hypothesis that states that the mentoring programme make no contribution towards the successful integration of newly recruited nurses at the Main Operating Theatre.

Traits and roles of mentors

For a successful delivery of quality induction, assigned mentors must possess the best mix of traits to fulfill the expected roles as facilitators for new nursing recruits. Operating theatre nurses were asked to indicate the four main roles that good mentors are expected to satisfy. The following table is a frequency table that outlined the preferred positive characteristics of good mentors as perceived by respondents.

Role	Frequency	Percentage	Cum. %
Model	31	17.2	17.2
Motivator	30	16.7	33.9
Feedback giver	29	16.2	50.1
Teacher	24	13.3	63.4
Supporter	24	13.3	76.7
Eye opener	11	6.1	82.8
Problem solver	5	5.5	87.8
Door opener	5	2.78	90.6
Investor	5	2.78	93.3
Envisioner	3	1.67	65.0
Energiser	3	1.67	99.7
Idea creator	2	1.1	97.8
Counsellor	2	1.1	98.9
Challenger	2	1.1	100
TOTAL	180	100	100

To fulfill their roles, good mentors are expected to have to their credit a number of years of experience in operating theatre nursing. While it was found that those who trained new recruits had a mean of 7.69 years, respondents identified that as regards the ideal number of experience years an effective mentor should have 5.18 years of theatre nursing experience.

Core Issues

In any successful mentoring programme, certain core issues must be addressed. These issues are critical subject material that must

be included in the induction programme irrespective of individual mentors' preferences, as they are seen as essential and critical attributes for the success of the programme. The identification of these topics will narrow the gap between subjectivity and objectivity, as conformity to standard practice will be considered as the rule.

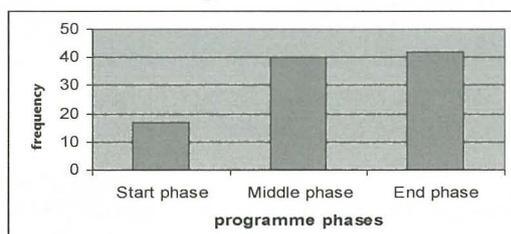
Many were the issues and topics mentioned throughout the questionnaires. Since this was perceived and expected by the researcher, respondents were asked to rank the six most important topics that should carry most weight during the programme. The table below outlines in detail the selected topics and the highest ranked issues considered as critical for the success of recruits' self and professional development.

Topic	Score
Sterility principles	206
Patient safety	156
Infection control	151
Scrub, gowning, gloving	108
Counts	107
Theatre environment	78
Ethical behavior	52
Specimen collection	36
Theatre management	12
Organizational framework	9
Surgical specialities	8
Patient positioning	7
Sutures	7
Job description	5
Operating accessories	3
Stapling devices	0
Total Score	945

While respondents recognised that the content of the induction programme was more practical than theoretical, and also agreed that induction should be more focused on practice rather than theory, however they proposed and perceive that more theory should be given, thus balancing theory and practice. Perceiving and accepting the fact that respondents prefer added theory to enhance the effectiveness of the programme, the following table below outlines the manner or the place in which respondents consider to be the best alternative for the successful delivery of added theory.

Place for added theory	Frequency	Percentage
Theatre	23	51.11
Seminars	5	11.11
Class/Seminars	5	11.11
Theatre/Class/Seminars	4	8.89
Theatre/Class	3	6.67
Theatre/Seminars	3	6.67
Class	2	4.44

Evaluation of programme: Unanimous response was received from the sample chosen as regards the need for evaluation of the programme. The following bar chart outlines the phase or stages at which evaluation should take place. The respondents could choose more than one stage.



The format and plan: As literature prescribes, training should be addressed to facilitate the transfer of knowledge, skills and attitude necessary for recruits to be able to work safely and effectively. To impart the right tuition, individual recruit

assessments must be performed to identify the actual needs on which the programme will be focused. Training needs analysis is thus a critical component and a pre-requisite for effective induction. The inconsistency of various mentoring techniques is shown in the table below, some of whom perform the required training needs analysis while others don't.

	Frequency	%
Training need analysis performed	15	33.33
Training need analysis not performed	9	20.00
Training need analysis partly performed	19	42.23
Don't know	2	4.44

The following further confirms the rather haphazard way of conducting and planning the format for mentoring. This highlights how mentors conduct their programme according to their own, often subjective preferences.

	Frequency	%
According to mentor's preferences	36	80.00
According to trainee's preferences	2	4.44
Mutual agreement	7	15.56



Another potential bottleneck in the process is highlighted in the following figure. Apart from evaluation, feedback is another critical component for ideal induction. As can be seen in the pie chart below,

feedback was not adequately given or not given due importance. However, the respondents perceived that their induction was performed in a positive manner. The following bar chart shows the positive opinion of the induction programme as perceived by the respondents.

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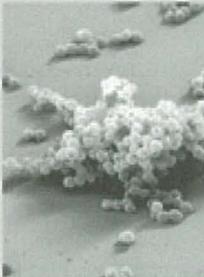


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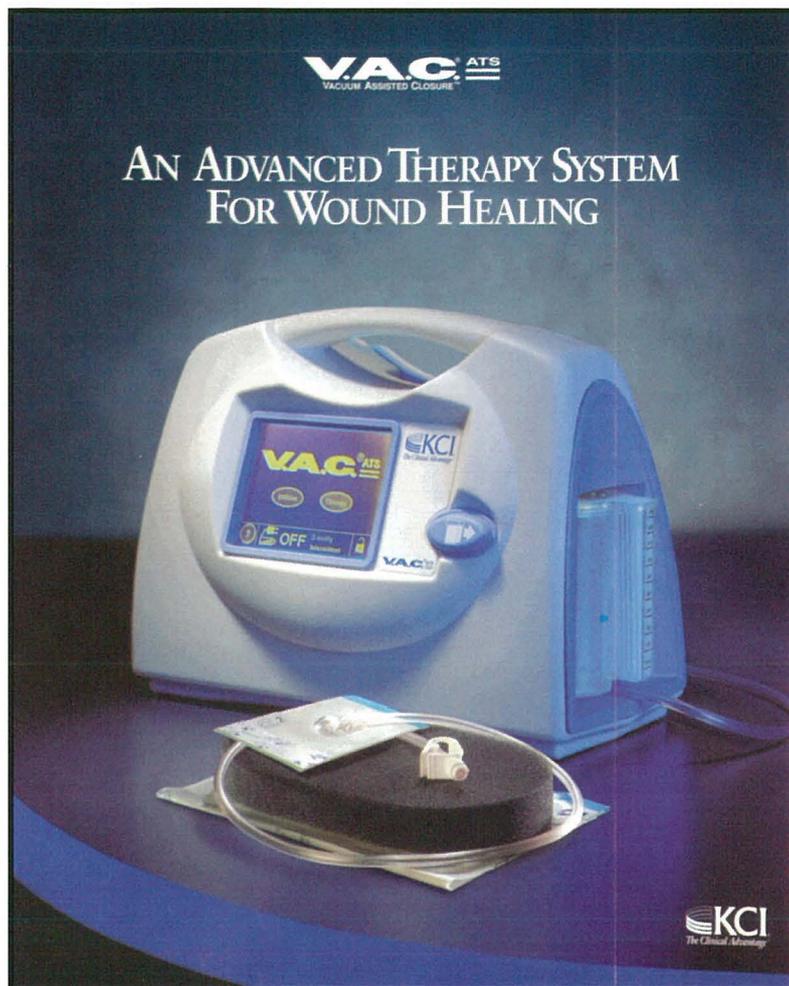


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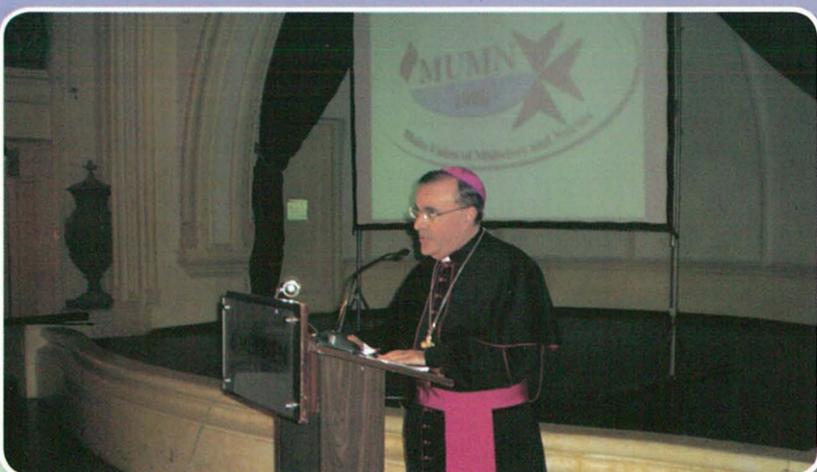
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1. Il-Kunsill il-ġdid għamel żjara ta' kortesija lill-Onor. Prim Ministru, Dr. L. Gonzi, fil-preżenza tal-Ministru tas-Saħħa, Dr. L. Deguara. F'din il-laqqgħa il-Kunsill ħa l-opportunita' sabiex jaqsam mal-Prim Ministru ċertu ħsibijiet fuq il-problemi li n-Nurses u l-Midwives għandhom fil-preżent.
2. Il-President ta' l-Union, Paul Pace qed jippreżenta paper fil-konferenza tal-Commonwealth Nurses Federation li saret f' Londra.
3. L-amministrazzjoni l-ġdida tal-Union, flimkien mas-Sur Winston Zahra, wara li ġe ffirmat il-ftehim fuq il-konferenza tal-Commonwealth li jmiss li ser issir ġewwa pajjiżna, f'Marzu li ġej. Din ser issir fil-lukanda SAS Golden Sands u l-MUMN tiringrazzja lis-Sur Zahra li jkun dejjem lest biex jgħin lin-Nurses u l-Midwives f'pajjiżna.
4. Bħala apprezzament tax-xogħol fejjiedi li wettaq tul kemm dam President ta' l-MUMN, il-Kunsill il-ġdid ippreżenta memento ta' tifikira lil Rudolph Cini u membri oħra tal-Kunsill li servew lill-Union mit-twaqqif tagħha.
5. Ms. Moira Grixti, Nursing Officer fid-Diabetic Out-Patients, ġiet ivvutata u pprezentata bl-unur ta' l- SLH Employer of the Year Award. Prosit ukoll lil numru ta' Nurses oħra li kienu wkoll finalist f'dan il-konkurs.
6. Il-Pensjonanti reggħu għamluha! Il-Group Committee tal-Pensjonanti organizzaw ħarga oħra sabiħa u nteressanti ġewwa l-gżira ta' Għawdex.
7. Mistiedna distinti li attendew il-Konferenza Ġenerali ta' l-MUMN fejn ġie elett Kunsill ġdid għal dawn l-erba' snin li ġejjin.
8. Il-mistieden speċjal tal-Konferenza Ġenerali, fejn anke aċċetta li jindirizza lil dawk prezenti, kien l-E.T. Mons. Arcisqof Pawlu Cremona. Dan kien mument storiku għal din il-Union peress li għall-ewwel darba l-Arcisqof ta' pajjiżna ndirizza lill-membri ta' l-MUMN.
9. Mhux faċli li jiġu mgħoddija l-voti ta' dawk kollha li vvutaw waqt il-proċess elettoral. Il-Kummissjoni Elettorali responsabbli mill-għadd tal-voti għamlet dan b'diligenza kbira.

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The journey of psychiatric nursing in Malta

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Ms Carmen Galea RMN, Dip Psych Nursing, BSc (hons) Mental Health Nursing

This article is an adaptation of the paper "The journey of psychiatric nursing in Malta" which was presented at the half-day conference organized by the Maltese Association of Psychiatric Nurses (MAPN): Psychiatric Nursing – The change agent in Mental Health.

Abstract:

The role of the psychiatric nurse has changed dramatically throughout the years. This article is divided into two sections. The first part will be looking at the historical factors that influenced this change, whilst the second part will be discussing the present role and functions of the psychiatric nurse in Malta.

Part A Historical factors which influenced the role of the psychiatric nurse

Since the time when patients were looked after by an attendant and cared for in a "room for madmen" (Muscat, 1973), the role of the nurse in the psychiatric field, changed dramatically.

Plenty of factors were responsible for this change, a few of them hindering, whilst the majority were enhancing and crucial to the role of the psychiatric nurse as we know it today.

One of the major changes was brought about by the advent of "new" psychiatric medication, in the 1950s. As reported by Moncrieff (2002), before this date, some form of medications was already in use. These were sedatives – for their sedative and restraining effects and stimulants, to stimulate depressed patients. These "old" psychiatric drugs were used alongside physical treatments, which were often painful and barbaric to patients. In a list of such treatments, both Incorvaja (1999) and Moncrieff (2002) included insulin coma therapy, the showering of patients' heads with cold water, and worse still, the rubbing of patients' heads with irritating chemicals. This happened, because up till that time, no one had any clue of what caused mental illness, which, was often attributed to the devil.

However, the introduction of new medications set the agenda for biological research into the causation and cure of psychiatric disorders. From then onwards, the need for educating the carers of mentally ill patients was strongly felt.

Here, one must not forget the contributions of people like Dr Paul Cassar and Dr Abram Galea who worked incessantly to educate the carers of mentally ill patients.

In fact, education has been the cornerstone of psychiatric nursing care. In the 1970s, Evelyn Zimmerman, who was American, led a course for 27

carers of mentally ill people, 9 of whom were nurses, about the theory and practice of psychiatric nursing. This course was reported by Incorvaja (1999) to have emphasized personal growth and development that boosted up the morale of the nursing staff and improved the delivery of care to patients.

Further attempts to update the nurses working at Mount Carmel Hospital were made Dr Abram Galea when he delivered a series of lectures at this hospital in the 1980s. Other in-service training courses were held in mid-1990s, whilst the latest Continuing Professional Development course was organized in 2005 by the Department of Health in collaboration with the Institute of Health Care. This was coordinated by Mr Martin Ward, who is an independent mental health nursing consultant and a lecturer at the Institute of Health Care.

Nursing, in general, was given a boost in 1988, when the baccalaureate and diploma in nursing courses were launched. These ensured that undergraduate nurses were taught about the care of mentally ill patients by enthusiastic and highly knowledgeable psychiatric nurses, like Mike Hayden and Fullbright scholars Catherine Vegan and Jeanette Ollodart, to mention but a few.

This education was influential in such a way that in 1994, a thesis focusing on the effects of psychiatric nursing education and experience on the attitudes of student nurses towards mental illness, was produced. This was the very first study carried out on this subject and notwithstanding its limitations, this thesis (the author of which was myself) highlighted the importance of education and contact with the mentally ill in positively shaping the attitudes of student nurses towards this cohort of patients.

The significance of such education continued to be highlighted when two newly qualified nurses having a baccalaureate degree chose Mount Carmel Hospital as their place of work as soon as they finished their nursing course. These two nurses, who were Charmaine Vassallo and myself, introduced new and

enthusiastic blood into the pool of nursing staff of this hospital when considering that most of the nursing staff at Mount Carmel Hospital have been working there for decades.

In 1990, the Committee for the Prevention of Torture of the EU reported that the *"Delegation was struck by the lack of professional training amongst the nursing staff. Of the 120 male nurses, only 5 were qualified as professional psychiatric nurses; and the 80 female nurses were generally trained but not qualified in psychiatric nursing."*

This set the ball rolling for the running of the first specific course leading to a Diploma in Psychiatric Nursing, in 1992. Before this, those who were interested in following a course in psychiatric/mental health nursing had to proceed overseas, usually the UK. This diploma in Psychiatric Nursing Course, coordinated by Mike Hayden and run at the Institute of Health Care, targeted registered nurses working in psychiatry in Malta and Gozo. There were 24 participants in this course, most of them were staff nurses and a few of them already had an RMN qualification from UK. This cohort of students graduated as Psychiatric Nurses in November 1994. The course leading to a Diploma in Psychiatric Nursing continued to be run until 1998 coordinated by Joseph Incorvaja.

Following this development, another CPT report written in 1995 acknowledged that the number of nurses who have received professional training has increased and that the members of staff concerned occupied the more senior nursing positions.

Nevertheless, it continued to state that the situation was still far from being satisfactory. The CPT report summarized the problem of lack of professional psychiatric nursing training by quoting from the National Policy on Mental Health Service (1995). This stated: *"Although by international standards the complement of nurses is sufficient to cope with the nursing demands, their level of training is inadequate to proffer effective psychiatric nursing care notwithstanding that a good number of nurses are motivated and make an effort"*.

The committee recommended that *"a very high priority should continue to be given to increasing the number of professionally-qualified psychiatric nurses at Mount Carmel Hospital"*. This recommendation came true when Psychiatric Nursing education was raised to a degree level by the introduction of the Diploma to Degree in Mental Health Nursing Course in February 2004. Ten students qualified from this course with an Honours Degree in Mental Health Nursing in 2006. Another two such courses are at present being run at the Institute of Health Care. Mr Martin Ward and the mental health nursing academic team at the Institute of Health Care are coordinating these courses.

In his report on the *"Treatment of Mental Patients"*, Joe Sammut – the ombudsman at that time – wrote that *"refurbishment, improvements and developments*

at Mount Carmel Hospital have been continuously in progress." Nonetheless, nothing has ever been done to improve the image of its nurses in the public eye.

So much so, my work experience at this hospital made me realize that nurses working at a psychiatric hospital are often stigmatized and labelled by their peers as unknowledgeable people, good for nothing that spend their time at work guarding patients.

This was also one of the findings of a qualitative research which studied *"The experiences and feelings of nurses working at a Maltese Psychiatric Hospital"*, namely Mount Carmel Hospital. I carried out this study as partial fulfilment of a Masters Degree in nursing studies. The following quotation sums up the negative criticism from other nurses, which all the participants of this study mentioned. *"Then there is the issue of being looked down upon by my own colleagues at the other hospitals ... When I accompany a patient to casualty they pass a lot of comments such as "Oh! You come from Mount Carmel! ... There you don't have anything to do...! ... Nurses at Mount Carmel are not good for anything..."* (Bason, 2002: 77)



Mount Carmel Hospital

Incorvaja (1999) asserted that the subject of mental health, its nursing and reform in Malta have long been a subject of frustration, hopelessness and anomalies. Mount Carmel Hospital was also described to have ignored for many years and left to decay the human qualities and potentials of many people. In fact, as reported by Sammut (1998) it has been used over the years by people in government for *"punishing"* nurses whose political affiliation differed from theirs.

Nowadays, however, this practice has been changed. As asserted by Mr Jesmond Sharples, the current Director of Nursing Services, only nurses who are motivated to work with mentally ill patients are being employed to work at Mount Carmel Hospital.

Notwithstanding the negative factors that hindered the development of psychiatric nursing care in Malta, certainly there has been a leap in the positive direction.

However, I must admit that what is being done

today – is just the beginning of a new era in psychiatric nursing.

Part B

The role and function of the psychiatric nurse

Psychiatric nursing has changed throughout the years. In the latter part of the 20th century in Great Britain, the role and function of the psychiatric nurse has experienced a level of unprecedented change. This was primarily due to changes in the health care policy with a move away from the large mental institution as the preferred option for care. During the 1950s and 1960s care of the mentally ill became reoriented towards a social model of care.

The new model of mental health policy provision for mental health services was comprehensive, community orientated and delivered by a multidisciplinary team with the psychiatric nursing role being extended to many new locations as described by Cowman et al (2001). During this period the nurse's role in the multidisciplinary team became established, though ill defined. Similar changes in Malta followed since the British influence had an impact on the local legislation. The social model was also introduced in psychiatric care. However, unlike our British counterparts the psychiatric nurse's role was still missing up till a few years ago. This was mainly due to the lack of qualified psychiatric nurses.

During the 1970s, it became more acceptable that mentally ill people could and should, where possible; live in the community with the rest of society. The more relaxed regimes in the mental hospital further brought about changes to the role of psychiatric nurses. These changes often met with resistance both within and outside the profession. Gradually the reliance on custodial care as the primary and preferred option to mental health care is gradually being reduced.

Psychiatric nursing has continued to be dominated by therapeutic shifts that have taken place within the discipline of psychiatry. As Nolan (1993) affirms, this has led to an inevitable sense of role confusion in psychiatric nursing with the resultant lack of power that such confusion generates. The origins of psychiatric nursing came from the asylums that were medically administered and dominated. The nurses' work was prescribed by doctors and changed according to influences that were outside the control of psychiatric nurses.

The current psychiatric nursing role is described as wide-ranging, occupying a pivotal and central role in the care of both inpatient and outpatient psychiatric services. Psychiatric nurses perform an independent role in addition to working in collaboration with other professionals. Cowman et al, (2001) identified that the level of independent therapeutic functioning is an important indication of the evolving role of psychiatric nurses in modern health services in our western societies.

A major part of psychiatric nursing appears to relate to managing patients and providing specific therapeutic interactions. These activities appear to be fundamental to psychiatric nursing and central to the mental health services. For example, with patients who have greater dependency levels, nurses perform those activities which the patients cannot perform. In other cases nurses support, supervise and work alongside patients in a way that enables patients to recognize their own strengths. Yet at another level nurses at times provide a presence, being with the patient where other active interventions are not possible, not required or inappropriate.

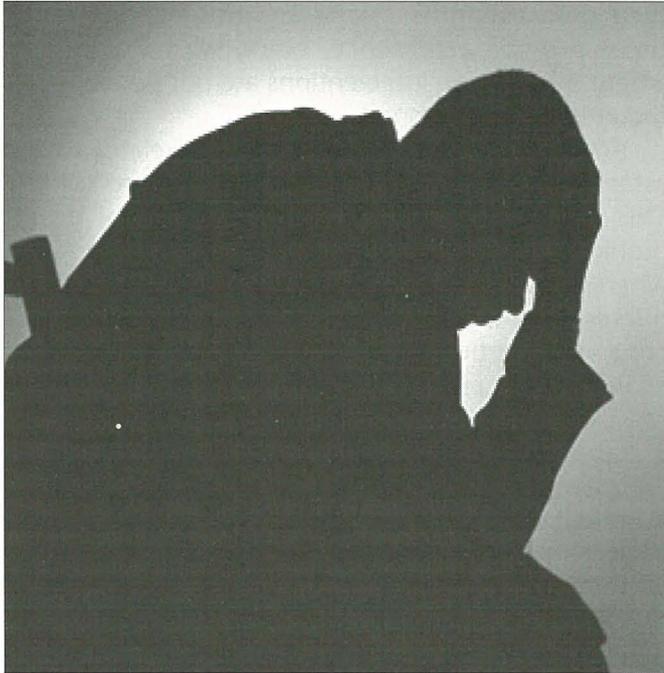
Another role in psychiatric nursing relates to the assessment and maintenance of the patients' safety. This is clearly an important role as mental health problems may place the patient or others in a position where their physical safety is threatened. Psychiatric nurses play a major role in the management of crisis, and particularly psychiatric emergencies such as including episodes involving violence. In mental health care an important characteristic is providing a stable and therapeutic environment. As Gijbels (1995) asserts psychiatric nurses are particularly good at anticipating and managing situations of crises in clinical environments.

Particular psychiatric nursing roles are evident in psychiatric acute admission wards. The nurse's role here involves extended observation and collection of information which is used by the multidisciplinary team in order to reach both a reliable diagnosis and prescribe appropriate treatment. *The interaction with patients is specifically therapeutic, as opposed to simply social, having a clinical focus.* The nurse administers psychotropic medication and supervises its use. The nurse also prepares and assists the patient during electroconvulsive therapy (ECT). A frequent role is the management of the physically ill person with a concurrent psychiatric illness. In addition the management of drug or alcohol withdrawal is increasingly becoming a common nursing role on our island.

Yet another role exclusive to psychiatric nursing is the management of the positive psychotic symptoms in those experiencing a thought disorder. The purpose of hospitalization is to control, contain and manage this difficult behaviour. The management of the negative symptoms is another challenge to the role of the psychiatric nurse. Here, as Bowers (2005) points out the nurse provides personal care and later rehabilitation, re-education and training in self-care and social skills to re-locate the patient back to the community. The nurse's role here often involves supporting the family and other informal carers through education and eliciting further professional support.

A final note about graduate psychiatric nurses though Martin has already addressed this issue, I would quote from the Department of Health (2005)

document: 'Standards for Graduate Psychiatric Nurses in Malta', where previous documents from the same Department support, from a local national perspective, the conclusions of the World Health Organization's (1998) report into the worldwide growth of mental health problems. The WHO states that, "...such a burden needs serviced by an appropriately trained and sophisticated specialist nursing workforce if care quality is to be developed and maintained".



Conclusion

The contemporary emphasis in mental health care embraces health promotion, early intervention and community development. Psychiatric nursing is being provided closer to where people live and work. Access to services has to be made easier for vulnerable groups of the population. But perhaps most important of all we need specialist psychiatric nurses to make a genuine contribution to the care, support and rehabilitation of people with mental health problems if we are ever to achieve our goal of providing genuine health care for these people. Professionally and only by having an educated nursing workforce are we ever likely to be able to provide such care.

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Students are very welcome. Join us to find out more about our practice and about the training offered to ZCH staff to ensure quality care delivery.

**Secretary to the General Manager,
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Targeting Mental Health

Patient Talk!

The International Council of Nurses
Informed Patient Project

Facts and Figures

- About one-fifth of the world's youth suffer from mild to severe mental health disorders.
- Mental disorders represent more than 12% of the total burden of disease.
- 450 million people suffer from a mental or behavioural problem.

What is mental health?

Mental health is more than the absence of mental disorders. It involves a state of well-being whereby the individual recognises their abilities, is able to cope with the normal stresses of life, works productively and contributes to the community.

How common are mental health problems?

450 million people suffer from a mental or behavioural problem and nearly one million people commit suicide every year. Depression, alcohol use disorders, schizophrenia and bipolar disorder are among the ten leading causes of disability worldwide.

Severe mental health problems, such as schizophrenia, are relatively rare affecting around one in 200 adults each year. However, in the UK, depression, anxiety and phobias can affect up to one in six of the population at any one time.¹

How can I help a friend or relative with a mental disorder?

- Encourage them to seek help from a health professional. Remind them that this is a legitimate illness and there is a treatment. The sooner the disorder is diagnosed, the sooner they will be on the road to recovery.
- Learn about the illness and what effects it may have.
- Be positive about the future and help the person become independent.

The stigma of mental illness

Adults with mental health problems are one of the most disadvantaged groups in society. Although many want to work, fewer than a quarter actually do, the lowest employment rate for any of the main groups of disabled people. Too often they do not have other activities to fill their days and spend their time alone.

Social isolation is an important risk factor for deteriorating mental health and suicide. Two-thirds of men under the age of 35 who die by suicide are unemployed.²

Unlike those with physical illness, people with mental health problems are generally subjected to stigma, prejudice and exclusion from access to social services and health care. Stigma is often due to public ignorance about the underlying causes of mental health problems. Often the stigma can be worse than the illness. One of the main challenges is to remove the stigma of mental illness so that people will talk freely about their emotional problems with health care professionals.

- Look after yourself and seek help when needed by finding support groups in your area.³
- Help stop the stigma of mental disorders by raising awareness of the danger of stereotypes. Be a media watchdog and call attention to the use of words which add to the misunderstanding of mental illness.⁴



¹ Office of the Deputy Prime Minister, Social Exclusion Unit, UK (2005).

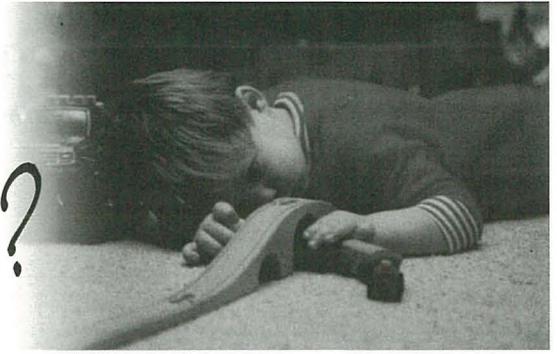
² Office of the Deputy Prime Minister, Social Exclusion Unit, UK (2005).

³ Mental Health Association NSW, www.mentalhealth.asn.au/home.htm

⁴ Canadian Mental health Association, www.cmha.ca



What Is a Safe Toy?



Who is responsible for ensuring safe toys?

Toys are a big part of childhood. We rarely expect a child's toys to cause injury. But there are risks and they are real. About 72,000 children younger than 5, went to hospital emergency rooms in 2002 for toy-related injuries, according to the National Association of State Public Interest Research Groups. Thirteen children died from toy related injuries in 2002. Nearly 80 percent were younger than 15.

In 2000, 160 children ages 14 and younger died from an obstruction of the respiratory tract due to inhaled or ingested foreign bodies. Of these, 40 percent were caused by food items and 60 percent by non-food objects, according to the Centres for Disease Control and Prevention.

In the not-to-distant past, little was done to ensure that toys were safe. All of that changed in 1994 when Congress passed The Child Safety Protection Act (CSPA). This law required toy manufacturers to place warning labels on toys containing small parts, including balls, marbles and other choking hazards. The label must state that the toy is not intended for use by children younger than 3. Also, the CSPA increased the size of small balls permitted in toys because of the choking hazard associated with round objects.

Even though the CPSC oversees toy safety, parents and other adults must take responsibility for making sure that their children's toys are safe. Each year, despite the enactment of the CSPA, several toys that have already hit the market are recalled after children are injured while playing with them.

Guidelines for selecting safe toys

The most important consideration when selecting toys is the child's age and developmental level. Too often, overzealous parents and friends select toys that are inappropriate for a child's age and skill level. Most manufacturers include a recommendation for the age level for which the

toy is appropriate. (This recommendation usually appears on the outside corner of the toy). A toy that is too advanced probably will be misused, and the likelihood of injury will increase.

Choking remains the leading cause of toy deaths. Most often, those deaths are caused by ingested balloons, balls and small toy parts. Carefully inspect a toy before purchasing it. All toy parts should be larger than a child's mouth, so that no part of it can be accidentally swallowed. Some retailers sell a cylindrical tube that serves as a reference when selecting toys. If a piece of the toy can fit through the tube, it also could fit into a child's mouth.

Inspect toys for quality construction and design before buying them. Check to see that small parts on stuffed animals or soft toys are securely fastened. Avoid toys with sharp or pointed edges.

Read the instructions for use before purchasing toys. Make sure that they are clear and will be understood by the child. Too often, children see toys advertised on television that look simple to set up and play, but, in reality, require more skill than the child possesses.

Discard all plastic wrappers that accompany toys. They pose a risk for suffocation if children place them over their heads.

Consider the noise level of the toy. Some toys such as caps and guns can produce sounds at noise levels that can damage hearing. The law requires that the following label be placed on boxes of caps producing noise higher than a certain decibel: "Warning - Do not fire closer than 1 foot to the ear. Do not use indoors."

Toys that shoot small objects into the air pose a risk for eye injury. Too often, children place objects not intended for firing into dart guns and, thus, create weapons capable of inflicting harm.

When shopping for infants or very young children, do not select any toys with long strings or cords attached. The cord or string can become wrapped around a small child's neck and cause strangulation. Don't ever hang toys over a crib or playpen using ribbon or rope because an infant easily can become entangled in them.

Toy boxes can be dangerous if a child falls inside and suddenly becomes trapped. Only purchase a toy box that has a lid that will stay open in any position. For added safety, look for a toy box that has ventilation holes for fresh air. Never use pieces of furniture not intended for use as a toy box (chests, cedar boxes or other cabinets) for storing toys, particularly if a small child could easily climb inside and get trapped.

Be cautious when selecting electric toys. Toys with heating elements can result in burns in younger children, and these toys are not recommended for children younger than 8. Older children also require adult supervision when using many electrical toys.

Suggestions for age-appropriate toys

The American Academy of Paediatrics recommends the following list of toys for children of specific age groups. This can be used as a guideline when choosing toys for children.

Newborn to 1 year

Choose toys that will appeal to a baby's sight, hearing and touch. Examples include:

- Large blocks
- Rattles
- Pots and pans
- Soft, washable animals, dolls or balls
- Bright, moveable objects that are out of the infant's reach
- Busy boards
- Floating bath toys
- Squeeze toys

1 to 2 years old

Children of this age are quite curious. Toys for this age group should be safe and able to withstand a toddler's manipulation. Examples include:

- Cloth or plastic books with large pictures
- Kiddy cars
- Musical tops
- Nesting blocks
- Push-and-pull toys (without long cords)
- Stacking toys
- Toy telephones

2 to 5 years old

Children this age like toys that imitate the activities of parents and older siblings. Examples include:

- Books (short stories or action stories)
- Blackboard and chalk
- Building blocks
- Crayons, non-toxic paints, clay
- Hammer and bench
- Housekeeping toys
- Tape recorders
- Puzzles with large pieces
- Dress-up clothes
- Transportation toys (tricycles, cars and wagons)
- Outdoor toys (sandbox, slides, swings and playhouse)

5 to 9 years old

Children this age enjoy toys that promote skill development and creativity. Examples include:

- Sewing kits with blunt scissors
- Card games
- Doctor and nurse kits
- Hand puppets
- Balls
- Bicycles
- Crafts
- Paper dolls
- Jump ropes
- Roller skates
- Sports equipment
- Table-top games

10 to 14 years old

Children this age often have hobbies and they enjoy toys with scientific activities. Examples include:

- Computer games
- Sewing, needlework, knitting
- Microscopes, telescopes
- Sports equipment (basketball and soccer nets)
- Table-top and board games
- Hobby collections (dolls, model cars, miniatures)

This article was reviewed June 2006, by Richard Lichenstein, M.D., F.A.A.P., Associate Professor of Paediatrics, The University of Maryland School of Medicine, Baltimore, MD.

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

Consultative Measures:

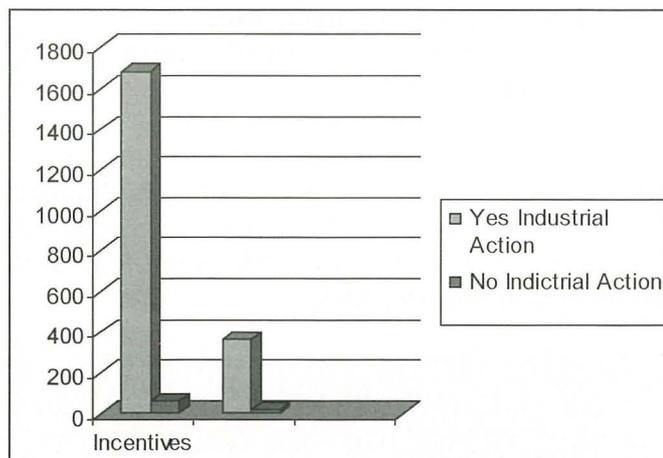
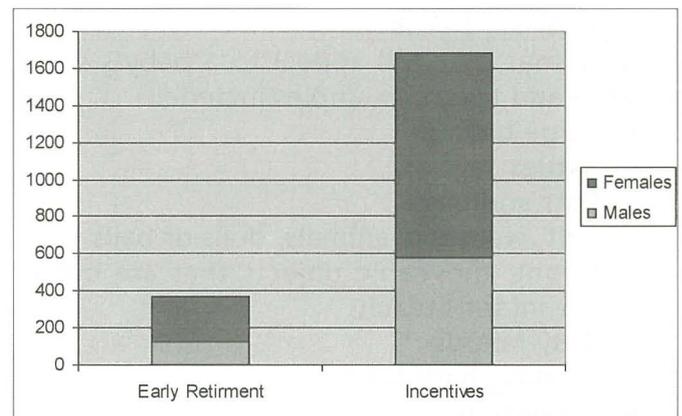
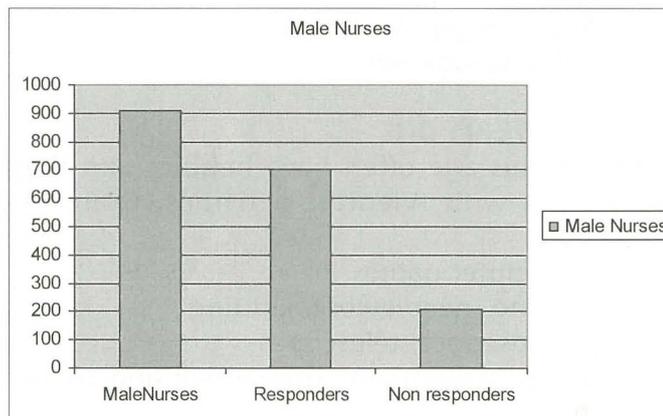
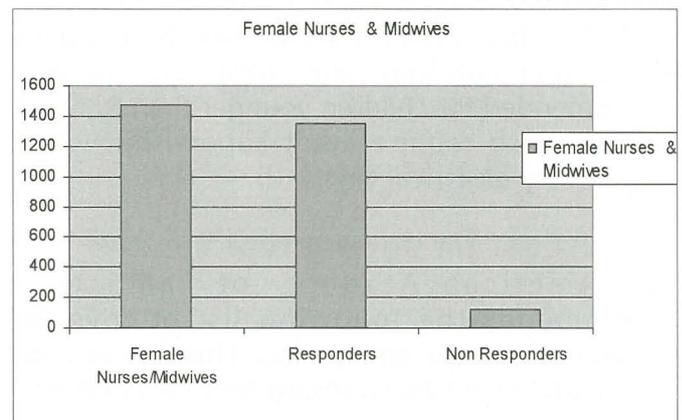
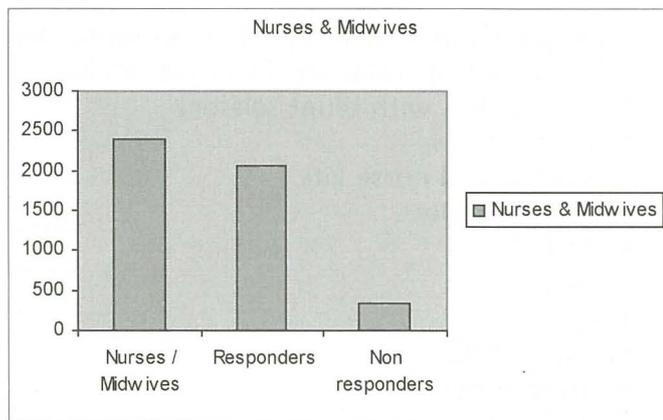


Incentive measures vs Early retirement

The Malta Union of Midwives & Nurses embarked on a consultative measure with all its members as to clearly indicate the directions that MUMN Council has to follow when discussing with the Health Division. The new elected Council was pleased with the number of replies (86%) and also about the comments and messages which were written on the questionnaire. These were also noted and evaluated.

Such exercise proved to be very effective and if similar circumstances would arise in the future, such consultative measure would be again repeated.

The outcome of the results is as follows:



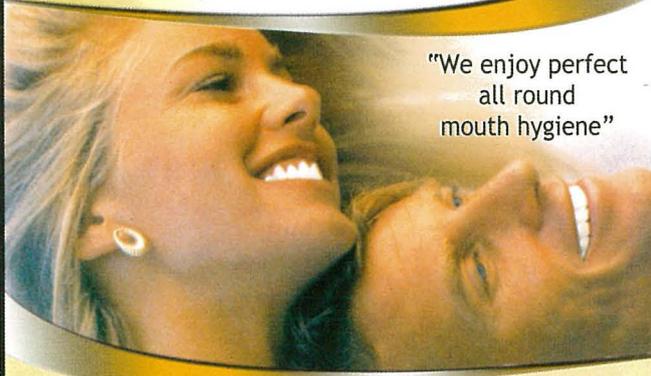
To comply with the members wishes (82%) the incentives package would therefore be the main focus when discussions with the Health Division take place. That does not imply that the early retirement (18%) has been completely removed from our agenda. I am grateful to all members who participated in this exercise since the results awarded through this fruitful exercise gave a clear mandate for the Union's Council to negotiate the incentive package with the Health Division.

Paul Pace
 President ~ MUMN
 ☐ mumn@maltanet.net

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Xi qrajt...

Joe Camilleri

N.O Resuscitation Nurse Specialist

□ joseph.f.camilleri@gov.mt

“Silta meħuda u addatata minn “It-Torċa” tal-Ħadd, 29 ta’ Novembru, 1959 mis-serje: storja ta’ kull ġimgħa: “Diżgrazzji li baqghu jissemew...”. (L-awtur mhux magħruf)

Ix-xjuħ ta’ l-Ospizju u l-Kolera ta’ l-1837

“Min hu bla ħtija biss jista’ jħallas il-ġustizzja t’Alla għall-ħtija ta’ min hu ħati”-din il-verita’ li għandha xeħta ta’ paradoss,-hija l-morali ta’ l-istorja, l-istorja tad-diżgrazzja kerha li ġrat f’Malta, meta fis-sena 1837 dehret għall-ewwel darba l-Kolera fil-gzejjer tagħna-dik il-marda tal-biża’ msejha wkoll “il-Marda Asjatika”.

Bosta kienu ċ-ċirkustanzi li għenu d-dhul u t-tixrid ta’ din il-marda: it-traskuraġni ta’ min kien responsabbli għall-kwarantina; in-nuqqas ta’ esperjenza tat-tobba; u x-xorta u s-sura ta’ sptar li kellhom il-Maltin dak iż-żmien li l-anqas ma kien tajjeb biex ifejjqu l-bhejjem.

Min-nuqqas ta’ sptar kien jiddependi n-nuqqas ta’ esperjenza tat-tobba Maltin, għax l-isptar huwa l-iskola ewlenija tat-tabib; u fis-sena 1837, f’din l-iskola Maltija, l-istudenti Maltin ma kienux jitgħallmu ħlief ikeffnu l-mejtin jew iħawwdu għara. Iżda mhux minn dejjem kien hekk.

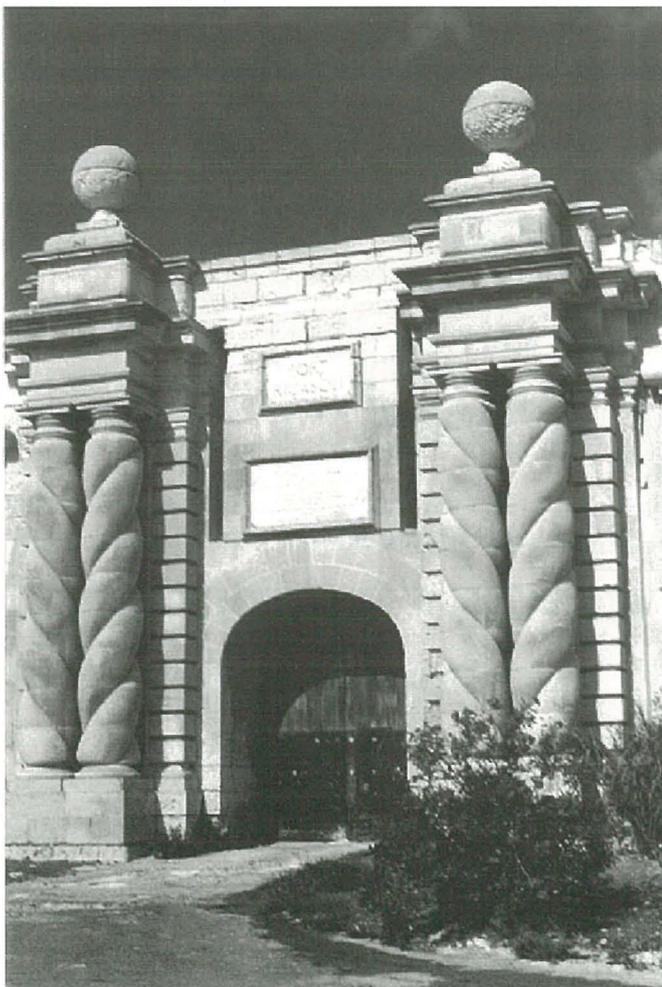
L-Ospizju tal-Furjana

Mela, għall-bidu ta’ Ġunju tas-sena 1837 kien hemm go l-Ospizju tal-Furjana 854 xjuħ, bejn nisa u rġiel, meta, mingħajr ħadd ma jaf kif, dehret fosthom il-kolera. It-tobba tal-Gvern għarf mill-ewwel x’kienet din il-marda, għax kienet dehret ma’ l-Ewropa u waslet ukoll l-Ingilterra xi sena qabel; imma esperjenza tagħha ma kellhomx, tant li l-parir tagħhom kien, li l-marda ma titteħdx minn wieħed għall-ieħor. Malajr intebħu bl-iżball tagħhom meta f’qasir żmien il-marda inxterdet barra mill-ospizju. Kif ġara fil-każ tal-pesta fis-sena 1837; kullħadd beda’ jibża’ u jitlef rasu. L-ewwel ħsieb li ġieħ il-Gvern kien li jwarrab l-infezzjoni minn go l-għeluq tal-Belt. L-isptar tal-Gvern, barra milli kien żgħir, bla kumdità’ ta’ xejn, u mimli bin-nies morda, kien jinsab f’parti iżjed iffullata bin-nies minn dak il-kwartier tal-Furjana fejn kien hemm l-Ospizju; post ieħor barra mill-bliet, fejn ix-xjuħ infettati kienu jstgħu jġu iżolati, ma kienx hemm. Malajr, malajr, ittieħdet id-deċiżjoni li jizolawhom go l-fortizza ta’ Rikażli, u ħin bla waqt, dawk il-povri xjuħ ingarrew bħal tagħbija bhejjem morda biex jeqirduhom go Lażżarett. U l-paragun tajjeb; għax għalkemm id-deċiżjoni kienet tajba, ma seta’ jinħaseb xejn għall-kura ta’ dawk l-iżvinturati għax kullħadd kien jibża’ jersaq lejhom, ibda’ mit-tobba stess. Dawn, barra li ma kellhom l-ebda esperjenza ta’ din il-marda tal-biża’, ma setgħux ilaħħqu ma’ post maqtugħ għal kollox bħar-Rikażli.

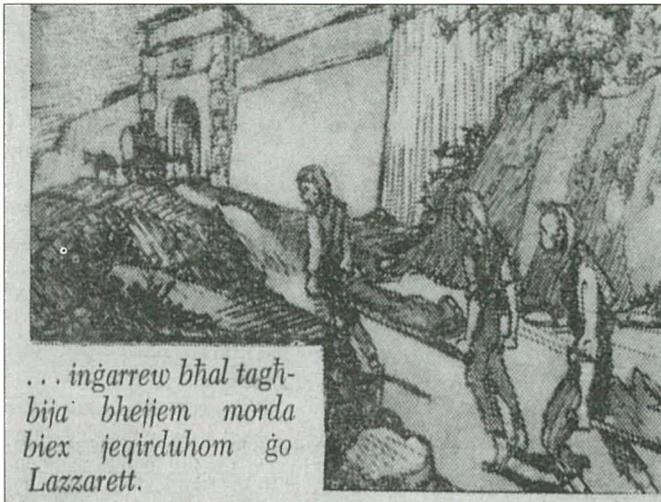
Lil min kienu jsibu iebes ma’ l-art, kienu jiġbduh b’ganċ mingħajr ma joqgħodu jitilfu ż-żmien biex jaraw kienx mejjet jew għaxi...

Marda tal-Biża’

U din il-marda kienet tassew tal-biża’. L-ewwel attakk tagħha kien aħrax u f’daqqa waħda. Il-vittma kien jaqa’ ma’ l-art mgħawweġ bl-uġieħ ma’ ġismu kollu, imma l-iżjed fl-istonku; wara ftit jibda’ jirriġetta bħall-ħdura u ġismu jinkesa b’għaraq kiesaħ. Il-polz jibda’ jonqos, għajnejh jidhlu fil-ħofra, u għalkemm għadu ħaj, jieħu x-xeħta ta’ kadavru. It-tobba ma kellhomx ħaġ’ohra x’jagħtu lill-pazjent ħlief oppju biex itaffu l-uġieħ qawwi li jġib miegħu. Min kien jibqa’ ħaj wara l-ewwel attakk ta’ xi tliet sigħat, kien ifieq. Fi żmien ħames xhur, jiġifieri minn Ġunju sa Ottubru, kien hemm b’kollox 8,785 każ ta’ kolera, li minnhom 4,252 mieta u 4,534 fiequ. Hekk naraw li iżjed minn nofs ta’ dawk li ġew attakkati bil-Kolera helsuha b’wiċċ il-ġid. Għal kuntrarju, minn dawk il-854 xjuħ ta’ l-Ospizju li tteħdu r-Rikażli, mieta 412 matul fl-ewwel ġimgħa, u l-oħrajn inqerdu kollha matul il-ġimgħatejn ta’ wara. Ir-raġuni kienet li wara li tteħdu għewwa r-Rikażli ftit jew xejn ma ħasbu fihom iżjed. Thaffret fossa go għalqa ma’ ġenb il-fortizza, u, f’xi ħin matul il-ġurnata kienu jidhlu d-deffiena biex iġorru l-mejtin. Lil min kienu jsibu iebes ma’



Fortizza ta’ Rikażli



... ingarrew bħal tagħ-
bija' bhejjem morda
biex jeqirduhom ġo
Lazzarett.

I-art, kienu jiġbduh b'ganċ mingħajr ma joqgħodu jtilfu ż-żmien biex jaraw kienx mejjet jew għaxi, iġorruhom għal ġol-fossa u jwittuhom bit-trab. Jingħad għalhekk, li ħafna minn dawk ix-xjuħ indifnu ħajjin, u xi nies li kien ikollhom jgħaddu minn dawk l-inħawi kienu jisimgħu krib u biki ta' ksir il-qalb ħiereġ minn ġewwa l-fossa; imma ħadd ma kien jissogra jersaq lejha, u d-deffienna kellhom l-interess kollu li jaħbu l-ħruxijiet tagħhom, barra mill-biża' naturali, kif kellu kullħadd, li jżidu l-periklu li jiċċappsu b'din il-marda.

Wara tliet ġimgħat il-krib ma nstemgħax iżjed; il-fossa twettiet sa fuq, u poġġew salib fqir ta' l-injam bħala tifikira ta' dawk il-854 żvinturati.

Erwieh Abbandunati

Iż-żmien ġeneralment itaffi kollox, imma ħaġa ta' l-għageb, lil dawk ix-xjuħ ħadd ma' seta' jinsihom, għad li ħadd ma kien jaf la x'jisimhom jew min kienu. Il-ħaddiema fqar tal-Kottonera baqgħu jzuru dik l-għalqa mħarbtu u mimlija ħaxix ħazin ħdejn ir-Rikazli, biex jitolbu għall-erwieh ta' dawk li mietu abbandunati minn kullħadd. Dik l-għalqa li kienet iġġiblek ħasra tgħaddi minn ħdejnha biss, u iżjed meta tidhol ġo fiha, saret bħal għoqda fuq il-kuxjenza ta' dawk in-nies, sakemm fis-sena 1881, kif tgħidilna l-iskrizzjoni li tinsab fiċ-ċimiterju, ħasbu biex huma stess jiġbru l-flus biex jitnaqqas xi ftit dak id-diżunur għall-kuxjenza nisranija. Thaffer qabar ġdid f'nofs iċ-ċimiterju, u ngabar l-għadam ta' dawk l-imsejknin minn qalb it-trab tal-fossa, u tqiegħed fuqhom monument forma ta' salib. Għadda iżjed iż-żmien; l-imħabba u d-devozzjoni għal dawk l-erwieh abbandunati ma naqset xejn; fis-sena 1948 il-monument iżzejjien bi xbiha tal-Madonna maħduma minn G. Galea tar-Rabat. Imbagħad f'dawn l-aħħar żmenijiet inbniet kappella żgħira wara l-monument, biex ikun jista' jsir il-quddies fil-magħluq.

Dwar ix-xjuħ ta' l-Ospizju li issa nistgħu insejnhom l-erwieh abbandunati ta' Wied Għammieq, dawn ix-xjuħ li ma kellhomx ħtija ħlief il-faqar tagħhom, ħallsu bil-martirju ta' tmiem ħajjithom għall-ħtija tan-nuqqas, l-indifferenza u x-xaħħa tal-Gvern ta' żmienhom. Imma x'ġara? Lil dawk il-kbarat, dawk in-nies importanti, dawk in-nies li ma kienx jinpurthom mit-tbatija tal-fqar, għalkemm l-oqbra tagħhom għamluhom ta' l-irħam, kullħadd insihom; ħadd ma jmur iżurhom bit-talb. L-erwieh abbandunati ta' Wied Għammieq ma seta' jinsihom ħadd: saru simbolu ta' "L-Erwieh Kollha Abbandunati" ta' l-erwieh ta' dawk l-għadd bla tarf ta' fqar, li wara ħajja ta' jasar u tbatija, ġisimhom jindifen ġo għalqa abbandunata, imħarbtu, mgħottija bil-ħaxix ħazin biex fit-trab u fil-miżerja, tintesa' l-aħħar tifikira tagħhom.

Ħidmiet Il-Group Committee tal-MUMN f'Għawdex

- Laqgħat mad-Direttriċi *Customer Services*, Ms. Joyce Dimech, fuq diversi suġġetti relatati mal-ħidma tan-Nurses u l-Midwives Għawdxin: Il-kundizzjonijiet tax-xogħol f' diversi swali; in-nuqqas ta' *staff complement* li jinħass sew f' ċertu swali u n-nuqqas ta' riżorsi li jfjixxklul l-ħidma tan-Nurses u l-Midwives ma l-pazjenti. Fil-maġġorparti ta' dawn il-laqgħat ir-riżultati kienu pożittivi. Qegħdin inżommu kuntatt kontinwu mad-Direttriċi.
- Laqgħat li għamilna mas-Sur Paul Buttigieg, Departmental Nursing Services: suġġetti u problemi relatati mal-ħidma tan-Nurses u l-Midwives, fejn sibna koperazzjoni sħiħa minnu.
- Ġew solvuti problemi li nqalgħu fir-Renal Unit bl-insistenza ta' l-MUMN.
- Bl-insistenza ta' din il-Union ukoll, ġiet iċċarata darba għal dejjem is-sitwazzjoni li tinqata' ġurnata *leave* għalxejn ma' kull jumejn *leave* li jittieħdu.
- Ġiet iċċarata wkoll il-pożizzjoni tal-*part-time* Nurses rigward il-ħidma tagħhom ġewwa s-swali.
- Bħalissa qegħdin isiru laqgħat u qed tinzamm komunikazzjoni bejn l-awtoritajiet konċernati dwar talbiet minn naħa tagħna li għadhom pendenti, fosthom:
 1. Bdil ta' apparat antikwat li jrid jintuż minn Nurses fir-rigward tal-pazjenti;
 2. *Monitors* ġodda għas-sala tas-CCU/ITU;
 3. Talba biex mas-*slip* tal-paga tingħata formola bil-*breakdown* tal-ħlas;
 4. Trasferiment ta' Nurses Għawdxin lejn l-Isptar Ġenerali t' Għawdex;
 5. Biex tinħareġ '*call for application*' għall-gradji vakanti li hemm fl-isptar, fosthom ta' Manager Nursing Services u Departmental Nursing Managers.
 6. Possibilità li ċertu korsijiet *post graduate* isiru fil-ġżira Għawdxija biex jitnaqqas kull inkonvenjent lin-Nurses u l-Midwives.

Atanasio Degiorgio

Chairperson MUMN Gozo Group Committee

✉ mumn@maltanet.net

Ejw Niegfu ftit

German vs. English language

Subject: **Kan yu pelif it?**

The European Union Commissioners have announced that agreement has been reached to adopt English as the preferred language for European communications, rather than German, which was the other possibility. As part of the negotiations, the British government conceded that English spelling had some room for improvement and has accepted a five-year phased plan for what will be known as Euro English (Euro for short).

In the first year, "s" will be used instead of the soft "c". Certainly, sivil servants will resieve this news with joy. Also, the hard "c" will be replaced with "k". Not only will this klear up konfuzion, but typewriters kan have one less letter. There will be growing public enthusiasm in the second year, when "fotograf" is 20 percent shorter.

In the third year, publik akseptanse of the new spelling kan be expected to reach the stage where more komplikated changes are possible. Governments will enkorage the removal of double letters, which have always ben deterrent to akurate spelling. Also, al wil agre that the horrible mes of silent "e's" in the language is disgrasful, and they would go. By the fourth year, people wil be reseptiv to steps such as replasing "th" by "z" and "w" by "v".

During ze fifz year, ze unesenary "o" kan be dropd from vords containing "ou" and similar changes vud of kors be aplid to ozer kombinations of leters. Und efter ze fifz yer, ve vil al be speking German like zey vunted in ze forst place.

Actual writings from Worldwide Hospital Records

1. The patient refused autopsy.
2. The patient has no previous history of suicides.
3. Patient has left white blood cells at another hospital.
4. She has no rigors or shaking chills, but her husband states she was very hot in bed last night.
5. Patient has chest pain if she lies on her left side for over a year.
6. On the second day the knee was better, and on the third day it disappeared.
7. The patient is tearful and crying constantly. She also appears to be depressed.
8. The patient has been depressed since she began seeing me in 1993.
9. Discharge status: Alive but without permission.
10. Healthy appearing decrepit 69-year old male, mentally alert but forgetful.
11. Patient had waffles for breakfast and anorexia for lunch.
12. She is numb from her toes down.
13. While in ER, she was examined, x-rated and sent home.
14. The skin was moist and dry.
15. Occasional, constant infrequent headaches.
16. Patient was alert and unresponsive.
17. Rectal examination revealed a normal size thyroid.
18. She stated that she had been constipated for most of her life, until she got a divorce.
19. I saw your patient today, who is still under our car for physical therapy.
20. Both breasts are equal and reactive to light and accommodation.
21. Examination of genitalia reveals that he is circus sized.
22. The lab test indicated abnormal lover function.
23. Skin: somewhat pale but present.
24. The pelvic exam will be done later on the floor.
25. Patient has two teenage children, but no other abnormalities.

Il-Funzjoni tal-MUMN SLH/KGH/MDH Group Committee

Bhas-soltu nixtieq ninforma l-membri sabiex ilkoll nibqgħu naħdmu u nkunu nafu x'inhu jsir u għaddej fejn jidhol l-Isptar San Luqa, Karen Grech u Mater Dei. Apparti li l-Group Committee, jiltaqa' darba fix-xahar u jiddiskuti affarijiet kurrenti ta' matul iż-żmien, isiru laqgħat apparti, minn żmien għall-ieħor minn kummissjonijiet magħżula mill-kumitat tagħna. Bħal issa waħda minnhom qed tieħu ħsieb il-Casualty biex jinstab mezz biex jitnaqqas il-queue ta' nies jistennew u titjib għall-Infermiera bħal saħħa u sigurta' fost affarijiet oħra. Laqgħat minn kummissjonijiet oħra kienu dwar il-Gynae Wards. Il-kumitat iltaqa' wkoll mal-president il-ġdid is-Sur Paul Pace u feraħ lill-Kunsill il-ġdid li hu kompost minn erbgħa ġodda minn SLH, fil-preżenza tas-segretarju ġenerali is-Sur Colin Galea.

Iċ-chairperson is-Sur Alex Manché u s-segretarju is-Sur Thomas Agius qed jieħdu sehem attiv fl-Industrial Committee darba fix-xahar. Is-Sur Manché huwa s-segretarju ta' dan il-kumitat u ċ-chairperson tiegħu hu membru tal-Kunsill, is-Sur Ray Chetcuti. Bħalissa qed issir ħidma kbira biex kull membru jippartecipa fil-kwestjonarju li tqassam.

Ħidma attiva tagħna wkoll qed issir kull meta niġu mitluba biex nagħtu għajjnuna lill-management fil-migration plan fost affarijiet oħra. Bħal dejjem niringrazzja lil membri tal-koperazzjoni li nsib minn għandhom u nwegħduhom kull għajjnuna fil-futur.

Thomas Agius SN, Seg. Group Committee, SLH/KGH
 □ thomas.agius@gov.mt

L-ISTORJA TAL-ISPTARIJET 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 tagħmilna kburin bis-servizz tal-isptarijiet Maltin għall-ġid tal-pazjenti

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

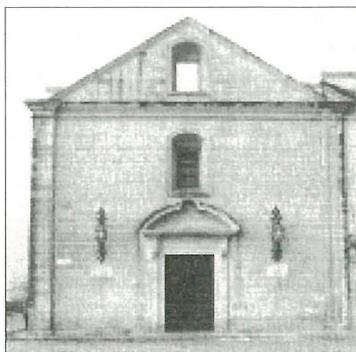
– IS-SACRA INFERMERIA –

Is-Sacra Infermeria tal-Belt Valletta L-aqwa servizz mediku



Wara r-rebħa tal-Kavallieri fuq it-Torok fl-Assedju l-Kbir ta' l-1565, l-Ordni ddecidiet li tibni belt ġdida ffortifikata, biex tgħasses il-Port il-Kbir ta' dawn il-gzejjer. Sacra Infermeria ġdida giet iddisinjata u s-sit magħżul kien dak tan-naħa tan-nofs in-nhar tal-Belt Valletta. L-ewwel binja, li kienet tikkonsisti oriġinarjament f'sala kbira u twila, inbdiet fl-1574. Fl-1583, kienet imkabbra biż-żieda ta' blokk ġdid u

ddisinjata mill-ġdid fl-1662 u fit-18 il-seklu. In-numru ta' sodod kien ivarja minn seklu għall-ieħor. Fi tmiem it-18 il-seklu, kien hemm 554 sodod singli li setgħu jiżdiedu għal 900 f'każ ta' emergenza. Il-maġġoranza tas-sodod (370) kellhom iċ-ċelu (canopy) ta' kuluri differenti u mtieraħ tas-suf. Is-swali ta' l-isptar kienu miftuħa għal kullhadd, sew jekk kienu membri ta' l-Ordni, ċivili jew skjavi. Kien hemm ukoll post fejn wieħed seta' jpoġġi l-orfni. Is-Sacra Infermerija tal-Belt Valletta kienet waħda mill-aħjar sptarijiet ta' l-Ewropa u kienet deskritta tajjeb ħafna minn numbru ta' barranin li kienu jżuru lil dawn il-Gzejjer fis-17 u fil-bidu tat-18 il-seklu. Fl-isptar kont tiltaqa' ma' l-aħjar tobba ta' l-Ewropa mħallsin mill-Ordni biex iżuru darbtejn kuljum lill-morda u jagħtuhom jew jagħmluhom dak li kien jinħtieg għall-fejqa. Mat-tobba kien hemm ukoll żewġ kirurgi approvati minnhom għal xi operazzjonijiet u fil-fatt l-isptar kellu fama tajba għall-fejqa, speċjalment għall-operazzjonijiet ta' qtugħ (amputazzjonijiet), għax kien f'dan l-isptar li t-tobba tgħallmu kif l-istrumenti għandhom jiġu sterilizzati bit-toġholija. Is-servjenti ta'



l-isptar kellhom filfors ikunu Nsara. Kien hemm ukoll servjenti nisa li jieħdu kura tat-trabi abbandunati mill-ġenituri tagħhom.

Fl-isptar ta' l-Ordni kienu kkurati mhux biss il-Kavallieri iżda baħrin, suldati, ilsiera, bonavolji u feruti. Bħala regola l-morda kienu mqassmin skond il-marda tagħhom iżda kultant kien hemm tqassim skond il-grad soċjali, il-kondotta morali, jew il-gravità tal-marda.

Is-servjenti ta' l-isptar kellhom bilfors ikunu Nsara

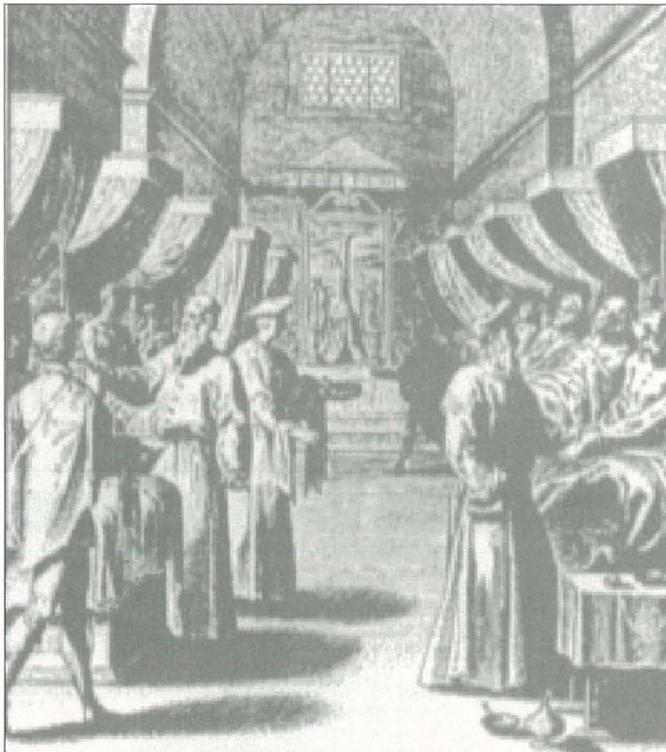
Kull nhar ta' Ġimgħa, il-Granmastru nnifsu kien iżur lill-morda. Madwar 200 tiġieġa kienu jinqatlu kuljum biex isir il-brodu għall-morda, u l-ikel kien jitqiegħed fi platti tal-fidda. Ħafna minn dawn il-platti ddewbu fuq ordni ta' Napuljun Bonaparti biex jużawhom għall-kampanja tiegħu fl-Eġittu.

Lejn l-aħħar tat-18 il-seklu, l-affarijiet ġenerali ta' l-Ordni marru lura ħafna u dan inkluda wkoll kif kienet immexxija s-Sacra Infermerija. Fl-1786, John Howard iddeskriva dan l-isptar b'mod ħażin ħafna. Huwa kiteb li: "Is-saqaf huwa kbir ħafna, iżda minħabba li hu ta' l-injam, issa sar iswed; it-twieqi huma żgħar u l-ħitan huma miksijin b'inkwadri kollha trab. Din is-sala nobbli għandha dehra li ddejqek. Is-swali kollha kienu maħmuġin u jintnu, tant li kien hemm il-bżonn li jiġu ippurfumati, u t-tabib kellu jżomm il-maktur ma' wiċċu waqt li kien jagħmel ir-ronda. Il-pazjenti kienu jiġu servuti mill-iktar nies maħmuġin, imċerċrin u bla ħniena li jien qatt rajt". Is-Sacra Infermerija baqgħet sejra lura matul is-sentejn tal-ħakma tal-Francizi bejn l-1798 u l-1800. Il-Francizi stabillixxew l-ewwel Sptar tagħhom fl-Imdina ma' l-ewwel jum tal-ħakma tagħhom u fil-fatt garrew il-morda, l-imġienen u t-ftal iltiema kollha, imma erba' tjiem wara ħarġet ordni biex is-Sacra Infermeria, li issa giet imsemmija Grand Hopital tiġi riservata għall-użu esklussiv tat-truppi tagħhom. Il-pazjenti ċivili l-ewwel ġew trasferiti għad-dar Casa delle Alunne u wara għall-Monasteru (Kunvent tar-Repentiti) u l-Knisja ta' Santa Marija Maddalena li sar magħruf bħala Hopital Civil. L-hekk imsejjaħ il-"Madalena" kien post magħluq minn kullimkien, bla arja ta' xejn, mibni għall-penitenza, bla kumdità għall-ħarsien tas-saħħa u li kien iżjed tajjeb għal xi ħabs kiefer milli sptar. Għalhekk is-Sacra Infermeria bdiet tintuża bħala Sptar Militari, funzjoni li kompliet isservi wkoll taħt id-dominanza tal-Brittaniċi sat-22 ta' Diċembru, 1919, meta giet mogħtija lill-Gvern Ċivili. Dan allura juri li wara li l-Gvern tal-Maestà Tiegħu litteralment ħa f'idejha il-Gżira kollha, bil-fortizzi, portijiet u kull ma

kien hemm fiha, qata' mill-ewwel li m' għandux jonfoq l-anqas sold wiehed biss mill-kaxxa Ingliża, sew għall-amministrazzjoni civili tal-Gżira, kif ukoll għall-bżonnijiet tad-difiża ta' Malta. Kull ma kien jinhtieg għall-bżonnijiet tal-Militar kellu jittiehed b'xejn mill-propjetà tal-Gvern tal-Ordni. B'hekk iċ-ċivili Maltin baqgħu għal xi żmien gol-penitenzjarju.

Wara dak iż-żmien, is-Sacra Infermeria kienet tintuża għal ħafna skopijiet, meta fl-1978 kienet mibdula f' Centru Mediterran għall-Konferenzi.

"Il-pazjenti kienu jiġu servuti mill-iktar nies maħmuġin, imċerċrin u bla ħniena li jien qatt rajt".



– IL-CASSETTA (VALLETTA) –

Minħabba li s-Sacra Infermeria fi żmien il-Kavallieri kienet esklussivament riservata għall-pazjenti rġiel, inhass il-bżonn li jkun hemm aktar sodod għan-nisa morda. Fl-1625, Caterina Scapi, bidlet dar żgħira fil-Belt Valletta, li kienet magħrufa bħala Santa Maria delle Scala, fi sptar żgħir għall-kura tan-nisa fqar morda. Din id-dar, eventwalment ġiet immexxija għal postijiet diffirenti. Dan l-isptar żgħir kien ingħalaq wara li dik li kienet fethitu, mietet fl-1655. Sptar ġdid għan-nisa li kien magħruf bħala Casetta jew ospidaleto kien ġie miftuħ fil-Belt Valletta mill-Gran Mastru Martin de Redin f'April 1659. It-tmexxija tal-Casetta ġiet fdata taħt id-direzzjoni tal-Governatriċi li kienet toqgħod f'din l-istituzzjoni, filwaqt li l-kura medika tħalliet f'idejn żewġ tobba u żewġ kirurgi. Numru ta' infermiera u qabla ġew impjegati f'dan l-isptar biex jaqdu varji funzjonijiet. Xi tibdiliet strutturali ġew magħmula fl-ewwel snin tat-18 il-seklu biex fl-1727, in-numru ta' sodod żdied għal mitejn, li kollha kellhom ċelu għal aktar privatezza. Il-kundizzjonijiet ta' l-isptar ħzienu ħafna għal tmiem it-18 il-seklu. Taħt il-ħakma Ingliża, l-isptar kien immexxi mill-Presidenti ta' l-Isptarijiet. Fl-1850, il-pazjenti



nisa fil-Casetta ġew trasferiti lejn l-isptar Ċentrali ġdid fil-Floriana u l-Casetta kienet riservata esklussivament għall-morda rġiel u nisa jsofru minn mard li ma jittfejjaqx. Il-Casetta ġiet distrutta matul it-Tieni Gwerra Dinjija, filwaqt li l-Orfanatrofju li kien imiss magħha ġie mwaqqa' biex jagħmel spazju għal skola ġdida tal-Gvern.

Referenzi:

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Ikompil fil-ħarġa ta' Settembru...

IL-MUSBIEH

MALTA NURSING AND MIDWIFERY JOURNAL

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Tel: 21 44 85 42

E-mail: mumn@maltanet.net



L-ewwel Programm Vokali u Strumentali tal-AESCULAPIAN ORCHESTRA

Reuben Cassar SN M5
PRO Aesculapian Orchestra
☐ reuben.cassar@gov.mt

L-Aesculapian Orchestra kienet idea tas-Sur Tonio Bonello li l-ħsieb tiegħu kien li t-talenti tal-ħaddiema tal-isptar għandhom jiġu sfruttati bl-aħjar mod. Għalhekk inholoq kumitat biex jibda' x-xogħol kollu li toffri din l-orkestra. Il-Kumitat huwa magħmul mill-ħaddiema fi ħdan id-Dipartiment tas-Saħħa, u wara ħafna laqgħat u kuntatti ġiet iffurmata din l-orkestra bl-isem ta' Aesculapian.

Il-kelma Aesculapian ġejja mill-Grieg, u fil-mitologija Griega Aesculapius kien alla tal-medicina u l-fejġan. Aesculapius kien it-tifel ta' Apollo: li kien Alla Ruman għall-fejġan minn mard kiefer ħafna. Huwa kien famuż ħafna għall-mod ġentili kif kien jirnexxielu jfejjaq ħafna nies morda serjament u mentalment. Fil-Greċja is-simbolu ta Aesculapius baqa' meqjus bħala s-simbolu tal-medicina li tfejjaq b'mod immedjat.

L-ewwel Programm vokali u strumentali ġie mtella' mill-Orkestra Aesculapian nhar it-18 ta' Mejju 2007 ġewwa L-Isptar Mater Dei taħt id-direzzjoni ta' Mro. M. Scicluna A MUS LCM, LLCM. Fil-fatt dan kien l-ewwel kuncert orkestrali ġewwa dan l-isptar. L-Onoroveli Segretarju Parlamentari H. D'Amato, l-Amministrazzjoni u Management mill-qasam tal-Isptarijiet u Divizjoni tas-Saħħa, flimkien ma mistiedna distinti ohra, kollegi u familjari kienu preżenti għal dan il-programm. Programm li ntlagħha tajjeb u kien divertenti. Ms. Marion Rizzo CEO SLH, SPB, MDH għamlet kelmtejn tal-okkazjoni. Daniela Cauchi kantat bħala soprano f'erbgħa arjiet sbieħ.



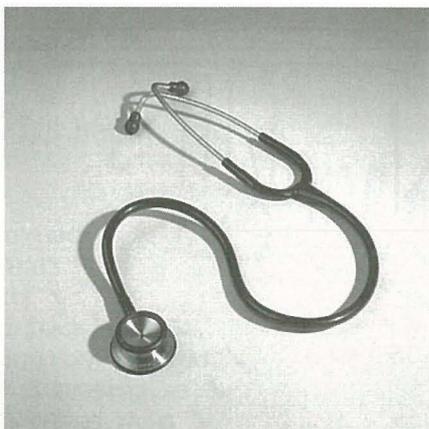
Il-Programm kien jikkonsisti f'dan li ġej:

- Can you feel the love Tonight (Mill-Film 'TheLion King') ta' Elton John
- Cranberry Corners U.S.A ta' John Klein
- The Merry Widow ta' Franz Lehar
- Czardas (Solista-Alfred Reale) ta' V. Monti
- The Gladiators b' arrangament ta' M. Scicluna
- Vivo Per lei ta' V. Zelli
- Yesterday Ta' Paul McCartney
- The Laughing Trombone (Solista- G. Spiteri) ta' Dave Baker
- Let it be ta' Paul McCartney
- The Magic of Lloyd Webber ta' A. Lloyd Webber

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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 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. Hence, the protection normally arising as a result of the imposition of the MFSA's investment and borrowing restrictions and other requirements to retail schemes, do not apply to PIFs. VFM is licensed by the MFSA.

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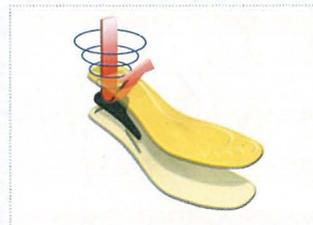
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