IL-MUSBIEH

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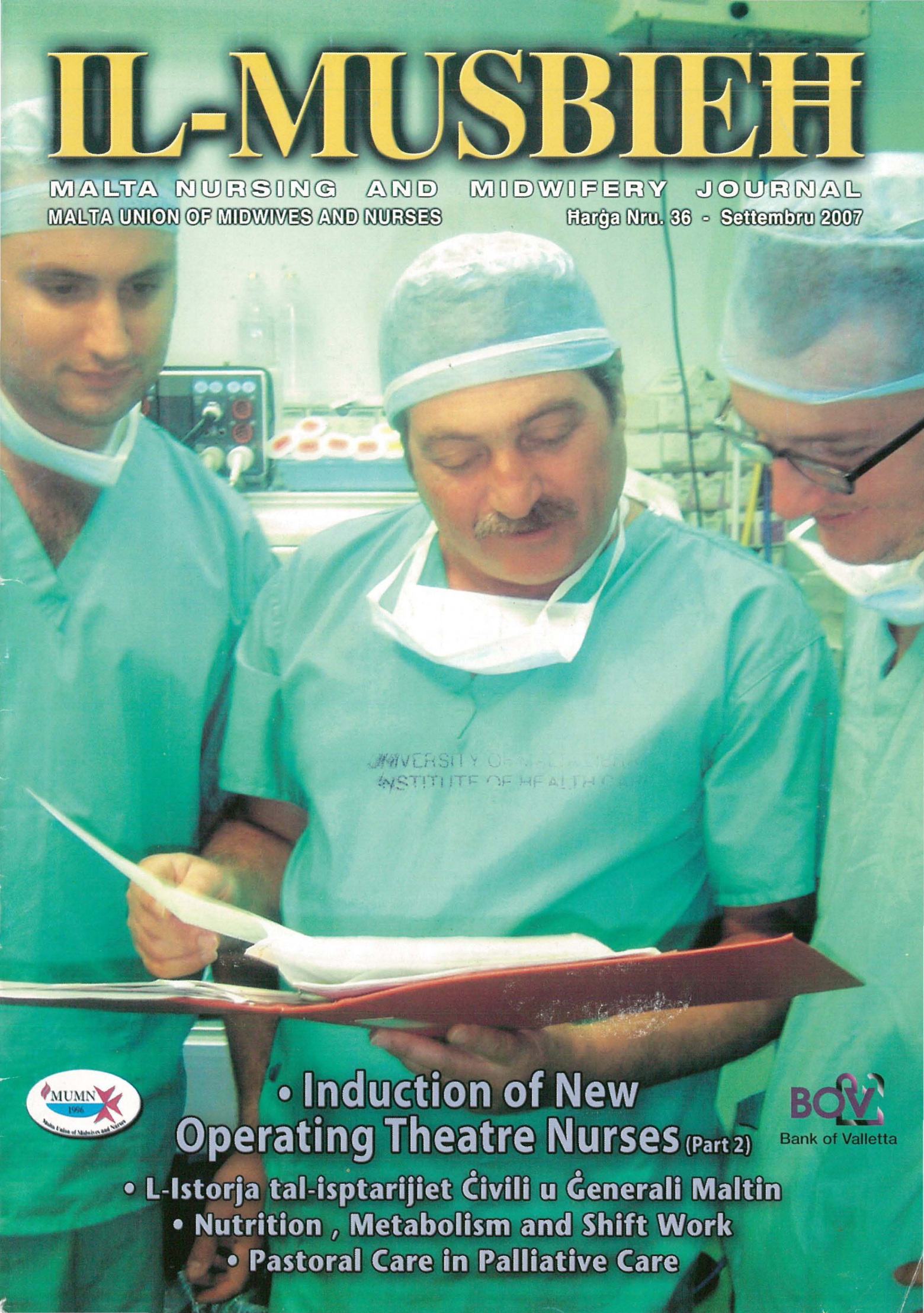

- Induction of New Operating Theatre Nurses (Part 2)
- L-Istorja tal-isptarijiet Ċivili u Ġenerali Maltin
- Nutrition , Metabolism and Shift Work
- Pastoral Care in Palliative Care

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Ritratt tal-Faċċata meħud minn Tonio Pace

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Editorjal

Expanded role, extended role-dilemma ta' akkontabbiltà?

Ir-rwoli fin-Nursing qed jespandu u b'hekk qed jinħolqu opportunitajiet ġodda. Din tista' tidher minn angolu ieħor: Mhux deħlin jew dħalna f'xi *minefield* professjonali jew legali u ma nafux? Minn se jġorr ir-responsabilità meta l-affarijiet imorru ħażin? Kultant jidher li hemm xi diżgwid fuq l-akkontabbiltà.

Tweġibiet sempliċi m'hemmx żgur. Aktar u aktar meta d-differenzi tal-professjonijiet fil-kura tas-saħħa m'humiex ċari ħafna anzi mċajpra. Jekk nikkonċentraw li noffru l-aħjar persuna biex t/jagħti l-aħjar kura lill-pazjenti tagħna allura irid ikollna ħassieba radikali rigward rwoli u responsabbiltajiet. Jidher li hemm ftit jew m'hemmx kunsens bejn gruppi varji fuq min hu akkontabbli meta r-responsabbiltajiet jaqsmu l-konfini professjonali. Ikun għaqli li nibdew nitkellmu fuq *sharing care, partnership* u *teamwork* u mhux ġerarkija. B'hekk biss insolvu d-dilemma biex neżerċitaw akkontabbiltà.

M'għandna qatt inneħħu minn quddiem għajnejna id-*'Do the right thing'*-'Għamel dak li hu tajjeb'. B'hekk biss isiru affarijiet raġonevoli u ġustifikabbli meta mhux ċar min hu akkontabbli għal x'hiex.

Meta Nurse taqsam in-naħa l-oħra f'xogħol it-tabib, tkun esposta għall-perikli professjonali, legali u ta' impjieg, u dan mhux qed jingħad biex nippruvaw inbeżżgħu bil-babaw, iżd' huma fatti. Allura wieħed isaqsi: Nafu eżatt x'inhuma d-dmirijiet u r-responsabbiltajiet ta' Nurses/Midwives f'xi qasam speċjalizzat, jew Nurse/Midwife f'rwol ġenerali li teċċedi r-rwol professjonali? Wara kollox tajjeb infakkru li n-Nurses fl-isptarijiet tagħna ilhom joffru *expanded* u *extended roles* għal ħafna snin u għalhekk inħass il-bżonn tal-ispeċjalizzazzjoni. X'se jiġi meta jiġu identifikati Clinical Nurse Practitioners, Nurse Consultants u jibdew joffru servizz ġdid fil-qasam tas-saħħa? Problemi li jistgħu jinħolqu speċjalment f'*posts* ġodda huma: Meta *job descriptions* ma jaqblux ma *expanded roles* u meta jkun hemm estensjoni tal-prattika malajr iżżejjed; titli li ma jindikawx identita' fin-Nursing; meta pazjent jassumi li n-Nurse kien tabib; meta Nurse ma jagħmilx ċertu xogħol għax mhux fil-kuntratt; meta Nurse iħoss li ma kienx imħarreġ u ssapportjat kif suppost; meta Nurse jaqbeż ir-responsabbilta' awtorizzata u mistennija minnu/ha. Żvilupp ta' rwoli kliniċi ġodda jridu jiġu mgħarbula sew fi pjan strateġiku kemm bħala Direttorat u anke f'ambitu Nazzjonali.

Huwa ċar li l-fenomenu tal-avvanzi fin-Nursing qed iseħħu minħabba raġunujiet varji; hemm il-fiduċja f'li wieħed javvanza mill-professjoni tan-Nursing stess; l-introduzzjoni ta' teknoloġiji ġodda; u tibdiliet ta' kif wieħed joffri sistemi tal-kura tas-saħħa b'enfasi fuq il-kura fil-komunità.

Ir-riċerka xejn ma turi li n-Nurses jistgħu b'xi mod jew ieħor jagħmlu aktar żbalji minn tobba; bil-pubbliku għajnejh miftuħa beraħ biex itella' xi każ il-qorti. Mistoqsija oħra li tqum hija: Jekk konsulent iqabbad Nurse tagħmel xi ħaga li hi mhix sodisfatta li għandha tagħmel, u din ma ssirx, ta' min hi r-responsabbilta'? Li hu żgur hu li n-Nurses u t-tobba jridu jkunu sieħba ugwali f' ippjanar, *management* u taħriġ ta' rwoli kliniċi ġodda.

Wieħed irid iżomm f'moħħu: li hu importanti ħafna, li Nurses li għandhom *extended role* iridu jaħdmu b'mod li jimminimizzaw r-riskji lill-pazjenti u għalhekk iħossuhom f'aktar sigurtà. Sigurtà professjonali, sigurtà ta' mpjieg u Alla ħares qatt, legali. Bis-saħħa statutorja tiegħu, id-Dipartiment tas-Saħħa jrid ikun ċar fl-assistenza tiegħu biex l-impjegati jiżviluppaw protokols effettivi. Ir-regolatur għalhekk irid joħloq qafas regolatorju għall-akkontabbilta'. Is-*service provider* ukoll irid joħloq stategiji ta' *risk management* effettiv biex l-akkontabiltà tkun aktar faċli. M' għandna qatt inneħħu minn quddiem għajnejna id-*'Do the right thing'*-'Għamel dak li hu tajjeb'. B'hekk biss isiru affarijiet raġonevoli u ġustifikabbli meta mhux ċar min hu akkontabbli għal x'hiex.

Is-soluzzjoni għall-*partnership* intra-professjonali u multidixxiplinarju effettiv huwa li nsibu relazzjonijiet ibbażati fuq fiduċja u rispett reċiproku. Din nistgħu nakkwistawa billi naqblu fuq x'nafu nagħmlu, x'hemm komuni, u x'differenzi jeżistu. Wara kollox, ħadd ma jista' jaħdem mingħajr 'l-oħrajn' u ħadd minna ma jeżisti minghajr il-pazjent.

Message from the President

The long awaited agreement has finally been concluded. For the newly elected council, we knew that this would be a difficult task to achieve especially in the light that such an agreement has to address the numerous problems Nurses and Midwives are facing in their work places. With this in mind we issued a set of incentives which we believed as a council, would be related to our local situation within the health care service.

After the wide consultative process which the Union undertook with all its members, the mandate derived from such a survey had given the Union a clear vision on which issues should be prioritised in these discussions. With the initiation of the discussions, our demands caused some eyebrows to be raised, but that did not discourage us from insisting on our goals. We were fully aware that certain measures in our package were quite innovative within the public service. The initial stages were indeed difficult; in fact we had registered a deadlock not once but twice.

Discussions involve two parties and I have to recognise that efforts and ideas had also originated from the government side in order to meet certain objectives.

What are the issues these incentives are meant to be addressing? From the very beginning the main issue to address were and still are the consequences caused by stress and burnout due to Nurses and midwifery shortages.

1) **Compensation**: Yes compensation to the Nurses and Midwives who are having their leave cancelled on a regular basis. It hurts me greatly when I receive frustrated pleas for cancelled leave for one's personal reasons. The other aspect was that Nurses and Midwives are taking in their stride a heavy workload where ward compliments are not being met even if an agreement has been reached. The Union is fully aware on the scenarios present in each and every government hospital. The increase in premiums to all Nurses is in line with this direction.
2) **Retention package**: The 25 hour week whilst retaining the equivalent of basic pay home was no easy task to achieve. We sincerely believe that such an incentive will retain all Nurses and Midwives within the profession and could be the winning horse in attracting young people into the profession.
3) **Students package**: To reduce the problem of Nurses and Midwives shortages the nursing profession needs new blood to join our profession. Numerus clausus on the diploma course was increased from 30 students to 50 students per intake. Although this was an achievement, the Union is not completely satisfied with such an arrangement especially in the light that the university closed its doors to 36 young men and women who wanted to join the nursing profession. Also the stipend of the BSc nursing student was increased to be classified as an essential worker and not as it was before as a non essential worker.
4) **Bridging**: As a Union we could not leave any stone unturned. We need to attract all Nurses and Midwives who had left back into the profession and facilitate their reinstatement. Nurses and Midwives returning back with the government service will have their previous nursing working experience given back to them. Such an incentive for Nurses or Midwives working within the profession would be a breath of fresh air to our depleted numbers within the health service.
5) **Warrant**: The nursing profession has gained the status which finally it deserves. The warrant which is an important recognition to our profession has been awarded giving our profession it's rightful status. Although the Healthcare Professions Act 2003 acknowledges that 1st level Nurses can work unsupervised, a warrant was never awarded. We should be proud that every nurse who has the necessary experience can obtain a warrant which only elite professions have. Again this was not an easy task to achieve but with the effort of all those concerned we managed to overturn the numerous obstacles.
6) **Equal to all**: The Nurses and Midwives who have qualified in these last 14 years would be receiving two extended increments in the following progressive scale. This would be equal with those Nurses and Midwives who have qualified prior 1993 and are already benefiting from such an arrangement. BSc Nurses have also benefited from the same previous agreement which had improved their salary structure from scale 10 to scale 9 after two years and not as it had been, from scale 12 to scale 10 after three years.

Every issue and every aspect which can relieve the nurse and midwifery shortage has been taken into consideration during our talks. As a Union we have remained loyal to the Nurses and Midwives wishes using our skills to get the best package of incentives ever. I should make it clear that this package of incentives would not solve our problems overnight but its effect would be felt on the long term. That is why as a Union we had to accept the government proposal for foreign Nurses as a short term solution. As a Union we could not allow more Nurses and Midwives to suffer at their work place. When we suffer, so do our patients. So our main obligations are towards the patients which are entrusted into our care. As a president, I believe that we still live in a homogenous society –predominately with one language, one religion and one culture and that the Maltese Nurses and Midwives are the ideal people to address our nation's needs.

The package is also intended to cope with the extensions of the health care services on our island. Nurses and Midwives are the back bone of any health care system and this issue was always the starting point in our discussion. I would like to thank all those who participated, even the government representatives since any agreement reached are with the ideas and the work of both parties involved.

MUMN strived to bring the rightful conditions, dignity and respect to our profession. I sincerely hope that members should appreciate the time and energy involved in reaching such an agreement. Now it is up to every nurse and midwife to contribute to the profession by always offering the best of their ability to the angels which are entrusted into our care. Make our profession proud.

Paul Pace
President
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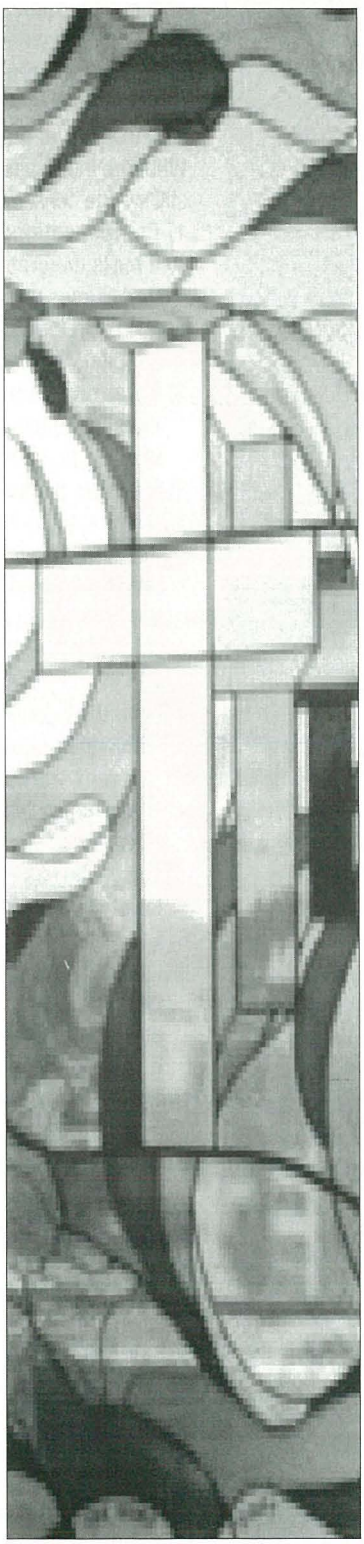
Pastoral Care in Palliative Care



Death is a very confronting reality. In front of death various feelings are triggered off. There are people who feel afraid, frustrated, lost, anxious and angry. Others seem to feel more relieved, peaceful and ready to undergo the experience. Given this complex array of feelings, pastoral care can, from its nature, be of an enormous help to dying people and their families.

It is a recognised fact that pastoral care's main and unique contribution is that of providing a caring, empathic and relieving listening. The chaplain is able to listen to dying people's stories with the utmost gentleness and compassion. Pastoral literature delineates three singular components for pastoral listening. The first qualification for pastoral listening is considering that the person's story is unique. The second requirement is keeping a vigilant eye between what the carer is listening in herself/himself and what is occurring in the subjective world of the person whom s/he is journeying with. This requirement is crucial since it can easily happen that the carer may unconsciously project her/his own personal feelings to the person s/he is attending to. In psychotherapy this dynamic is often referred to as counter transference. The third and last prerequisite for pastoral listening to happen is that is offered by a person who is professionally trained to be able to go deeper into a person's inner world if the situation permits.

The goal of pastoral care in palliative care is to help people befriending the inescapable dilemmas of life-threatening illnesses, to explore interior abilities to cope with ambiguity or anxiety, and to assist them as they strive to examine their lives' meaning and venture to make sound choices.

The first qualification for pastoral listening is considering that the person's story is unique.

Pastoral care can offer immense relief and comfort to dying people and their loved ones in four ways: relationship, listening, ritual, and bereavement care. A caring pastoral relationship is one whereby spiritualities and meanings can be integrated, realistic hopes are supported, time and continuity are kept to nurture the relationship. By being a listening presence the chaplain empowers the person to personally take her/his own initiative to become aware of the values, hopes, strengths, and desires amid the struggle to die. Listening means offering a space where a dying person's thoughts and feelings are told and heard with care. Ritual is important for the dying person, the family and also for the team members at the palliative care. It is deflective when it offers a possibility of venting out feelings so as one can better receive and give care. Ritual is reflective when the team members reflect how dying people and their carers have touch them personally and let these experiences encourage them to be with those who will need their care. In bereavement the chaplain accompanies the dying person and her/his carers as they respond to their issues of fears, loss, and separation.

The chaplain can effectively fulfil her/his mission if s/he integrates her/his spiritual journey with her/his ministry. Pastoral supervision, having a wise spiritual companion and listen to the people that are being ministered to can really be sources of grace where one's ministry is enriched, empowered, affirmed and reformed.

Fr Mario Attard OFM Cap
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Kelmtejn mis-Segretarju Ġenerali

Il-ħidma sħiħa u soda li l-MUMN ilha għaddejja biha f'dawn l-aħħar ħdax il-sena issa laħqet il-qofol tagħha u rnexxielna nilħqu ftehim li b'wiċċi minn quddiem nistqarr li jiżboq dak ta' l-1993 fejn joffri diversi inċentivi lin-Nurses u l-Midwives f'pajjiżna.

F'dan il-Ftehim, barra l-aspetti finanzjarji, irnexxielna wkoll niksbu l-istatus professjonali kif ukoll ineħħu kull forma ta' differenza bejn il-membri tagħna u issa għandna lil kulħadd bl-istess kundizzjonijiet tax-xogħol. Dan kollu seta' kien possibli bis-support kontinwu tiegħek.

Però dan ma jfissirx li l-isfidi tagħna spiċċaw. Altru minn hekk!! Għandna quddiemna sfida kbira, dik tan-nuqqas kbir ta' Nurses f'kull sptar, sitwazzjoni li mhux ser tiġi solvuta mill-lum għal għada.

Bil-migrazzjoni ta' l-Isptar San Luqa lejn Mater Dei kif ukoll dik ta' l-Isptar Żammit Clapp lejn l-Isptar San Luqa u żieda ta' pazjenti lejn ir-Residenza f'San Vincenz de Paule ħolqot kriżi ta' nuqqas ta' Nurses. Bil-Ftehim li sar mal-Gvern din il-kriżi ser tibda tiġi ndirizzata però l-frott mhux ser jinqata' mill-ewwel. Iżda l-Kunsill tal-Union huwa sodisfatt li l-Gvern huwa issa sensittiv għall-problemi li qed iħabbtu wiċċhom magħhom in-nurses u l-midwives u flimkien ser inkomplu naħdmu sabiex dan in-nuqqas jibda jiġi riżolt.

In-negozjati biex ilħaqna dan il-ftehim ma kienux faċli u ħadu għexieren ta' siegħat però minn hawn irrid nirringrazzja lill-uffiċċjali fl-Uffiċju tal-Prim Ministru kif ukoll lil Prim Ministru inniffsu, li għalkemm bosta drabi ma konniex qed naqblu, rajna kif sibna t-toroq li wassluna għal qbil li huwa aċċettabbli għaż-żewġ naħat. Irrid nirringrazzja wkoll minn qalbi lil Mario Galea MP, li kien preżenti fil-laqgħat kollha u bl-interventi tiegħu wasslu biex iż-żewġ naħat stajna nifmhu lil xulxin aħjar.

Irrid ukoll nirringrazzja liċ-Chairpersons u l-Membri li jmexxu l-Group Committees tal-ħidma kontinwa tagħhom u l-kuntatt li jżommu ma l-membri tagħna f'kull sezzjoni, kif ukoll mal-membri tal-Kunsill li għalkemm għadna kif ġejna eletti ftit tax-xhur ilhu, ingranajna mill-ewwel u komplejna bil-ħidma tagħna fl-interess tal-membri kollha ta' l-MUMN.

Nitlobkom sabiex tarblu u tanalizzaw b'ċertu reqqa dan il-ftehim sabiex dawk il-klawsoli li jolqtu lilek tagħraf tieħu l-opportunità u tisfruthom. F'każ ta' diffikulta għamel kuntatt mar-rappreżentanti tal-Union sabiex ikun jistgħu ifhemuk aħjar.

L-MUMN mill-bidu nett tagħha dejjem kienet kommessa li tgħoli l-livell tal-professjonijiet li tirrapreżenta kemm fl-interess tan-nurses u l-midwives kif ukoll tal-pażjenti tagħna li jiddependu ħafna fuqna sabiex jirċievu dik il-kura mistħoqqa li tant tixirqilhom. U din il-union dan dejjem għamlitu mhux bil-paroli imma bil-fatti konkreti.

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Press Release

May 12, 2007

NURSES WORKING CONDITIONS ARE FUELING A GLOBAL SHORTAGE

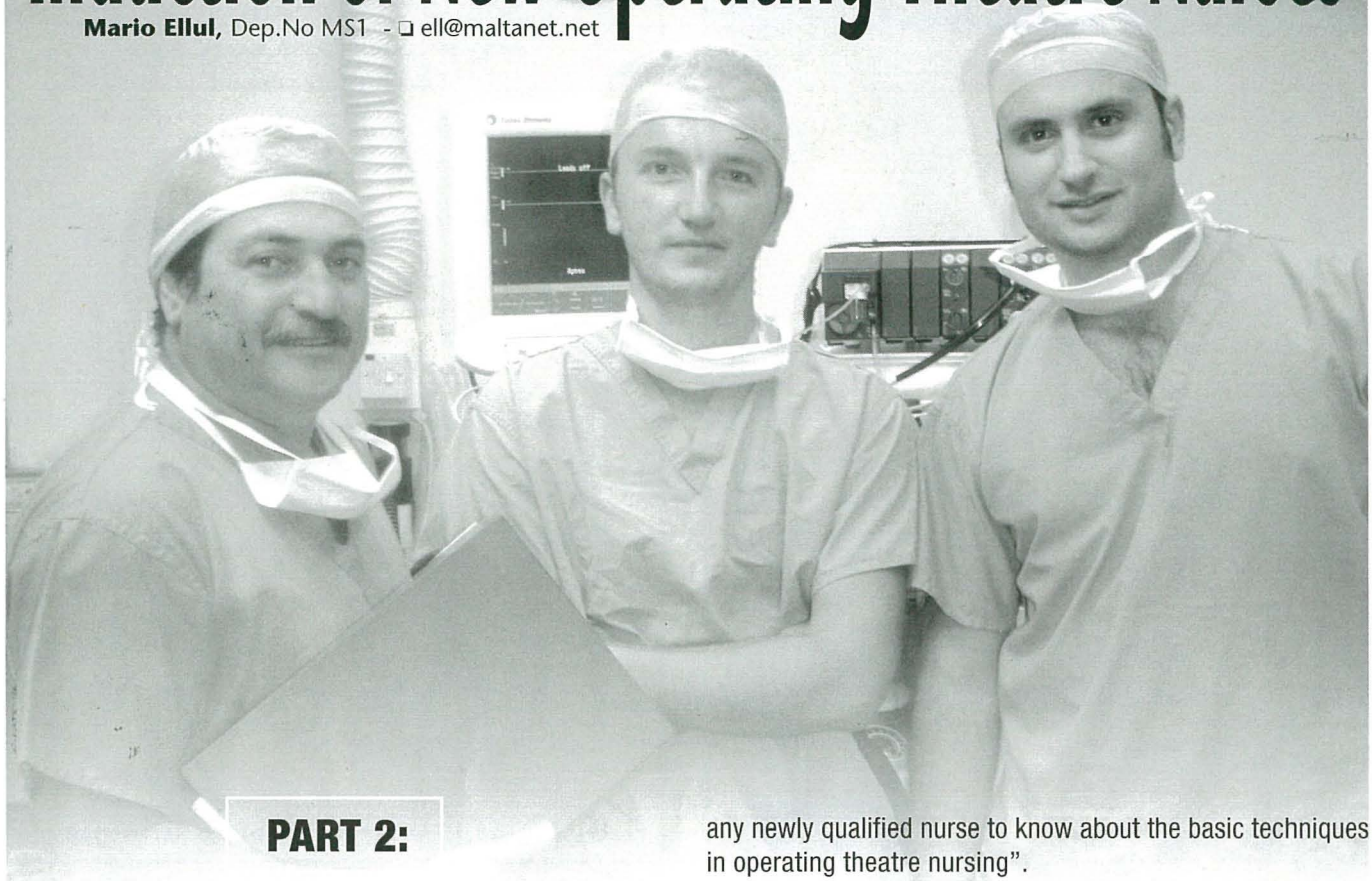
When Andrea Buchheit became a nurse in 1999, it was her dream come true. She was thrilled at the opportunity to care for people in need. Eight years later, the dream has turned sour. Low staffing numbers, heavy workloads, inadequate resources and insufficient compensation, are taking a toll on her morale. Like many nurses around the world, Buchheit, a registered nurse at St. Mary of Nazareth Hospital Center in Chicago, worries about working conditions to properly care for her patients. She typically is responsible for seven to eight patients, when five to six is more manageable with the diabetic and cancer patients she cares for. She recalls the time when she alone had to care for nine patients and two emergencies at once, as her worst experience. "It's that these are people's lives. I'm so afraid someone is going to die and it's going to be because I couldn't get to them." A 2002 study published in the Journal of the American Medical Association found that patients face a 7% greater likelihood of death, for every patient above four assigned to a registered nurse. Each year 20,000 deaths in the United States are linked to inadequate nurse staffing levels, says the report. As International Nurses Day is celebrated on 12 May, Public Services International, a global union federation that represents 7 million health care employees in more than 150 countries, continues to campaign for reasonable staffing ratios, improved working conditions, and better wages and benefits for nurses. "Nurses play a central role in the care of patients," says Hans Engelberts, General Secretary of PSI. "Their role goes beyond the professional services they provide. They are the most direct and continuous link between patients and all of those involved in their treatment." In most countries, nurses provide the majority of health services, up to 80 percent in some cases. Yet, the working conditions are driving many nurses to leave their profession early. They are the victims of shrinking budgets, mismanaged privatization and the urge for market-driven policies. Leading to unreasonable nurse-patient ratios, excessive workloads, growing incidence of workplace violence, low wages, under-valuing of work, and inadequate protections from occupational hazards. These conditions contribute to a growing global shortage of nurses and drive migration from countries that sorely need them, to wealthier countries who are also facing shortages. "We have to do everything with nothing", says Thembi Mngomezulu, PSI's Sub-Regional Secretary for Southern Africa, herself a former nurse. "Employers pay no attention to our voices and do not care about our needs. Nurses in Southern Africa are voting with their feet. They move to other countries to find better opportunities, as they are taken for granted in their own country". Most of the nurses move to UK and Australia. "Around 40% of Australia's recruitment of nurses are foreigners", says Mngomezulu. "Governments and health care institutions must go beyond elegant speeches on International Nurses Day," said Engelberts, "and make consistent efforts, every day, to provide nurses with the resources, pay, benefits, working conditions, and the recognition and respect they deserve for the service they provide to society. PSI is committed to continue to campaign for quality health services for all."

For further information, please contact: Dr. Jorge Mancillas
+ 33 450 40 64 64 or communications@world-psi.org

Public Services International (PSI) is a global trade union federation that represents 20 million women and men working in the public services around the world. It has some 600 affiliated unions in more than 150 countries. PSI is an autonomous body, which works in association with federations covering other sectors of the workforce and with the International Trade Union Confederation (ITUC). PSI is an officially recognised non-governmental organisation for the public sector within the International Labour Organisation (ILO) and has consultative status with ECOSOC and observer status with other UN bodies such as UNCTAD and UNESCO.

Induction of New Operating Theatre Nurses

Mario Ellul, Dep.No MS1 - ell@maltanet.net



PART 2:

In the previous issue, we have seen the rationale of the study, literature and seen the results obtained from the questionnaires distributed. In this second and final part, data obtained from interviews as well as some discussion and recommendations will be addressed.

Demographic data for qualitative analysis

The sample for the qualitative approach consisted of 2 sets of staff members of the Main Operating Theatre, who underwent the same semi-structured interview. These included five administrative nurses responsible for the management of the unit. The other set consisted of ten senior scrub nurses who underwent a different method of training in theatre nursing.

Themes from qualitative data

From the fifteen interviews performed, five different themes emerged. The following section will highlight the results obtained per individual theme, including also various issues respective to particular themes that emerged during the interviews. To maintain anonymity, direct quotes identifiable by the assigned respondents' code will also be included.

THEME 1: TIME FRAME

• The right duration for the programme (TF1)

Eleven of the interviewees commented that the time period of three months is the right period through which a nurse recruit can obtain the necessary knowledge, skill and attitudes to function safely. As SN3 remarked, ''3 months are enough for any newly qualified nurse to know about the basic techniques in operating theatre nursing".

While still agreeing with the 3 month period as the right duration for a good programme, SN7 and AD3 expressed some reservations as to the actual time period that is being observed during the current mentoring. More specifically, SN7 stated that,' I wonder if the 3 month period is being observed as, according to my knowledge, the last two batches of new nurses were given less time for their induction".

However, the rest of the respondents (n=13) did confirm that the 3 month induction period is being observed and that this is congruent with the policies set 9 years earlier for the duration of the programme.

• Output in relation to the time frame (TF2)

Amongst the interviewees, six respondents registered a negative consequence to mentoring. As described by AD5, mentoring can lead to ''impaired output". SN8 and SN10 have attributed this decreased level of output to the paternalistic role that mentors act in favour of their mentees. As SN10 commented, ''Some mentors over-protect their mentee, impose rather than facilitate while they also neglect and omit the chance for recruits to reflect upon their actions. This, in turn, lead to decreased level of output, motivation and commitment from the mentee".

AD3, SN4, SN1 and SN2 commented that for the simple reason that recruits are considered as 'extra persons' during their induction, they tend to slack and rely on the 'day after' rather than 'today'. As SN1 said, ''Some recruits do not commit themselves fully to the programme as they can always have another day to recover something that they didn't do today.

Instead of giving 100%, they can afford a lower percentage of effort".

• Customised assessment for the right time frame (TF3)

There was a unanimous response that each recruit must have an individual assessment right at the start of the programme. As SN5 commented, ''This will help to identify the necessary and right tuition, addressing the gaps in knowledge that the new nurse will have".

Individual assessment, as commented by AD1, will lead mentors and mentees to focus their efforts towards common objectives and ''to facilitate rapid integration of the recruit for him to function safely within the large operational framework of the Main Operating Theatre".

This issue further led to discuss the element of the time duration for the ideal programme. SN6 stated that once a proper assessment is performed, "Mentors and mentees can work together to arrive to the targets. Once reached, and an evaluation of what has been learnt is done, then the recruit can start working on his own, irrespective of time".

AD2 further commented on this issue and stated that the time frame could be less or more than 3 months depending on the commitment and progress of the mentoring relationship that ''Must be addressed to reach the desired outputs, meet the required needs and all this within a respectable, non-uniform time frame".

THEME 2: CRITICAL SUBJECT MATERIAL

• Critical topics (CSM1)

Recognising and accepting the fact that tuition is most often based on individual mentor's perceptions and opinions, thirteen respondents commented that the determination of core issues is a critical component and a requisite for a successful programme. AD1 argued that, "All mentors must deliver core issues to all recruits at the beginning of the programme. This will allow equal opportunities and a strong foundation for the progress of the mentoring programme and CPD for the new theatre nurse".

SN3, SN10, AD2 and SN5 also commented that since core issues are identified, standard practices of tuition will somewhat ''eliminate or reduce subjectivity in favour of objectivity". (SN10)

• Pre-registration learning (CSM2)

Defining core topics or issues in theatre nursing can also serve as a reference to the academic body in Malta, the Institute of Healthcare, that provide the foundations for nurse practice on our island.

As described by SN8, these core topics are ''the foundation, basics and critical components of theatre nursing". Taking also in consideration the large number of nurses within the eight operating theatres within St. Luke's Hospital, prospective theatre nurses can be provided with relevant teaching on these topics at the Institute of Health Care as students.

AD3, AD4, AD5, SN6, SN8 and SN9 commented how the Institute of Health Care can be the catalyst for future theatre nurses. As SN8 pointed out ''Exposure to theatre nursing through teaching of core issues may motivate student nurses to be a part of the operating theatres once qualified"

AD3 also commented that ''by providing basic knowledge of core topics in theatre nursing, new recruits wouldn't have so many problems to overcome during the first weeks of their professional working life".

• Ongoing Continuous Professional Development (CSM3)

In today's hectic, fast changing work environment, professionals need to constantly update their knowledge, skills and attitudes in order to remain current and competent. Acknowledging the fact that not many opportunities exist for post-graduate course in theatre nursing in Malta, efforts and the limited resources should be directed towards these core issues that are so important for the delivery of quality service.

While none of the interviewees followed a post-registration course specifically in theatre nursing, five respondents received a scholarship to specialise in a particular area of surgery. All fifteen interviewees agreed upon the importance of Continuous Professional Development and as AD2 argued,''At least, important topics about theatre nursing should be well taught and available for qualified nurses as an opportunity to exploit as part of their Continuing Professional Development".

SN10 argued and agreed that ''Although resources at the Institute of Health Care may be limited, however, having defined the most important subjects for theatre nursing may help the persons concerned to focus potential resources on these critical topics".

AD1, AD2, SN5 and, SN8 shifted their attention and idea of professional development to the clinical unit. The concept of the Practice Development Nurse in theatre nursing has been put into light. As AD2 commented, ''Considering that nearly in every area of nursing there is a Practice Development Nurse, I do not see the reason why there shouldn't be one for theatres".

SN5 commented that ''with a Practice Development Nurse for theatre, the chances of having more expert and academically trained nurses will considerable increase". SN8 added that, ''Practice Development Nurses may and should serve as clinical experts and mentor new operating theatre nurses in such a way that more quality time could be dedicated to the new recruit".

THEME 3: TRAITS OF MENTORS

• Choice of mentors (TM1)

Over the years, the choice of mentors has been at the sole discretion of the administrative nurse in charge of the scrub section. No nurse that has served as mentor has ever followed a course to act as such. Thus, on the unit, as SN3, SN4 and AD4 argue, there is no person who is the ''ideal mentor".

While eight interviewees commented that all things considered, assigned mentors served their function in a remarkable way, seven others do have reservations. SN 5, SN7 and SN10 argued that while experience is important, there are more important factors that determine a good mentor. SN7

commented that ''Adults learn in different manners and if a mentor cannot or does not possess the teaching skills or have the ability to transfer the required knowledge, the new nurse will not be able to develop the necessary knowledge to function safely on the unit".

SN10 argued that although mentors do have many years of experience,' The knowledge capacity of each is different and their teaching is based only on what they know, not on what should they know. There is no rule, standard on which mentors can focus their tuition and mentees will suffer".

AD4 and SN2 both agree that the choice is subjective as no one nurse has the true professional capacity to act as a mentor. As commented by AD4, ''Unless there is a formal post-registration course in either mentoring, operating theatre nursing or, preferably in both, I doubt whether we can ever have the ideal mentor with the right traits".

• Professional mentoring (TM2)

AD4's comment is in line with most arguments brought up by the rest of the interviewees. SN2 further added that, ''Professional facilitation can only be provided subject to mentors knowing everything, or most of the role they are expected to act".

Critical to the success of mentoring programmes, and as stated by AD1, to enhance the quality of established theatre nurses are ''formal, structured courses in theatre nursing". While such courses are expected to provide updated opportunities for Continuing Professional Development, ''They should also provide for mentoring and teaching techniques enabling course followers the opportunity to apply what they learned and transfer learned knowledge for the benefit of recruits and ultimately, to our patients". (SN3)

THEME 4: CONTRIBUTION OF THE PROGRAMME

• A positive response (COM1)

All fifteen interviewees unanimously agreed that the mentoring programme is a positive initiative by which new nurses can be helped to overcome their initial professional healthcare working life. As AD1 states,''Mentoring has now become a part of the theatre environment, a culture through which students can only benefit from"

SN3, SN5 and SN10 have described how the new nurses assigned at the Main Operating Theatre in the recent years have soon integrated and upheld the necessary knowledge required to function in an effective manner. As SN3 argued, ''I have noticed over the years, that new nurses are integrated more quickly and effectively into the system then they were in the early days of when mentoring started".

SN10 continued to say that "this positive thing led to have quality nurses who are more assertive, knowledgeable and capable to do their job". AD4, AD2, SN2 and SN4 argued that ''we should not stop here now!" As SN 2 commented ,''Like any other thing, needs are constantly changing. This means that the mentoring programme should be periodically evaluated, corrected and implemented to deal with the new need brought up through change".

• Immediate benefit (COM2)

It is well known and agreed that newly qualified nurses do encounter problems during their first weeks or months of professional practice.

''As the initial period is the most stressful time for a new nurse, efforts should be directed to help students to overcome these barriers" (SN7).

Eight respondents commented that the most of the immediate benefits that recruits can benefit from is socialisation. AD4 commented that, "The fact that a recruit is integrated quickly with the rest of the staff will help him to apply what he knows and develop his full potential"

SN8 further agreed that socialisation can make new staff" loosen up" and so ''be able to face the initial problems and concentrate on new learning--operating theatre nursing".

AD1, SN4, and SN6 commented on the benefits that mentoring could provide in order for students to bridge the theory/practice gap. SN6 said that through mentoring, new staff can ''apply what they learnt at school having the required help, guidance and friendship".

AD1 continued on the theory/practice gap however, was more negative that the rest. He commented that mentoring can help students overcome the theory/ practice gap, "....given and assuming that some theory about operating theatre nursing at the IHC has been delivered. However, from what I can hear, very little is provided."

• Long term outcome (COM3)

Mentoring does not only serve during the induction period of new staff. Ten interviewees mentioned that it can be the foundations on which Continuing Professional Development can be based. AD3 commented that while Continuing Professional Development is absolutely necessary for any professional at work,

"Mentoring will provide the tools by which new staff are led in the right direction in order to increase their knowledge in nursing, particularly in theatre nursing."

SN4 argued that mentoring is only the start of a long journey in theatre nursing and can "lead theatre nurses to identify their preferred area of surgery and specialise in that particular field. Specialisation is of the utmost importance in nursing."

As mentoring is expected to provide the best opportunities for recruits to develop their potential, "quality service is also expected to be delivered once they've become experienced theatre nurses". (AD2) SN9 remained on the issue of mentoring and sounded more proactive and longer term minded. SN9 commented that "as recruits, with the help of mentors, will become experienced nurses, they in turn will be the ones who will help other recruits to acquire the necessary skills. They will then be expected to provide the knowledge they received from others when they arrived on the unit."

THEME 5: PRACTICE EVALUATION

• Programme evaluation (PE1)

''Evaluation of any programme is necessary", commented SN9. A comment that is in line with all opinions of the other respondents. AD4 said that ''it is a pity that evaluation has never been done as things evolve constantly and what applied for 9 years ago may not necessarily apply today".

There were mixed opinions on the way that evaluation

had to be done. While three respondents preferred a meeting between the mentor, mentee and the nursing officer, five respondents commented that a report would be more ideal. As AD5 said, ''Written assessments are out of the question. Meetings may lead to subjectivity and as I see it, a separately written report prepared by both mentor and mentee can be the best possible option".

• Programme planning (PE2)

Most of the interviewees, in particular the 'SN' batch, argued that the programme is not well planned. SN5 stated that most programmes are conducted solely ''according to what the mentor thinks" while SN6 argued that ''programmes are structured to suit the preferences and abilities of particular experienced nurses".

SN3 and AD1 said that the programme should be planned to meet the needs of the student. As AD1 stated ,"It is only after identifying the needs of the recruit that the programme can be planned and structured".

SN7 argued that while student, needs are to be addressed, "core topics should always be included as they provide the foundations on which mentoring and further tuition can be done".

• Feedback to recruits (PE3)

When asked about whether feedback is being given by mentors to mentees, nine interviewees stated that feedback is being provided. SN6 said that, "Whenever I was a mentor, and I also think that other, do the same, I talk to my student. I explain what he has done wrong and suggest alternative things".

While four other respondents argued that feedback is partly given, two others state that feedback is rarely given. AD1 and in particular AD3 argue that ''from what I hear from recruits, they are left in the dark and very rarely they are given some feedback on their progress". (AD3)

• Programme to continue (PE5)

Unanimous response was given and all agreed that the programme should continue. AD2, SN5, SN7 and SN9 stated that the programme should continue with minor changes in the choice of mentors. AD2 stated that,''Efforts should be made with the Institute of Health Care and the Directorate Nursing Services to provide tuition for existing experienced nurses to become more competent, complete mentors".

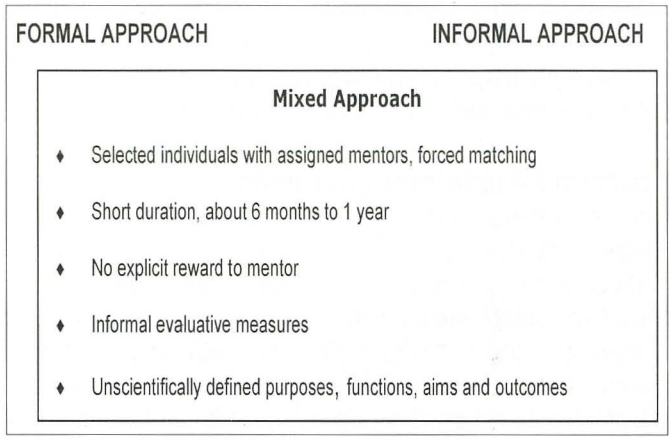
AD1 and SN10 stated that they would be happier if the theory-practice mix should change. SN10 preferred that, ''More theory in theatre nursing, either at an under or post graduate level, should be provided to reinforce the level of practice".

DISCUSSION

The induction approach

Most of systematic programmes like that at the Main Operating Theatre consist of a mix between formal and informal practice. Lorriman (1997) states that the philosophy behind successful programmes is that formal training is complimented by procedures. Like for the case at the Main Operating Theatre, while certain core issues need to be identified and delivered, informal practices enable programme co-ordinators and participants to develop the necessary flexibility required to overcome the effect of change and to maintain a healthy programme.

The mentoring programme at the Main Operating Theatre satisfies all these essentials. Through different stages and a determined time frame, a strong win-win relationship is established by which mentors help mentees to develop self and professionally. This is complimented by a mix of both mentoring approaches, enabling organic and dynamic approaches to short term changing scenarios that may arise in the hectic operating theatre environment. The following figure outlines the mix of the formal and informal approaches that characterise the current mentoring programme.



Clinical supervision

Formal tuition in mentoring and theatre nursing requires an academically trained person who should be the expert in these fields (Campbell, 2000). For the sake of efficiency and financial implications, such a person can serve two different functions. While teaching of core issues and mentoring can be provided by this individual in an academic environment, clinical supervision and mentoring can also be provided by the same person in clinical units.

Some literature argues that mentors like mentees should not be considered as part of the required nursing compliment but dedicated entirely to mentoring. The implications are many but to strike a balance between financial burdens and quality induction, the appropriately selected and trained individual should extend the academic roles to the clinical practice. Clinical supervisors will take to role of mentors facilitating and guiding recruits to acquire the basic, core principles in theatre nursing. This can be delivered both at an undergraduate and postgraduate level.

Clinical supervision and mentoring of a formal nature has been for some time been integrated in nursing in the United Kingdom. The roots of clinical supervision stemmed from the perceived need for such a system of support from several key documents like Vision for the Future (DOH, 1993), Clothier Report (1994), Delphi Study of optimum practice (Butterworth, 1994) and, position statement on clinical supervision (UKCC, 1995). The United Kingdom Central Council stated that clinical supervision is necessary in clinical practice to enable practitioners to establish, maintain and promote standard facilitation and innovations in practice in the interests of

patients and clients. While clinical supervision applies entirely throughout ones professional working life, it is particularly indicate in the early stages of one's career (UKCC, 1995).

On a smaller scale, approximately for the last five years, clinical tutors from the Institute of Healthcare are following nursing students on their clinical attachments. Together, practice and theory is being amalgamated while students are observed to benefit from such supervision. Such practice may also be improved and extended to theatre nurses that make up approximately 17% of the nursing workforce at St. Luke's Hospital. As Corlett (2000) identified, new theatre nurses in the United Kingdom attribute utmost importance to clinical supervision as not enough time could be devoted by their mentors who had to comply with other professional duties. As they described, clinical supervision permit a discussion, relationship between students and others who have an understanding of the core issues—the kind of role, duties and responsibilities that an experienced nurse has when acting as a mentor facilitating the mentoring process.

Practice Development Nursing

On more practical terms, a relatively new concept at St. Luke's Hospital has been the appointment of Practice Development Nurses in various areas of nursing. Considering issues that have emerged from this study namely, the need for academically trained mentors and theatre nurses, the need for mentors to be like mentees and not be considered as part of the nursing compliment during the induction programme and also, the need to expand theatre nursing at an undergraduate level, the appointment of a Practice Development Nurse for theatres is indicated.

Practice Development Nurses are responsible for the continuing education and professional developmental needs of staff in the clinical unit. In Nottingham City Hospital in the United Kingdom, Practice Development Nurses for theatres are also responsible for ensuring that all aspects of theatre nursing are represented within the University of Nottingham curriculum, ensuring continuity and parity across the service and the academic centres.

Amongst the expected practical key result areas and roles of these nurses, a large number of issues are congruent with the findings of this study. More specifically, Practice Development Nurses: -

- Should create a conducive learning environment within the clinical and classroom settings, facilitating professional development through individual and shared learning.
- Contribute to the development and review of the nursing care element of pre and post registration education programmes.
- Support pre and post registration nursing courses and provide expertise and specialist knowledge in relation to the competent field.
- Lead, develop and co-ordinate the induction and orientation programme for new staff and evaluates the effectiveness of the programme.
- Co-ordinate the development of an annual training needs analysis for the clinical unit.
- Lead in the development and advancement of clinical practice, emphasising the relationship of theory and practice.

Findings of this study indicate that some modifications need to be made to the current mentoring programme. As mentioned in various interviews with administrative and senior theatre nurses, such modifications can be satisfied after the appointment of a Practice Development Nurse for the operating theatres. Moreover, other elements and themes that emerged from this study conform to the essential and desirable person specification prescribed by the Nottingham City Hospital for their Practice Development Nurses. These specifications are: -

- Teaching competencies
- Experience of mentoring/preceptorship
- Knowledge of the Training Needs Analysis process
- 4-5 years clinical nursing experience
- Good organisation of pre and post registration courses

A comprehensive view of the results

Overall, this study attempted to reach many aims and objectives. It assessed the technical and functional aspects of the current mentoring programme at the Main Operating Theatre. Through a mixed approach of data collection, namely through interviews with administrative and senior nurses as well as through questionnaires with operating theatre nurses with nine or less years of experience.

Undoubtedly, it has been determined that the mentoring programme positively affects new theatre nurses in their abilities as theatre nurses. This effect has been investigated to ascertain whether any demographic variable impacted on these findings. No significance has been detected. The practice of mentoring has been intensively analysed and several issues have been determined. The current time period of 3 months for tuition under the current circumstances is considered as satisfactory. However, as individual assessments have been identified as a requisite for good practice, this time period may vary per individual recruit. Mentors are primarily expected to act as role models for their recruits focusing their method of facilitation on core issues namely sterility, safety, infection control and, scrubbing.

The model of the mentoring process at the Main Operating Theatre seemed to have various elements from several models while it lacks some elements from others. However, overall, the model of the mentoring process in question seems to be more congruent with the four-staged mentoring model of Furlong and Maynard depicted earlier. In particular, the distribution of the stages is not equal primarily because, as confirmed through the findings of this study, mentees do not have the capacity to conceptualise and reflect on their actions. The following figure shows the variation model congruent to the mentoring practice at the Main Operating Theatre.

Beginning Stage	Supervision Stage	Conceptualising Stage	Reflection Stage

Being the first evaluative study of the mentoring programme that is expected to continue, future research should be promoted to monitor such practice in order to enable a longitudinal trend to emerge. Efforts and commitment from theatre and organisational management are encouraged in order to enhance the quality of mentoring for patients to reap the benefits that mentoring is expected to achieve.

Strengths of the study

Evaluating programmes is a necessity for its long-term success. This study provides the first in-depth evaluation of the mentoring programme at the Main Operating Theatre, St. Luke's Hospital. It will therefore serve as a baseline against which eventual future studies may be compared and contrasted.

The triangulation approach used in this study to collect primary data serves to strengthen the findings. Both quantitative and qualitative methods were used to support perceptions, expectations and opinions of the two sets of participants who contributed to this study.

Reliable, scientific findings are expected to contribute to one of the critical areas in the Maltese Health Sector. It should provide adequate guidance and improved quality service to theatre nurses that represent 17% of all nurses at St. Luke's Hospital. Enhanced quality service may be then exploited at the new hospital Mater Dei once its doors are open in 2007.

Analysis of data was performed in considerable depth. While manual thematic analysis was done for qualitative data, the Statistical Package for the Social Sciences (SPSS) was used issuing results pertaining to statistical significance of the quantitative findings.

Limitations of the study

Being the first evaluative study of a mentoring programme at St. Luke's Hospital, limited literature has been found against which results from this study could be gauged. Since it was also a retrospective study, this increased the difficulty to find reliable and relevant studies and literature to compare and contrast results from this study.

Another problem and a limitation is recall bias. This study had to portray theatre nurses into an environment or a scenario that they had experienced in the past, going as back as nine years. This in itself may have created problems for participants to think objectively and remember facts that happened some time before.

Another limiting factor for this study is the fact that the researcher worked at the Main Operating Theatre that is the site where the research has been being performed. However, the commitment and strong identification of the researcher to mentoring and the organisation enabled objectivity to prevail and kept at high levels at all times during the study.

The number of subjects used for quantitative method of data collection (n=45) was small. However, as described, it was not possible to recruit a higher sample, as all the population of this study has been included. In order to address and alleviate this limitation and to strengthen the reliability of the study, triangulation of methods were used including qualitative methods through 15 interviews with administrative and senior theatre nurses.

Recommendations

After evaluating the data collected in this study, the researcher was able to forward a number of objective and realistic recommendations.

Recommendations for Practice

• Formal Training Needs Analysis - This technique will identify the real, actual needs of individual recruits. Induction will then focus on these needs and the programme structured in a manner by which gaps in knowledge, skills and attitudes would be alleviated.

• Mutual agreement - Having identified the needs to be addressed, mentors and mentees should determine specific, measurable, achievable, realistic and time bound objectives to be satisfied during the induction programme. Through healthy discussion, mutual agreement should be reached to structure the mentoring programme in a way to facilitate the attainment of the pre-agreed objectives.

• Core Issues - While mentoring should be flexible enough to accommodate individual needs, core issues that have been identified through this study should be given their due importance and taught in a uniform, standard manner by all mentors to all mentees at the start of the mentoring programme.

• Evaluation of progress - Formal evaluation must take place to ascertain that recruits are receiving the expected benefits of mentoring. Such evaluation has been determined to be more constructive and relevant if performed in the middle and last stages of the mentoring process.

• Feedback - This core component of the mentoring process requires more attention. Mentors and mentees must give adequate importance to feedback as it may outline possible alterations to the programme in progress as required. Feedback should become an integral element in the culture and philosophy of successful mentoring.

• Location for theory - More theory is to be added to the current mentoring programme. As it is implied and determined throughout the study, a location is necessary to be determined where this added theory will be delivered. Participants prefer the theatre to be the place where this can be delivered. This further implies that the required space, equipment and furniture to be made available for the successful delivery of this theory.

• Review of programme - The methodology used in this study may be used and improved to evaluate and review the mentoring programme periodically. This will determine whether mentoring will still be imparting the expected benefits and also, to identify any possible variations to the programme in order to remain current and up to the required standards.

Clinical and Academic Recommendations

• Collaboration - Formal channels of communication and collaboration should be established and enhanced between the operating theatre and the Institute of Healthcare. This relationship will enhance the benefits of mentoring as the necessary information and academic knowledge can be transferred for the benefit of both healthcare bodies.

• Mentoring Course - The possession of the necessary mentoring know how in order to transfer the required knowledge is considered a requisite for effective mentoring. Efforts should then be directed between the clinical unit and academic bodies to provide formal courses in mentoring, possible at both under and post registration level. This will outline the roles and responsibilities that mentors need to act for good mentoring. It will also contribute to provide quality, complete and academically trained mentors for the benefit of nursing recruits and their own quality of work.

• Theatre Nursing Course - Theatre nurses account for 17% of the current nursing workforce at St. Luke's Hospital. These nurses base their practice on some undergraduate knowledge relevant to theatre practice, the 'non-academically' prepared mentors and, experience. To keep up with modern practice and technologies, Continuous Professional Development is required at post-registration level. While it is an individual responsibility to enhance one's professional development, academic courses in theatre nurses that may include as their main subjects the core issues of theatre nursing identified in this study, can be an added opportunity for qualified nurses to improve their knowledge and quality in their practice.

• Training at an undergraduate level - Like many academic bodies over the world, the Institute of Healthcare does not formally provide tuition for theatre nurses at an undergraduate level. However, considering the substantial number of theatre nurses at St. Luke's Hospital, the need to be proactive and, the growing expectations and perceptions of patients for quality service, a short module in theatre nursing could be considered. The nature of theatre nursing and in particular, the basic core topics most relevant in theatre practice may constitute the basic foundations for this course. Exposure to theatre nursing at an under graduate level may motivate student nurses to make part of the large multi-disciplinary team within the operating theatre framework once qualified.

Recommendations to Management

• Support for programme - Managers should walk the talk. Their presence on the clinical unit is highly appreciated while feedback, observation and discussion constitute a requirement for good management in support of the mentoring programme.

• Recognition to mentors - The contribution of mentors in providing quality nurses should receive adequate support and recognition when it comes to important situations in ones' professional career. Recognition may motivate mentors to commit themselves fully to the programme for the benefit of new operating theatre nurses.

• Practice Development Nurses - Considerations should be made as regards the appointment of a Practice Development Nurse for the Operating Theatre. This position will extend the already existing benefits available for other areas of nursing derived from the appointment of respective Practice Development Nurses. Moreover, this nurse will contribute to the effective delivery and evaluation of the mentoring programme for new operating theatre nurses, enhance the opportunities for continuous professional development of qualified nurses and also, co-ordinate efforts and resources with academic bodies for the provision of pre and post registration courses for theatre nurses.

Mentoring for Malta

Although very little mentoring literature originating from Malta can be found, the benefits and possibilities of mentoring to overcome initial problems in nurse transition are also applicable and can be attained on our island. Mentoring is also expected to provide the foundations for the Continuous Professional Development plans of Maltese nurses. Much has been said about the problems encountered due to the factors of transition of a newly qualified nurse.

However, these problems are expected to persist and Malta is no exception. Sharples (2004) highlighted that nursing, like any other profession, is in a continuous state of flux and is also subject to new knowledge, technological advance and public needs and demands. Thus, he recommends new graduates for an immediate search for learning opportunities and to develop themselves professionally. Induction through mentoring may be the immediate channel through which new staff can find assistance, guidance and expertise that can lead them towards fulfilling their role of becoming expert, quality nurses.

High standards in mentoring provide quality nursing services and eventually imparts the required guidance, knowledge and skills to operating theatre nurses. Well-mentored operating theatre nurses will have an impact not only on the quality of services provided by the Hospital but also on the level of care perceived by the patients. This study clearly showed that nurse graduates in possession of academic qualifications but lacking clinical skills, do not fully equip them with the right knowledge, skills and attitudes required for operating theatre nurses to function safely and effectively. Therefore, the integration of a structured mentoring programme is an absolute necessity.

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From Our Diary... Mid-djarna...

1. President Paul Pace and Vice-President Maria Cutajar meets ICN President Hiroko Minami where the ICN Congress 2011 in Malta was discussed. About 3,500 Nurses from all over the globe will visit our island to attend this important Nurses' Congress.

2. An Agreement between BOV plc and MUMN was again reached. In the photo MUMN President Paul Pace together with BOV Chief Officer Operations Igino Xuereb.

3. MUMN Council was invited to meet MLP Leadership where current issues where discussed and MUMN's vision for Nurses and Midwives.

4. The CEO of Mater Dei Hospital, Ms. Marion Rizzo, presented the keys of the new MUMN Office in this hospital to Paul Pace, President.

5. MUMN Vice-President, Maria Cutajar presented a paper during the last ICN Congress. The subject was better conditions of work for Nurses and Midwives in a new hospital set up.

6. MUMN's Executive Committee organised a conference on Primary Health Care and Community Services where two foreign speakers, amongst others, addressed the delegates present. Mr. Frank Mifsud, Permanent Segretary, Health Division also addressed the Conference.

7. A record number of Nurses and Midwives attended the Extraordinary General Conference to hear the President, Paul Pace explaining the proposed agreement reached with the Government. It was a very positive meeting where unanimously the Members voted in favour of the said agreement.

ICN Calls for Positive Practice Environments to Ensure Quality Patient Care

Geneva, 12 May 2007 – Based on the conviction, supported by evidence, that quality health care workplaces provide quality patient care, ICN has launched a global call to address and improve the serious deficiencies currently existing in the health work environment in all regions. The delivery of safe, high quality and efficient health services depends on the competence of health workers and a work environment that supports performance excellence. The ongoing underinvestment in the health sector in many countries has resulted in a deterioration of working conditions. This has had a serious negative impact on the recruitment and retention of health personnel, the productivity and performance of health facilities, and ultimately on patient outcomes. Positive practice environments (PPE) must be established throughout the health sector if national and international health goals are to be met.

"The goal of ICN's call for positive practice environments is to improve the quality of health services through health care work environments that support performance excellence," declared Hiroko Minami, President of ICN. "We believe patients and the public have the right to the highest performance from nurses and other health care professionals. This can only be achieved in a workplace that enables and sustains a motivated, well prepared workforce."

ICN has brought this issue to light on the occasion of International Nurses Day, with the publication of an information and action toolkit entitled, *"Quality workplaces = quality patient care"*. The toolkit is designed to raise awareness and stimulate action, and can be used by managers, front-line nurses, chief executive officers, professional associations and/or regulatory bodies. It provides data on positive practice environments to all health stakeholders who are interested in improving the delivery of quality services. The toolkit has been distributed to all ICN member associations and to nursing representatives worldwide. It can be accessed online at www.icn.indkit.htm_

The establishment of positive practice environments will continue to be a priority programme in the years to come, both for ICN and its recently launched International Centre for Human Resources in Nursing (ICHRN). The goal of ICHRN is to improve the quality of patient care through advancing nursing and health care services and promotional activities for positive practice environments will be supported by the data, tools and standards found on its website (www.ichrn.org).

Editor's note

The International Council of Nurses (ICN) is a federation of 129 national nurses' associations representing the millions of nurses worldwide. Operated by nurses for nurses since 1899, ICN is the international voice of nursing and works to ensure quality care for all and sound health policies globally.

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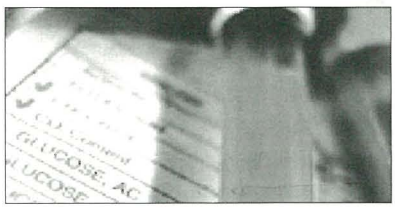
Why Regular Screenings Are So Important

By **Melissa Tennen**, Health AtoZ writer



Too busy? Your body may be busy, too - quietly dealing with a disease such as cancer or fighting off a heart attack - and you won't even know it until it becomes "mission critical."

That's why you need regular screenings, which can diagnose diseases in their earlier, more treatable stages. This is true if you are young or old, male or female, active or sedentary. Your need for certain screenings changes as you age. You may need them more often - or at a younger age - if you have risk factors for a disease. For instance, obesity is a major risk factor for diabetes, certain cancers and other health problems.

As many as one-third of those with diabetes don't know they have it until it is diagnosed by a doctor. It can run unchecked for years, hurting the body in many ways - increasing risks for eye disease, amputation, kidney disease and many other conditions. Screenings for diabetes can reduce the damage it does to the body. The same is true of undetected high blood pressure. With every beat of the heart, high blood pressure damages organs and increases the risk for heart attack.

Depending on screening results, you can change your lifestyle habits. For instance, if your doctor says you are prediabetic, you can make changes to help ward off full-blown diabetes - a condition of high blood sugar that isn't high enough to be considered diabetes.

What screenings do you need? Talk to your doctor. Not everyone has the same risks or needs. The following are guidelines based well-designed research to help your doctor decide when or if you should be screened:

GENERAL RECOMMENDATIONS

Screening	How often?
Blood pressure	Adults 18 and older at least every 2 years.
Cholesterol	Every 5 years starting at age 20. More often if you have risk factors such as diabetes.
Colon cancer	Starting at age 50 if you have an average risk. With family history or inflammatory bowel disease, may be needed more often.
Skin exams	Self exams at least yearly. Talk to your doctor about screening, particularly if you are fair-skinned or spend a lot of time outside.
Diabetes	Starting at age 45 - every 3 years. Earlier and more often for those with risk factors (overweight, racial minority, family history or high blood pressure).

WOMEN

Screening	How often?
Mammograms	With or without breast exam - every 1-2 years for women 40 and older.
Pap smear	Within 3 years of start of sexual activity or age 21 (whichever comes first), and screening at least every 3 years.
Osteoporosis	Age 65 and older - should be screened routinely. Age 60 with risk factors (such as small frame) - may need sooner.
Chlamydia	Routine screening for all sexually active women 25 and younger. Talk to your doctor about screenings for other sexually transmitted diseases.

MEN

Screening	How often?
Prostate cancer	If you are 50, yearly digital rectal exam and prostate-specific antigen test.
Testicular cancer	Whenever you get a physical, which should be yearly if you are 50 or older.
STDs	Talk to your doctor about how often.

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

This article was reviewed June 2006, by Stephen Colucciello, MD, Adjunct Professor of Emergency Medicine, University of North Carolina, Chapel Hill and Associate Chair Department of Emergency Medicine, Carolinas Medical Center.

Agreement

The Government of Malta and the Malta Union of Midwives and Nurses agree to take the following measures aimed at promoting these professions and attracting more Midwives and Nurses to the Public Health Sector that is significantly expanding. Both parties also agree to monitor the situation and jointly agree to take the necessary corrective measures.

1. A **Warrant** will be issued to all First Level Nurses. First Level Nurses holding a degree in nursing will receive the Warrant after two years from their Registration with the Nursing and Midwifery Council (NMC). Other First Level Nurses will receive the Warrant after five years from their Registration with the NMC. The grandfather clause will be awarded to all first Level Nurses who were registered with the NMC prior the date of signing of this agreement on the same criteria as above i.e. - First Level Nurses holding a degree and were registered for more than two years with the NMC, and other First Level Nurses who were registered for more than five years with the NMC from the enactment of the relevant legislation.

2. The **Bridging** process will be applied to all those Nurses and Midwives who decide to return back and be employed with the Public Health Sector. This means that all the nursing/midwifery experience in the Public Health Sector before leaving the same Sector will be recognized on their return and will be reflected in their salary, progression of scales and computation of service.

   Nurses/Midwives who before resigning occupied a nursing/midwifery managerial post, on their return, will be employed in the maximum of scale 10.

   Nurses/Midwives holding a degree and who before resigning were assimilated in salary scale 9, on their return will be assimilated in the same salary scale 9.

   This process will be also applied to those Nurses/Midwives who returned back to work with the Public Health Sector during these last ten years from the date of the signing of this agreement. The emanating benefit from the applicability of this clause will be restricted only to the adjustment of their salary and grade with effect from the date of the signing of the agreement.

   Nurses and Midwives who opt to leave the Public Health Sector will remain on the Reserve List of the Public Health Sector. Should they wish to return, they can do so on the first available vacancy.

3. The Director of Social Security will consider positively requests by the Director Nursing Services to apply the provisions of Legal Notice 13/1987 as long as the services of these nurses and midwives are required by the Public Health Sector.

4. A system will be set up, by the Director Nursing Services, for those Nurses/Midwives who choose **to invest a number of hours worked or/and a number of vacation leave** per year so as to reclaim them after a number of years in relation to family responsibilities, health reasons, personal and professional development.

Agreement

5. The Parties agree to set in place a ward/department management appraisal system, evaluating the clinical/management performance of nurses and midwives, by December 2009.

6. A process of **Mobility** will be set up enabling Nurses/Midwives who after 30 full years of nursing/midwifery service in the Public Health Sector, or the equivalent, can opt to move from one hospital/department/ward to another. A committee made up of three persons (core group – two officials from the Health Division and one official from MUMN) would receive and analyse the requests and recommend to the Director Nursing Service. Appeals can be put forward to the Director General (Health).

7. The provisions of the Addendum signed on 1 February 2000 regarding First Level Nurses/Midwives and Second Level Nurses who were employed with the Public Service before May 1993, **benefit with two extensions** in salary scale 9 and 10 respectively, after 12 years and 17 years respectively will also be extended to First Level Nurses/Midwives and Second Level Nurses who were also employed after May 1993.

8. In view of the agreement of 12th April 2006 where it was agreed that "the whole process (Continuous Professional Development) would be eventually revised as part of the overall reform in this regard", and the agreement of 1st March 2007 where it was agreed "to strive to reach agreement on the quantum of the capping", the Parties undertake to engage in discussions to review by January 2010 , the current CPD process so as to guarantee the maximum benefit to the nursing and midwifery staff and the clients of the Division of Health as well as ensuring the programme's sustainability.

9. The Annual Nursing Premium to all Nurses and Midwives will be increased by Lm250 as from 1 October 2007. On 1 January 2009, this premium will be increased by another Lm250.

10. After 30 full years of nursing/midwifery service in the Public Health Sector, or the equivalent, a Nurse/Midwife will be awarded an increase in the Nursing Premium of Lm 1000; this will be increased by Lm 250 after 35 full years of service in the Public Health Sector, or the equivalent, and another Lm 250 after 40 full years of service in the Public Health Sector, or the equivalent.

11. Nurses/Midwives who, after 30 full years of nursing/midwifery service in the Public Health Sector or the equivalent, following the recommendation of the committee referred to in article 5 above, opt to work a reduced week of at least 25 hours in terms of 3.1.6 of the Public Service Management Code, will have their income pro rata according to 3.1.6.11 of the same management code. However all the income, not exceeding the basic wage received prior to the reduced hours, will be considered as basic wage for pension calculation purposes.

Agreement

EFN POSITION PAPER ON THE INFORMED PATIENT

The complexity of health systems calls for improved communication, coordination, continuity, education and management and the increased use of new technology.

Effective information and education in health enable patients to take on more responsibility for the management of their condition. It also helps patients to maintain their independence and can lead to better health outcomes.

All patients have a right to access to clear and accurate information about their health and choice of care. Patients require different types of information, presented in different forms depending on literacy and educational levels, and cultural and social needs.

Empowerment of patients depends partly on patients having sufficient information to understand their condition and choice of treatment and care. Health professionals should respect the choices patients make under these conditions and assist them to implement these choices.

Nurses are the largest occupational group in health care, providing front-line care and thus play an essential role in providing patients with clear information. They can also have a pivotal role in initiating change and improvements in healthcare systems at local and national levels.

Nurses should take part in programmes which develop access to literature and quality assured health related web-sites where patients can obtain information about their illness or condition, likely outcomes, and factors that promote health and prevent disease.

Attention is drawn to the International Council of Nurses report on the "Informed Patient Project" and to the Advisory Committee "Report and Recommendations on the competencies required to take up the profession of nurse responsible for general care in the European Union" (XV/E/8481/4/97).

EFN Position Statement – 18 June 2004 - (Reviewed - June 2007)

Għamel salib

Minn żmien għall-ieħor ikollna nagħmlu bħall-eżami tal-kuxjenza. Dan sew bħal meta tasal xi elezzjoni jew meta rridu nieħdu deċiżjoni għall-futur. Ilkoll irridu ngħażlu u nieħdu deċiżjoni, anke aħna bħala Infermiera u Qwiebel. Għalhekk nixtieq li twieġbu fis-skiet ta' qalbkom dawn il-mistoqsijiet:-

- Thossok kuntent bil-*management* tiegħek kif qed tiġi trattata jew tħossok li trid tobdi bilfors?
- Issa li ilhom li ħargu l-applikazzjonijiet għall-promozzjonijiet u ma ġara xejn, qed tħoss li kienu daħk fil-wiċċ?
- Tinsab kuntent kif ġew magħżula l-hekk imsejjħa *acting deputies* jew *nursing officers*?
- Tħoss li qed tiġi trattat u stmat l-istess bħal ħaddieħor rigward l-informazzjoni dwar l-Isptar Mater Dei?
- X'taħseb rigward l-għajnuna li l-Union tiegħek ġabet bis-CPD? Qed tieħu li ħaqqqek u fi żmien stipulat?
- Tara xi bidla fil-professjoni tan-Nursing issa li qegħdin membri fl-EU?
- Kuntent tara kollegi tiegħek filli jagħmlu xogħol ta Nurse u ftit wara jsibu xogħol aħjar: bħal speci hawn tagħna?
- Taħseb li l-għajdut ta 'l-forka għall-iżvinturat' għada teżisti qalb l-Infermiera u l-Qwiebel?
- Qatt ġejt mitlub biex tagħti l-*feedback* tiegħek għalkemm m'intix NO jew DNO minn xi uffiċjal ta' l-Isptar?
- Tħoss li l-marid qed jiġi ttrattat aħjar issa li hawn Nurses bil-BSc u Diploma, *Specialised Nurses*, *Practice Development Nurses*? Jew il-*bedside nursing* sparixxa?

Dawn huma xi ftit mistoqsijiet li ħassejt li għandi nagħmel. J'Alla s-salib li għamilt fil-kaxxa jkun pożittiv u permezz tar-riżultat in-nuqqas jiġi mwarrab u jkompli jsir titjib għall-aħjar minn min tela' l-fuq u mhux jisma' l-karba ta dawk t'isfel. Inkella jista' jkun hemm tbatija u skuntentizza li tista' tirrifletti fuq il-klijenti tagħna l-morda!!!

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Nutrition, Metabolism & Shift Work

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Do you ever think that working could modify your lifestyle, metabolism, eating habits, and body image? If one were to think about how our body metabolism works, one would quickly realise what I mean? Our metabolism works well and regularly when we eat regularly – moderate portions of food spread out evenly throughout the day. When we spend long hours not eating anything, our metabolism automatically slows down to save calories and prevents us from starving.

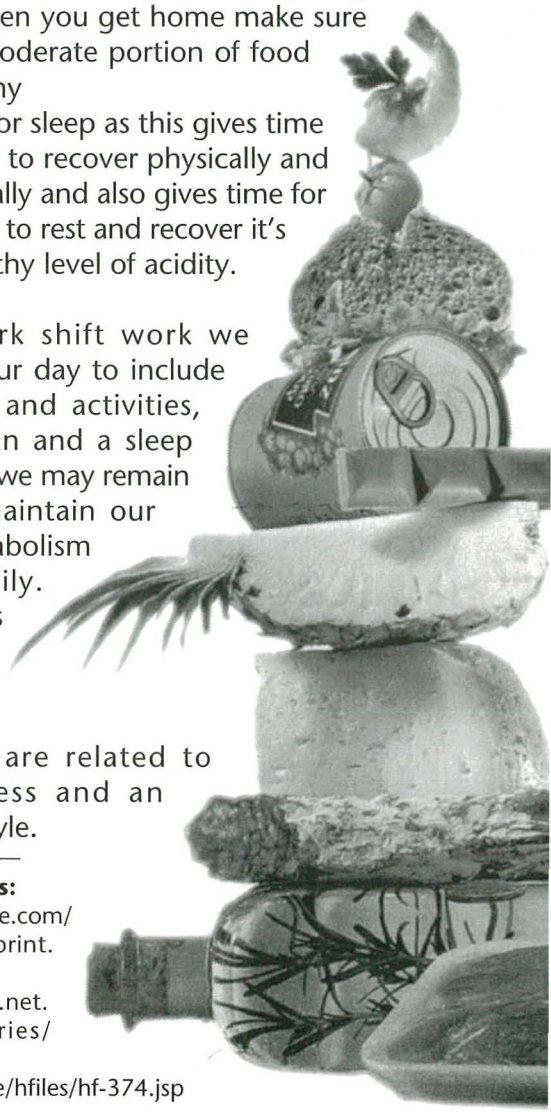
During shift work we start our morning or day shifts at 7am. There we have time for a good breakfast, at a decent time. When our day finishes at around 1.30pm we already have problems to eat a healthy meal or snack, that is determined by our break time and what we find available (unless we prepare our lunch from home). Even so, we normally bring bread with us and that poses another problem – too much bread at one time (and we put on weight!). Then we go home and have a rather late meal. People who finish at 7pm have an even bigger problem. They have three breaks, are more dependent on break times and still have the same meal options as their colleagues. When they can include a meal in their daily plan it might be the most convenient one available, rather than the healthiest and ideal. Most of these workers end up going home after 7pm and eating a meal that, more often than not, is abundant and sometimes convenient rather than healthy (and they put on weight!). Some of them might not even find time to eat regularly and this makes their metabolism slow down (and they put on weight!).

Night shift workers are the extreme. They have spent a whole day doing different activities and eating and are tired before work. Night work almost induces a worker to eat, nibble or snack to keep himself from sleeping and to obtain a small amount of energy to endure the night. Where as in other people, at night, the body has time to recover some sleep and to plan their daily food intake, these people cannot do so. They have to remain alert and attentive. The lack of sleep and the tendency to nibble or snack to keep awake and fight boredom all cause the person's metabolism to slow down and his weight to increase (and they put on weight!). Many times, working overtimes, long hours or frequent night shifts leaves the workers too tired to attend a gym or to do some exercise – that would help them lose some weight and increase their metabolism and this makes matters worse.

Hence what should one do to help himself go through the shift work but still be healthy? One should:

- Plan out daily activities and meals so that you have small frequent meals that are healthy and balanced in nutrients, fats, proteins and carbohydrates.
- Take nutritious snacks to work, limiting and balancing out the amount of fruit, bread and avoiding junk food and snacks.
- Plan for some exercise during the week – at least half an hour, twice to three times a week.
- Go easy with caffeinated drinks as these are stimulants that can increase blood pressure and gastrointestinal problems.
- Avoid vending machines as these provide fast foods that often provide a large number of calories.
- Either prepare your meal before you get home or when you get home make sure you eat a moderate portion of food that is healthy
- Leave time for sleep as this gives time for the body to recover physically and psychologically and also gives time for our stomach to rest and recover it's normal healthy level of acidity.

When we work shift work we need to plan our day to include healthy meals and activities, an exercise plan and a sleep routine, so that we may remain healthy and maintain our body and metabolism working steadily. This will keep us healthy and help us avoid unnecessary illnesses that are related to excessive stress and an unhealthy lifestyle.



Some useful links:

- http://sparkpeople.com/resource/articles_print.asp?id=217
- http://www.abc.net.au/canberra/stories/s11243287.htm
- http://www.vhi.ie/hfiles/hf-374.jsp

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Xi qrajt...

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DOVERI TA' L-INFERMIERA FI SPTAR FL-AMERIKA FL-1887

Dan li hawn miktub hawn isfel huwa biċċa minn gażżetta li nstabet f' Bibbja antika.

Dan ix-xogħol ġie mogħti lill-infermiera fis-swali mill-awtoritajiet ta' l-Isptar fl-1887.

Minbarra l-għajnuna li għandha tiġi mogħtija lill-50 pazjent, kull infermier/a għandha timxi fuq dawn ir-regolamenti:

1. Ta' kull jum trid tiknes u taħsel l-art tas-Sala tiegħek, tfarfar l-għamara tal-pazjent/a, kif ukoll il-ħoġor tat-twieqi.
2. Iżżomm temperatura kostanti fis-sala billi ġġib barmil faħam għax-xogħol tal-ġurnata.
3. Id-dawl huwa mportanti biex tosserva l-kundizzjoni tal-pazjent/a. Għalhekk, kulljum trid timla l-lampi bil-pitrolju, tnaddaf iċ-ċmieni u tqasqas il-ftejjel. Aħsel it-twieqi darba fil-ġimgħa.
4. In-noti ta' l-infermiera huma mportanti biex jgħinu fix-xogħol tat-tobba. Agħmel il-pinen tajjeb; tista traqqaq it-tokok għall-gosti tiegħek.
5. Kull infermier/a ta' matul il-jum, trid tirraporta għax-xogħol fis-7 ta' filgħodu u tispiċċa fit-8 ta' filgħaxija minbarra s-Sibt, meta dak inhar, int tkun wieqfa minn nofs inhar sas-sagħtejn ta' wara nofs inhar.
6. Infermiera li jiggradwaw tajjeb, bil-permess tad-Direttur ta' l-Infermiera ikollhom lejla barra kull ġimgħa biex ikunu jistgħu joħorġu ma' ħbiebhom jew żewġt iljieli kull ġimgħa jekk imorru l-knisja regolarment.
7. Kull infermier/a għandu/a twarrab kulljum somma tajba minn dak li taqla' biex tfaddalha għal meta tikber biex ma tkunx ta' piż. Per eżempju, jekk inti taqla $30 fix-xahar, int għandek twarrab fil-ġenb $15.
8. Infermier/a li jpejjpu, jużaw ix-xorb f'kull forma, jagħmlu xagħarhom fis-salon, jew jiffrekwentaw swali taż-żfin, jistgħu jagħtu x'jifhem lid-Direttur ta' l-Infermiera jekk humiex tajbin u x'inhuma l-intenzjonijiet u l-integrita' tagħhom.
9. L-infermiera li jaqdu xogħolhom u jservu l-pazjenti u t-tobba mingħajr żbalji għal ħames snin sħaħ, jingħataw żieda ta' 5 ċenteżmi kulljum, sakemm ma jkunx hemm xi djun pendenti ta' l-Isptar.

Maqlub għall-Malti minn ***R. Camilleri***

Communicating...!?

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The quality of our life is determined by the quality of our relationships, and communication is the key to relationships at all levels, whether it is domestic, professional or social. Lack of communication has caused untold havocs in human history. Wars were waged, friendships were spoiled, harmony at work was ruined for want of proper communication.

Communication increases and multiplies in the present communicating society. There is a veritable communication explosion. It is an expanding field and is, therefore, considered by many to be new and exciting. However, the excitement is short lived. Communication is now researched on as any branch of science is. It is written about and discussed as an art form. In universities it is studied as a sociological phenomenon. Contacts, exchanges, dialogues, sharing of information – all these are greatly expanded as a result of the great advances in communication technology.

But amazingly the present facility discourages concentration and fosters disorientation.

It is also in our time that we often hear complaints about lack of communication-communication gaps, cross communication and so on. In some instances, the lack of communication is pointed at as the culprit behind friendships that go sour, families that break up, nations that go to war, suffocating atmosphere at work.

Many people talk **at** or **to** each other but rarely **with** each other. One can see why so many people hear what they want to hear and not what is being said. Truly there is lack of communication, of tolerance, of respect, of affection, of caring or concern.

Man is a communicator. As a social being he needs to relate, a need that comes from his very nature. Communication is so interwoven in our daily life that few persons realize how much time is devoted to it. The awareness of the need to communicate is the first step to communicate in a society that is rapidly changing. Effective communication fosters understanding of one another and brings people closer together.

I believe that all health professionals are desperately in need of understanding amongst ourselves. Whatever promotes better communication and understanding, promotes cooperation, solidarity and in the end better care for our clients. We live and work in a communication society, and this society cannot go on unless its members communicate with one another, acting and interacting on one another so as to form a working community. We need to

communicate among ourselves. It has to operate at every level of relationship, one to one, one to two and one to many. As we tend to become more complex or to treat others as objects, the ability to communicate also becomes more complex.

Communication means getting your own ideas across to others. This implies more than speaking or writing clearly in simple, direct language. Communication is the ability of two or more people to get through to each other. It is rooted in openness and responsiveness. It is based on a deep respect for each other. Every communication is a two-way process. When one person speaks directly to another person, he/she expects some kind of a response. Silence should indicate a disinterest in communication and equivalently, a disinterest in the person.

Communication is capacity of encounter, is a process of maturation. The person who is emotionally mature communicates also more effectively. Good communicators are persons psychologically healthy, rich of interior life. People who cannot receive or listen, give, conserve, perceive, choose, confront can hardly communicate.

In conclusion I would taunt and ask a few questions. Is there any type of communication going on between different health professionals, nurses and nurses, managers and nurses...? When do we intend to start communicating with each other for our own benefit and that of our clients? It is never too late to start.

Ejjew Nieqfu ftit

Nursing Fun

Because laughter really is the best medicine

3 Nurses and a Wish

A nursing assistant, floor nurse, and charge nurse from a small nursing home were taking a lunch break in the break room. In walks a lady dressed in silk scarfs and wearing large polished stoned jewlery.

"I am 'Gina the Great'," stated the lady. "I am so pleased with the way you have taken care of my aunt that I will now grant the next three wishes!" With a wave of her hand and a puff of smoke, the room was filled with flowers, fruit and bottles of drink, proving that she did have the power to grant wishes before any of the nurses could think otherwise.

The nurses quickly aurgued among themselves as to which one would ask for the first wish. Speaking up, the student nurse wished first. "I wish I were on a tropical island beach, with single, well-built men feeding me fruit and tending to my every need." With a puff of smoke, the student nurse was gone.

The floor nurse went next. "I wish I were rich and retired and spending my days in my own warm cabin at a ski resort with well groomed men feeding me coccoa and doughnuts." With a puff of smoke, she too was gone.

"Now, what is the last wish?" asked the lady. The charge nurse said," I want those two back on the floor at the end of the lunch break."

Top ten reasons to become a nurse:

1) Pays better then fast food, though the hours aren't as good.
2) Fashionable shoes and sexy white uniforms.
3) Needles: "Tis better to give than receive"
4) Reassure your patients that all bleeding stops...eventually.
5) Expose yourself to rare, exciting and new diseases.
6) Interesting aromas.
7) Courteous and infallible doctors who always leave clear orders in perfectly legible handwriting.
8) Do enough charting to navigate around the world.
9) Celebrate all the holidays with your friends - at work.
10) Take comfort that most of your patients survive no matter what you do to them.

Hero in a Mental Hospital

Jim and Mary were both patients in a Mental Hospital. One day while they were walking past the hospital swimming pool, Jim suddenly jumped into the deep end. He sunk to the bottom & stayed there.

Mary promptly jumped in to save him. She swam to the bottom and pulled Jim out. When the medical director became aware of Mary's heroic act he immediately ordered her to be discharged from the hospital, as he now considered her to be mentally stable.

When he went to tell Mary the news he said, "Mary, I have good news & bad news. The good news is you're being discharged because since you were able to jump in and save the life of another patient, I think you've regained your senses." The bad news is, Jim, the patient you saved, hung himself with his bathrobe belt in the bathroom. I am so sorry, but he's dead."

Mary replied "He didn't hang himself, I put him there to dry."

Taking Mother To Nursing Home

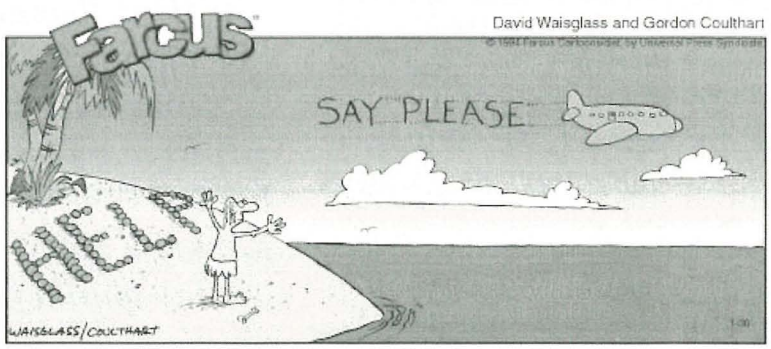
One evening a family brings their frail, elderly mother to a nursing home and leaves her as planned, hoping she will be well cared for.

The next morning, the nurses bathe her, feed her a tasty breakfast, and set her in a chair at a window overlooking a lovely flower garden.

She seems OK, but after a while she slowly starts to lean over sideways in her chair. Two attentive nurses immediately rush up to catch her and straighten her up. Again she seems OK, but after a while she starts to tilt to the other side. The nurses rush back and once more bring her back upright.

This goes on all morning. Later the family arrives to see how the old woman is adjusting to her new home. "So Ma, how is it here? Are they treating you all right?" they ask.

"It's pretty nice," she replies. "Except they won't let me fart."



L-ISTORJA TAL-ISPTARIJIET ĊIVILI U ĠENERALI MALTIN

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

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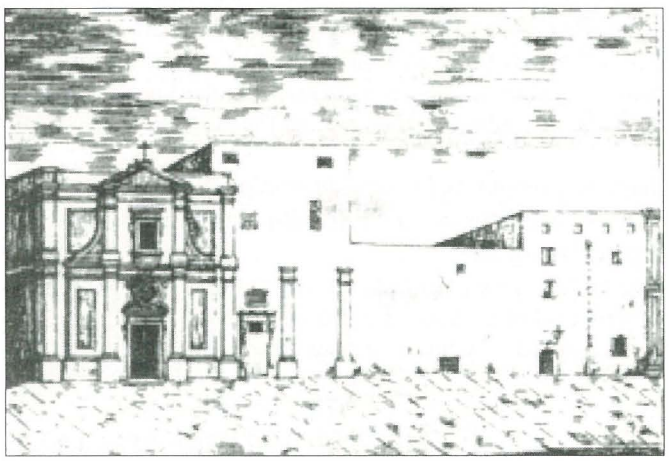
IĊ-ĊIVIL - VALLETTA



Qabel il-wasla tal-Franċiżi, is-servizzi ta' sptarijiet fil-Belt Valletta kienu jikkonsistu fis-Sacra Infermerija għall-irġiel u l-Casetta għan-nisa. Dawn is-servizzi żdiedu b' Santu Spirtu fir-Rabat. Taħt il-ħakma tal-Franċiżi, is-servizzi ta' sptar għan-nies ċivili rġiel ġew trasferiti għall-Isptar Ċivili. Fit-18 ta' Ġunju, 1798, Napuljun ħareġ Artiklu Nru. 12 fejn ġie dikjarat li l-isptarijiet kellhom jiġu ri-organiżżati fuq sistema ġdida u l-propjetajiet miksuba mill-għeluq tal-kunventi kellhom jiġu wżati għal dan l-iskop. Fid-29 ta' Lulju, 1798, il-Kummissarju Franċiż ordna wħud mis-sorijiet u pazjenti nisa tal-Mary Magdalen Asylum, li kien viċin il-Casetta biex joħorġu minn dak il-post. Fis-21 t'Awissu, il-Kummissjoni tal-Gvern, ħatret sotto-kumitat ta' tlitt membri biex jirraporta fuq it-trasferiment tal-pazjenti ċivili rġiel lejn il-Casetta. Il-kumitat irraporta li l-Casetta u l-Case delle Alunne, dar għat-tfal illeġittmi setgħu jakkomodaw 210 sodda. Huma pproponew, għalhekk, li kellhom isiru xi alterazzjonijiet strutturali biex iż-żewġ sessi jiġu separati u għalhekk l-isptar seta jakkomoda 108 sodda għall-irġiel u 170 sodda għan-nisa. Fil-21 ta' Diċembru, 1798, 70 pazjenti rġiel ċivili ġew trasferiti mis-Sacra Infermerija għas-swali l-ġodda. Dan l-arranġament ma kellux ħajja twila u akkomodazzjoni alternattiva ġiet irranġata fil-Kunvent ta' Maria Maddalena li kien fil-viċin. Fl-4 ta' Mejju, 1799, l-Isqof ġie ordnat mill-Franċiżi biex il-Knisja ta' dak li qabel kien Monasteru tiġi desagrata biex tkun tista sservi ta' Sala t'Emerġenza. Is-sular ta' fuq tal-Monasteru kien jintuża għas-Swali tad-deni, filwaqt li fis-sular t'isfel kien hemm is-swali tal-kirurġija u l-imħażen. Il-kantina kienet tintuża għall-pazjenti b'mard mentali. In-numru ta' professjonisti kien jikkonsisti f'ħames tobba, ħames kirurgi u żewġ 'barber-surgeons'. Mal-waqa' tal-Franċiżi, l-Isptar Ċivili ġie meħud għall-użu tat-truppi morda ta' Napuljun, iżda f'Novembru, 1800 reġa' nbidel għall-użu ċivili. It-tmexxija ta' l-Isptar Ċivili, kif ġie msemmi issa, ġiet taħt ir-responsabilta' tal-Presidenti ta' l-Isptarijiet u numru ta' regolamenti għat-tmexxija tiegħu ġew magħmula fl-1802. Il-professjonisti kienu, erba' tobba, seba' kirurgi, *Maestro di Fisica* u erba' apprendisti li kienu responsabbli mit-teħid tad-dmijja (bloodletting) u biex japplikaw il-vesikanti (*vesicants*). Kien hemm ukoll *chirurgo d'appareccio* u *braghista* responsabbli biex japplika l-istikki/*splints*, faxex u affarijiet oħra f'każijiet ta' ksur, minbarra numru ta' studenti tal-kirurġija. L-Ispiżerija kienet taħt id-direzzjoni t'Apotekarju Prinċipali u erba' assistenti. Sa l-1837 is-Swali kienu ġew iffullati wisq. Kull xorta ta' mard kien qed jiġi trattat fl-isptar filwaqt li fi swali separati kienu jitpoġġew il-morda bil-każi ta' 'scabies', kankri u mard ieħor tal-għajnejn. F'Mejju 1850 il-morda ġew trasferiti lejn l-isptar il-ġdid Central Hospital (Sptar Ċentrali jew Iċ-Ċentrali) fil-Floriana. Dak li qabel kien kunvent, fl-1851 ġie rikonoxxut bħala Orfanatrofju biex jilqa' 50 tifel u 60 tifla ta' l-etajiet bejn il-5 u 10 snin. Il-bini ġie distrutt matul it-Tieni Gwerra Dinjija u l-unika knisja, li issa qed tintuża bħala maħżen, kienet salvata.

Kull xorta ta' mard kien qed jiġi trattat fl-isptar filwaqt li fi swali separati kienu jitpoġġew il-morda bil-każi ta' scabies, kankri u mard ieħor tal-għajnejn.

L-ISPTAR IL-QADIM TAL-IMQABBA

Dan il-post ġie mibni mill-Kavallieri (li ma nafux hux Cottoner) fit-18-il seklu għall-vittmi tal-Pesta. Iskrizzjoni legali mnaqqxa fuq il-

bieb fil-faċċata taqra: "A DI PRIMO LUGLIO 1715 LI SIGNORI COMMISSARII DELLA FUNDAZIONE COTTONERA HANNO CONCESSO A TITULO DI EMFITEUSI PER ANNI CENTO CINQUANTA A MARIUZZO ZAHAVA CINQUE TERRENI U LUCO DI CASE U GIARDINO ET UN GARDINETTO TUTTI CONCIONT POSTI E SITI IN CASAL MICABIBA NELLA CONTRADA DETTA TEL MENTNA A RAGIONE DI SCUDI SESSANTA DUE L'ANNO".

Plakka kommemorattiva moderna taqra: "L-Isptar il-Qadim. Mibni mill-Kavallieri ta' San Ġwann fit-18-il seklu biex jieħu ħsieb u jfejjaq il-vittmi tal-pesta u mard ieħor".

Dan il-bini propabbilment kien iservi biss ta' sptar ta' emerġenza waqt ċirkustanzi speċjali. Ftit li xejn għandna dokumenti miktubin dwar dan il-post u lanqas dokumenti dwar l-użu tiegħu regolari bħala sptar ġenerali fi żmien il-Kavallieri.

L-ISPTAR NAVALI TA' BIGHI

Kull min iħares mill-Ġonna tal-Barrakka ta' fuq jew minn xi post fil-Belt Valletta fuq il-famuż Port il-Kbir ta' Malta, jitgħaxxaq b'dehra li m'hawnx oħra bħalha fil-Baħar Mediterran, jekk mhux fid-dinja. Fost il-ħafna bini li wieħed jista' jara u japprezza hemm dawk li jfakkruna fid-difiżi tal-Kavallieri ta' San Ġwann u binjiet oħrajn li kienu mibnija għall-użu tal-flotta Navali Ingliża. Fil-fatt wieħed jista' jara wkoll l-Isptar Navali ta' Bighi, binja li għadha wieqfa u li issa qed tintuża għal bżonnijiet differenti.

Kien il-Kavallier Taljan Fra Giovanni Bichi, li fit-tieni nofs tas-17-il seklu, bena r-residenza tiegħu fuq l-għolja li tagħti fuq il-Port il-Kbir. Minbarra l-Villa arjuża, kien hemm ukoll ħafna art madwara kif ukoll knisja ċkejkna tonda. Ftit wara, faqqet l-epidemija tal-pesta fil-Gżejjer Maltin u Fra Bichi miet fl-1676. L-art għaddiet f'idejn l-Ordni u ġiet mikrija lil diversi kavallieri.

Mal-wasla ta' l-Ingliżi f'Malta fl-1800, u wara bil-miġja ta' Lord Horatio Nelson f' dawn il-Gżejjer, dan immedjatament irrealizza l-potenzjal ta' din il-binja. Lord Nelson issuġġerixxa li jekk l-Ingliżi jiddeċiedu li joqgħodu f'Malta, huma kellhom jikkunsidraw li jibnu Sptar Navali minnflok din il-Villa. Il-post kien idejali, għax minbarra li kien jipprovdi arja friska, kien eżatt max-xtajta tal-port.

Għalkemm is-suġġeriment ma tteħidtx mill-ewwel, wara l-battalja ta' Navarino fl-1827, l-Ingliżi ddeċidew li kellhom jibnu Sptar Navali. L-Isptar kien lest fl-1831. Inbnew żewġ binjiet mal-ġenb tal-Villa tal-Kavallier Taljan u bidlu ftit mill-Villa nfisha biex tkun konformi ma' l-istil neo-klassiku li kien qed jintuża. L-isptar kien ikkunsidrat bħala struttura mibnija tajjeb ħafna u attrezzat bl-aħjar teknoloġija medika.

Fil-fatt dan kien il-post fejn saret ir-riċerka għall-kura ta' dik li kienet tissejjaħ Mediterranean Fever (Deni Rqieq). Kien ġie magħruf li dan id-deni beda mill-ħalib tal-mogħża li kien għadu mhux pasturizzat li kien jiġi mqassam lill-konsumaturi sewwasew minn fuq l-għetiebi tad-djar tagħhom. Dawn kienu jagħmluh ir-raħħala tal-ħalib mill-annimali tagħhom, dak il-ħin stess.

Fuq in-naħa tal-lemin tal-Isptar hemm struttura li tidher maħruġa l-barra mill-binja stess u li kienet twassal l-isfel sax-xatt. Dak kien il-*lift*, li kien iservi biex jitrasferixxi dawk in-nies feruti jew morda minn fuq il-vapuri tagħhom sa l-iswali ta' l-isptar. Dan kien ifisser li l-pazjenti ma kellhomx għalfejn ibgħatu biex jitilgħu dik it-triq wieqfa u twila sa l-isptar, u f'emerġenzi, kienet effiċjenti ħafna.

L-isptar jinsab viċin il-Kalkara, wieħed mill-irħula tipiċi matul ix-xatt tal-port ta' dawn il-Gżejjer. Hemm ukoll il-Forti San Salvatore imperreċ fuq l-għolja, li kien ġie mibni preċiżament biex iżid il-protezzjoni tat-Tlitt Ibliet mill-attakki ta' l-għadu.

Mat-tluq tal-forzi Ingliżi minn Malta fl-1979, il-bini għadda f'idejn il-Gvern ta' Malta. Wara ħafna snin ta' nuqqas ta' deċiżjoni x'għandu jintuża dan il-bini, fil-mument qed jintuża bħala Ċentru ta' Restawr, fejn Maltin qed jitgħallmu it-teknika tar-restawr.

Għalhekk, minn Sptar Navali importanti li kien iservi biex ifejjaq saħħet dak li jkun issa qed jipprepara esperti fl-arti tar-restawr lill-wirt artistiku tal-Gżejjer Maltin.

Ikompli fil-ħarġa ta' Diċembru

Referenzi:

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EFN Policy Statement

Long-Term Care

The EU has recognised the challenges of providing high quality, accessible and affordable long-term care.

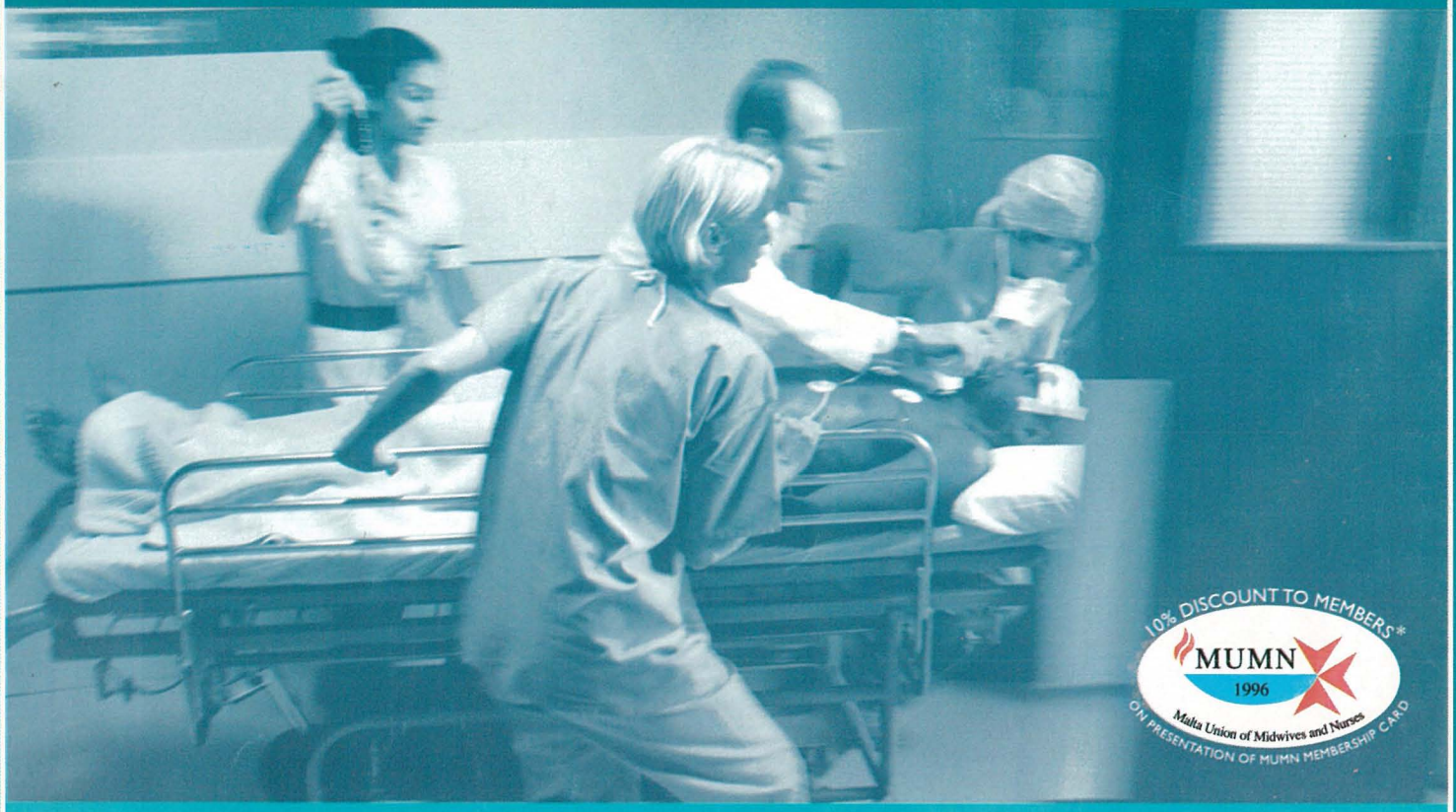
The European Federation of Nurses makes the following recommendations regarding the key principles and strategies required for long-term care.

- The artificial distinction between health and social care should be removed and combined into a single integrated care system;
- Legislation should ensure appropriate nurse/patient ratios in healthcare environments;
- Carers should be integrated into health systems, the value and support available of such a career needs to be increased and there should be capacity building for carers

Please contact Mr. Paul de Raeve, General Secretary of the European Federation of Nurses Associations for a position paper on this issue.
efn@efn.be or Tel: +32 2 512 74 19

EFN Policy Statement – June 2007

PROFESSIONAL FOOTWEAR



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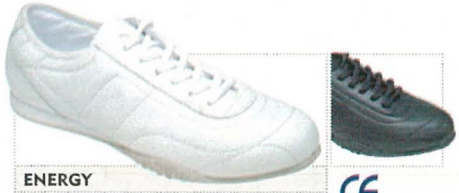

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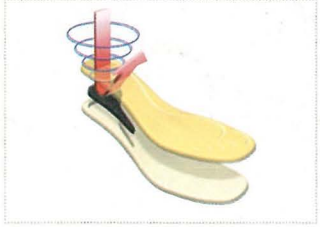

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