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MALTA NURSING AND MIDWIFERY JOURNAL

MALTA UNION OF MIDWIVES AND NURSES

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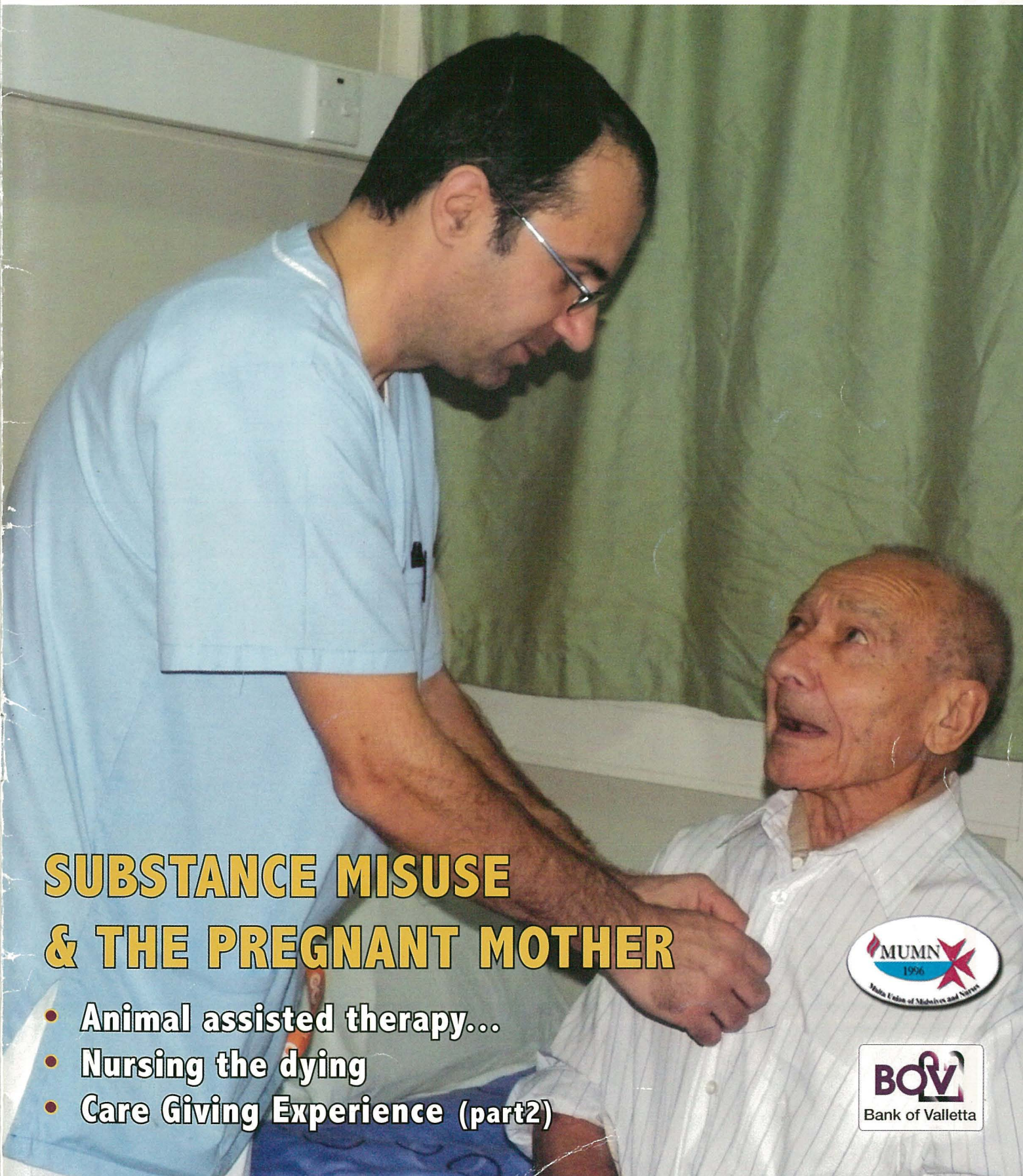
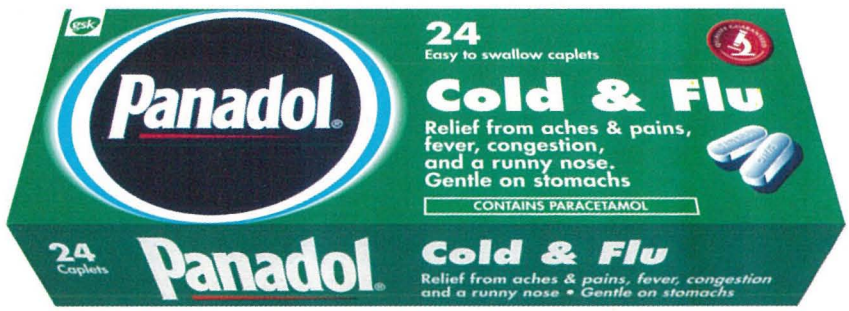


SUBSTANCE MISUSE & THE PREGNANT MOTHER

- Animal assisted therapy...
- Nursing the dying
- Care Giving Experience (part2)

Effective relief from cold and flu symptoms.



Panadol Cold & Flu is highly effective on...

Runny Nose • Blocked Nose • Sneezing
Headache • Itchy Eyes • Fever

Dosage - Adults and children of 12 years and over:
Two caplets up to four times a day

Panadol Cold & Flu Caplets Product Information

Description:
Each tablet contains: Paracetamol 500mg
Pseudoephedrine Hydrochloride 30mg
Chlorpheniramine Maleate 2mg

Pharmacology:
Paracetamol is clinically proven analgesic and antipyretic. Pseudoephedrine is a sympathomimetic agent, for symptomatic relief from nasal congestion. Chlorpheniramine maleate is an antihistamine.

Indications:
PANADOL Cold & Flu caplets are indicated for the relief of symptoms of the common cold and influenza such as: fever, nasal congestion, sinus congestion, headache and sinus pain, sneezing, itchy and watery eyes.

Dosage and administration:
PANADOL Cold & Flu caplets are suitable for adults and children of 12 years of age and over.
Adults and children of 12 years and over: two caplets up to four times a day. If necessary the dose may be repeated every four to six hours but do not take more than four doses (8 caplets) in 24 hours.

Contraindications:
PANADOL Cold & Flu caplets are contra-indicated in patients with known hypersensitivity to paracetamol, pseudoephedrine hydrochloride or chlorpheniramine maleate or related compounds. Not to be used by patients taking monoamine oxidase inhibitor antidepressants or within two weeks of stopping such treatment.

Precautions:
Keep out of reach of children.
This preparation contains paracetamol. Do not exceed the stated dose.
Do not take other paracetamol, containing medications, nasal decongestants, or antihistamines at the same time as PANADOL Cold & Flu caplets.
PANADOL Cold & Flu caplets should be administered with caution to patients with hepatic or renal dysfunction, severe hypertension, cardiac or peripheral vascular disease, hyperthyroidism or on antihypersensitive or antidepressant therapy. Pseudoephedrine should be given with care to patients with diabetes mellitus, closed-angle glaucoma, or prostrate enlargement. Anginal pain may be precipitated in angina pectoris. Antihistamines should be used with caution in conditions such as epilepsy, prostatic enlargement, urinaryretention, glaucoma, severe cardiovascular disorders or pyloroduodenal obstruction.
Do not take this product for more than 10 days or for fever more than 3 days unless directed by a doctor. If pain persists or gets worse, if new symptoms occur, or if redness and swelling is present consult a doctor because these could be signs of serious condition. If nervousness, dizziness or insomnia occur, if a sore throat is severe and persists for more than two days and is accompanied by fever, headache, rash, nausea or vomiting, consult a doctor promptly.
Use in Pregnancy and Lactation:
Although there are no known risks associated with the use of these active ingredients during pregnancy, as with all medicines, medical advice should be sought before using this product. PANADOL Cold & Flu should not be used during breast feeding as there may be risks associated with the use of antihistamines in infants.

Use in Children:
Do not give to children below 12 of age.

Driving and Operating Machinery:
Since PANADOL Cold & Flu caplets contain an antihistamine, sedation may occur impairing the ability to drive or operate machinery.

Side Effects:
Paracetamol: When taken in recommended doses, paracetamol is usually free from side effects. However skin reactions such as urticaria have been reported rarely.
Pseudoephedrine: May occasionally cause anxiety, tremor, dizziness, cardiovascular effects including tachycardia and hypertension, insomnia reported rarely.
Chlorpheniramine: The antihistamine may cause sedation, gastrointestinal disturbances and antimuscarinic effects.

Drug Interactions:
Paracetamol: PANADOL Cold & Flu caplets may interact with anticoagulant agents on prothrombin time. The liver effects of PANADOL Cold & Flu caplets may be increased by the use of alcohol and the concomitant use of certain drugs which enhance the metabolism of paracetamol in the liver (i.e. barbiturates, tricyclic antidepressants).
Co-administration of pseudoephedrine and MAOI's may lead to hypertensive crisis. The effect may persist for up to 2 weeks after discontinuation of MAOI's.
Enhanced sedative effects of chlorpheniramine can occur with simultaneous administration of alcohol, anxiolytics and hypnotics. Tricyclic antidepressants and antimuscarinic can increase antimuscarinic side effects.

Overdosage:
In massive paracetamol over dosage, Panadol Cold & Flu caplets may cause liver damage. Early symptoms may include pallor, nausea, vomiting, (diaphoresis) and general malaise.
Clinical and laboratory evidence of liver damage may not be apparent for 48 hours to 72 hours post-ingestion. Overdose should be promptly treated by gastric lavage followed by intravenous N-acetylcysteine or methionine without waiting for the results of plasma paracetamol levels.
Additional antidote therapy is normally considered in light of further plasma paracetamol levels and the time elapsed since ingestion. In all cases of suspected overdose, prompt medical attention is critical for adults as well as for children, even if you do not notice any signs or symptoms.
Pseudoephedrine overdose is likely to result in effects similar to those listed as adverse effects, and may also produce excess sympathetic stimulation. 7-8 caplets have been shown to cause hypertension in normotensive subjects. Treatment of pseudoephedrine overdose is mainly symptomatic. Measures should be taken to support respiration and control hypertension. Convulsions should be supported with an anticonvulsant if required. Elimination of pseudoephedrine can be accelerated by acidification of the urine. Antihistamine over dosage may cause sedation and central nervous system depression.

Pharmaceutical precautions
Store below 25°C. Store in a well sealed container.

Legal Category: OTC
Market Authorisation Number: MA575/00101

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Editorial

The Challenges Ahead

As we head into Christmas and then the end of another year, it would do us all some good to pause and consider the one thing that remains inescapable in our pursuits. The one thing that is a constant, always passing us by, always with us chasing it. Unfortunately, it is like chasing a vapor in the wind and no matter how we try to manage it, it always seems to manage us. It is the great equalizer that cuts across cultures, eras, and political differences. It is time, and as always it is running out.

So, it's time to take a moment to reflect on our accomplishments during 2008, and indeed there have been many promises but very few achievements. Nurses and midwives have been called upon throughout the year to respond to the demands of providing the best care possible to all who needed our care. We have met this challenge time and again, thanks to all nurses and midwives who work directly with the patients and all those who support them. This commitment has been the key to our success that is, we can hold our heads up high and say that we truly did our best to give our clients the best possible care with the limited number of nurses and midwives that we are. Many are those who had the opportunity to witness first-hand the enthusiasm and dedication of many of the nurses and midwives, and feel confident that it will not wane.

As we look forward to the year 2009 we can expect to face even greater challenges in consideration of the dynamic world stage. Rest assured that many are aware of the effort asked of nurses and midwives in the past year. Many have seen our faces and heard our comments and know that the past year has not been easy. However, we have to work very hard to facilitate the future and provide ourselves with the mechanisms necessary to continue moving forward in our careers. We are definitely on our way towards ensuring that we are there for each and every member of the nursing and midwifery team, both today and in the future.

I would be remiss by not acknowledging all the families and loved ones who have supported each one of us throughout the year. The contributions of those who are closest to us are all too often overlooked as they too are making many sacrifices! They deserve our appreciation and mutual support, and are worthy of our recognition. Our most sincere appreciation goes out to them as well.

We are living in challenging times. The contribution of each one of us will continue to be vital in the year to come. I hope you will take advantage of the holiday season to rest, enjoy life, recharge your batteries, and be with your families.

We are looking forward to the New Year and the challenges and accomplishments that will surely follow. We wish each and every one of you, your families and loved ones, a very safe and happy holiday season and all the best for 2009.

Message from the President

The year 2008 will be characterized as a very important year for MUMN due to the major events which took place. It will definitely be a landmark in the MUMN history.

The opening of our new premises in Mosta will put MUMN in a position to offer better services to its members. Such premises which can be described as state of the art can allow us to offer better facilities to our courses and have concurrent meetings. This is not only an investment but hard work and dedication to our members from MUMN Council.

During 2008 MUMN was instrumental in removing the extra duties pertaining to the 46.67 hours. As from the 1st January 2009, all Nurses and Midwives who have a 46.67 hours rooster (DDNRO roster) will now all be harmonized and no extra duties will be pertained to contribute to the 6.67 hours. As you all may appreciate this was not a small achievement to gain for our members.

In 2008 MUMN was involved in the setting up of various committees to achieve all the benefits of the October 2007 agreement. Certain benefits in the October 2007 will come into place again in 2009 such as the new rise in the premium of 584 Euro and the bridging at Zammit Clapp Hospital. I would like to note to the members that this year, the premium will be in March, June, September and December with the new raise so that the whole premium will be received in these months and not how we experienced last year where the new raise was given to us in different months from the normal nursing premium.

2007 will also be marked with the recent industrial actions taken up by the industrial action committee within each hospital and health centres due to the lack of implementation of the Oct 2007 agreement, lack o reform within university amongst other important issues. I would like to take this opportunity to thank all members in making the industrial actions a complete success which clearly shows the strong message which MUMN can deliver to the Health Division. Such industrial actions have been temporary suspended due to meetings being chaired by Minister John Dalli to address the Nurses' and Midwives' issues.

MUMN was also one of the catalysts of getting all Unions in this country together against water and electricity tariffs. MUMN is loyal to its principles and statute and therefore it is totally apolitical in principle. But we are totally loyal to our members and MUMN has been consistent in this issue even when other Unions backed down quickly. On this issue we were proven right and we strongly believe that such tariffs need adjustments since people will be pulled below in the poverty line.

Well Nurses and Midwives are the hub of MUMN. Whatever the issues and the directives the MUMN Council issues during the year, these have always been driven from its members. The main principle has always been that the power is from the Nurses and Midwives to the MUMN Council and not from the MUMN Council to its members. That is why MUMN Officials had numerous meetings with the staff in various hospitals. As President I am looking forward to the challenges our professions will bring about next year to the benefit of our same professions and patients. I would like to take this opportunity to wish you and your families a Happy and Prosperous New Year.

Paul Pace
President

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The classical Roman poet, Publius Verigilius Maro (70 BCE – 19 BCE), better known in English as Virgil, used to say: "The greatest wealth is health". Health is an incomparable gift. It is the spring board for myriads of opportunities. Obviously when speaking about health we need to specify what we are meaning by the term. These short reflections will be concentrating on what is spiritual health.

It is a noted fact that spiritual well being or illness affects the psychosomatic condition of the person. If the medical term health is synonymous with life then a person can be said to be ill not only if her/his physical and psychological condition is impoverished but also if s/he is not spiritually sound. In Bernard Häring's words such an individual is spiritually sick, precisely because s/he suffers from "the loss of a focal point", or, we may say, "deficiency of the spirit of wholeness". From my pastoral experience at Mater Dei Hospital I constantly learn that when a person lacks an authentic spiritual life, s/he hardly manages to recover holistically. On the contrary, when a person has a solid spiritual life s/he tends to interpret what is happening to her/him in a rather positive, constructive and fruitful manner. In fact, even if the kind of disease a person has cannot be cured that person's spirit can open for her/him interesting avenues in vue of a dignified conclusion of her/his life.

How can a person, then, be spiritually healthy? An honest, open and trusting relationship with God is the key. My pastoral reflection helped me realize over the years that a peaceful and harmonious relationship with the world's Creator is actually a powerful source of healing. God is the source from which everything emanates. In monotheistic religions, God is presented as the one who holds everything together and gives meaning and direction to what he created. In God everything has its place, movement and purpose. Thus, one's friendship with God supports that person's recovery or gives a hopeful meaning to one's life termination. By relating to her/his own God the person will experience profound peace whilst her/his spirit will become universally creative. In God, the person starts discovering new life perspectives. S/he can better understand her/his existence, why s/he has to die and where her/his death is leading her/him to. S/he can peacefully dialogue and befriend the mystery of her/his own suffering. As a matter of fact, the latter is not regarded anymore as a curse but rather as an opportunity to know and appreciate the great gift of life.

When the transcendent takes baptizes what is immanent, the person starts realizing that God is in fact a person who knows, listens, cares and loves. Under God's wings, the person understands that in life there is more than what s/he can feel and see. Deep within her/his heart, the person knows that having God as her/his ongoing companion in her/his life journey there is the infallible assurance that evil, personal guilt, natural disasters, illnesses etc do not have the final word. With God goodness always triumphs over evil, new birth over destruction, hope over hopelessness, and peace over despair.

By living in friendship with God a person gets the strength to love others, to show mercy and to offer unconditionally her/his helping hand to those who suffer. Being a companion with God automatically means living for others, show solicitude, being humane, good, honest and virtuous. In other words, being God to the people around her/him. In this sense, the prayer attributed to Saint Teresa of Avila makes a lot of sense. "[God] has no body now but yours, no hands but yours, no feet but yours. Yours are the eyes through which [God's] compassion must look out on the world. Yours are the feet with which He is to go about doing good. Yours are the hands with which He is to bless us now".

Spiritual health needs to be safeguarded against the tyranny of volatile feelings. A prayer written by a Jewish man who was killed in a Nazi concentration camp can be of great help to us in order to prevent our lifegiving relationship with God from getting tarnished by the influences of evil that are found within and around us. "I believe in the sun although I do not see it. I believe in love even though I do not feel it. I believe in God even if he chooses to remain silent". If God is the essence from whom anything comes into being can we not say then that our greatest wealth is our spiritual health? If our answer is in the affirmative can we not tie the knot with God?

Fr Mario Attard OFM Cap
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Kelmtejn mis-Segretarju Ġenerali

Mill-aħħar artiklu sa llum seħħew bosta avenimenti fejn l-MUMN kienet il-protogonista tal-ġurnata sabiex twassal il-lehen ta' kull wieħed u waħda minnkom.

Meta bdejna naraw li l-Gvern beda jonqos milli jħaddem miegħu numru sabiħ ta' Nurses u fl-istess waqt ma kienx qed jonora l-klawsoli kolla tal-Ftehim ffirmat f'Ottubru 2007, iddeċidejna li nipprotestaw fuq dan l-aġir, aktar u aktar meta bdejna nisimgħu li l-postijiet vakanti tan-*Nurses* li hemm fit-*Theaters* ser jimtlew minn *theater technicians*. Fl-istess waqt l-MUMN ingħaqdet ma l-Unions kolla fil-pajjiż u protestat mal-Gvern dwar iż-żieda fit-tariffi tad-dawl u l-ilma. Dan kien żmien movumentat ħafna għall-Union tagħna fejn kienet qed tipprotesta fuq żewġ binari.

Però r-rieda tajba minn kull parti għenet sabiex dawn il-kwistjonijiet inbidlu f'diskussjonijiet fertili. Dwar il-problemi li kellna fil-qasam tas-saħħa intlaħaq qbiel mal-Ministru John Dalli li hu nnifsu ser imexxi kumitat magħmul mis-Segretarji Permanenti f'kull Ministeru fejn għad hemm kwistjonijiet sabiex b'dan il-mod jinstabu s-soluzzjonijiet meħtieġa fl-interess ta' kulhadd. Nistqarr li kemm ilhom isiru dawn il-laqgħat diga nstabu s-soluzzjonijet għal numru ta' problemi li kien hemm pendenti. Għad baqa' aktar x'jiġi diskuss però mexjin b'ritmu tajjeb.

Bħal ma ħafna minkom tafu f'dawn l-aħħar ġimgħat kellna ftit ċaqlieq intern li wassal sabiex ikollna żewġ membri ġodda fil-Kunsill. Dawn huma Antoinette Saliba (*Midwife* - MDH) u Mario Aquilina (*Nursing Officer* - SVPR). Nawgurawlhom kull suċċess fil-ħidma tagħhom bħala r-rappreżentanti tagħkom ilkoll.

Fl-aħħar laqgħa li kellna għall-membri kollha ħareġ, b'mod qawwi, punt interresanti f'dak li jirrigwarda l-bżonn ta' aktar komunikazzjoni bejn il-membri u r-rappreżentanti tagħhom fl-MUMN. Hemm il-ħtieġa urġenti li jinġabru l-emails tal-membri kolla sabiex il-komunikazzjoni issir aktar malajr u b'mod effettiv kif ukoll jiġu ffrankati somom kbar ta' flus. Kien suġġeriet ukoll li l-ġurnal il-'Musbieħ' kif ukoll in-newsletter tal-'Florence Nightingale Benevolent Fund' jibdew jiġu ppublikati *online* fuq il-*website* liema *website* ser tkun *upgraded* fil-ġranet li ġejjin. Dan ser ikun proġett interessanti u dinamiku li ser iwassal sabiex tiżdied il-komunikazzjoni fost il-membri kollha tal-Union.

F'dawn l-aħħar ġranet kellna fostna wkoll id-Direttur ta' l-Amministrazzjoni ta' l-*International Council of Nurses*, Ms Myriam Gomes, sabiex tara f'hiex wasslu l-preparamenti li qed tagħmel l-MUMN għall-Konferenza Internazzjonali tan-Nurses fl-4 - 7 ta' Mejju, 2011. Kellna ġimgħa sħiħa ta' appuntamenti ma bosta organizazjonijiet, lukandi, agenti etċ però b'sodisfazzjon ninfurmakom li l-ICN hija sodisfatta ħafna bil-progress li sar u qed iħarsu l-quddiem li jkollna Konferenza ta' livell għoli b'attendenzi li joqorbu ta' l-inqas it-tlett t'elef Nurse minn madwar il-globu.

Jidher li fix-xefaq ta' sena ġdida jidher li ser ikollna aktar ħidma fl-interess taż-żewġ professjonijiet li nirraprezentaw kif ukoll biex insaħħu dak li għandna llum. L-MUMN mhiex kontra t-tibdil u l-progress però basta dan ikun għall-ġid ta' kulħadd u mingħajr esegarazzjonijiet kif ukoll ma jkunx iħares biss kemm ser jiġu ffrankati spejjeż. Huwa mportanti li jkollna *Nurses* u *Midwives* kuntenti fuq il-post tax-xogħol tagħhom għax b'hekk biss jistgħu dawn jagħtu l-aqwa servizz lill-pazjenti u ommijiet li jkunu qegħdin fl-isptarijiet u ċ-ċentri tas-saħħa.

Irrid nieħu din l-opportunità sabiex nawguralkom lilkom u l-familji tagħkom sena ġdida mimlija risq u barka u li tkun bil-bosta aħjar minn dik li għaddiet.

Colin Galea
Segretarju Ġenerali

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Animal Assisted Therapy in The Institutionalised Elderly

Christa Gauci, Diploma Nurse, Member of the MUMN Group Committee SVPR

'The man-animal bond has existed since time immemorial and has always been a beautiful one.' (A. Maitra 2003). Human beings care naturally. We bloom and thrive when we have others to love and look after. Animal assisted therapy (A.A.T) is also known as animal assisted activity (A.A.A). Pet therapy has been proven to be an effective and rewarding experience and delivers a host of benefits to a diversity of patients amongst these, the elderly...

According to R. Windale (2008), animal assisted therapy works in more ways than one. Pets provide therapeutic activities for the elderly, such as reducing the stress and anxiety of hospitalisation, reducing residents' loneliness and isolation, enhancing self-esteem, promoting socialisation, improving communication, enhancing relationships with the residents and staff, and they also give unconditional love and loyalty which the elderly need. The most common animals kept as pets include dogs, cats, birds and fish. J.Blake (2006) stated that apart from companionship dogs have various uses, such as dogs which help the blind and disabled.

G. Colombo and M. Buono wrote about a study conducted in Veneto region of North Italy. It involved 144 elderly residents. 48 of which were given a canary, 43 were given a plant, and 53 subjects were given nothing. Observation period lasted 3 months were at the end, the elderly cognitive status and their perception of quality of life, were assessed. The group that received a plant seemed to benefit from the experience but they did not receive the same positive results as exhibited by the group that received a pet. The study reinforces the hypothesis that A.A.T has a beneficial effect on the psychological well being of institutionalised elderly, especially those related to depressive symptoms and perception of the quality of life.

The inclusion of A.A.T in the elderly is a complimentary additional factor to health care management. 'The natural release of endorphins, sometimes called the 'feel-good' mood enhancing hormone, has been the result obtained with residents experiencing a relaxing interlude with animal visitations.' (L. Holloway 2008). The Wishard Health Services initiated pet therapy program in November 2002. Since then pet therapy in rehabilitation centers, hospitals, and residential homes, continues to grow in leaps and bounds. The staff in the ward where i work in St. Vincent De Paule, has also acknowledged the effectiveness of the program as we are training a dog as an additional factor to health care management, to help with healing and give a warm presence to ailing the elderly. Please observe that A.A.T does not offer an alternative cure, therefore treatment and medications should not be stopped.

We have observed the interaction and reactions to the animal's presence. Previously withdrawn residents have become very involved and some of their unknown personality traits have emerged, such as social interactions. Physical health benefits which have resulted include, the lowering of blood pressure (resident relaxes and this reduces stress), decreased risk of stroke and heart attack, and other medical conditions due to a positive approach to getting better. Mental illness among the elderly can also react well to pet therapy. Feelings of isolation and despair, and reduction of aggressiveness and hostility can be alleviated. 'Dementia patients can show periods of increased attention span and awareness and recognition of their surroundings when the pet is visiting them.' (F. House 2008). A.A.T is not an option to consider if the elderly person has a fear of pets, as this therapy will have an adverse effect on the resident. Therapeutic values will only be shown among those residents who accept the pet, as it will bring out their nurturing instinct.

A.A.T is a recognised method of treatment more so in developed countries as it is a nice, natural, and holistic approach. Studies have shown that pet therapy has promoted physical movement, cognitive awareness, emotional well being, and social involvement, whilst requiring less medical care and adding years to their lives. Pet therapy works wonders as it makes them feel unconditionally accepted by providing non-judgmental love and affection.

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Substance misuse & the pregnant woman

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Without doubt, drugs are one of the most common substances that are being misused by young adults. A drug is a substance that when introduced have an effect on the body. Thus, drug abuse or misuse refers to the haphazard use of drugs or other chemical substances for non medical purposes. Drug effects are influenced by the amount taken, the route of administration, frequency, surroundings, age, sex, body weight, tolerance and genetic factors (Sciberras, n. d.). The woman may misuse drugs for various reasons. Siney (1999) states that most of the time, drugs are introduced to the woman by her friends or by her partner. Drug taking may be used to alleviate stress, anxiety or depression. Moreover, drugs could have been introduced for recreational activities. Little does the woman know what serious consequences will follow! Drugs misused include narcotics, opiates, hallucinogens, marihuana, central nervous system stimulants, sedative and hypnotic drugs (Sciberras, n.d.). The author chose to discuss in depth about heroin, which is classified under opiates (Info facts on heroin can be found at the end of this article).

Reactions to women using drugs are by and large negative in all nations (Klee, Jackson & Lewis, 2002). The incidence of opiod misuse is still increasing in many countries, with a significant proportion of this population being woman of childbearing age (Fischer, 2000). Heroin use in Malta is of 10:1000, which for comparative purposes is similar to or higher than the leading 3 or 4 countries within the EU reporting such figures (European Monitoring Centre for Drugs and Drug Addiction, 2005).

Drug misuse is especially tragic more than ever, when the person is a pregnant woman. The risks of drug misuse doubles because the health and safety of two persons (the mother and the fetus) is placed in jeopardy (Forbes & Lyon, 2006). Most of the time, the pregnant substance misuser is seen not as an individual human being but rather as a 'baby machine' with problems. These problems are considered to be both self inflicted and harmful to the pregnancy (Siney, 1999).

▪ Effects of substance misuse on the woman

The pregnant woman with a drug problem is at a higher risk for maternal and perinatal morbidity and mortality (Hepburn, n. d.). Heroin dependence can lead the pregnant woman to ignore her medical, nutritional, and social wellbeing; resulting in a detrimental effect on her overall health and that of the fetus (Fischer, 2000). Moreover, the substance misuse women are known to have irregular menstrual cycles, hence their pregnancies are often accidental together with a chaotic follow up (Kayemba- Kay's & Laclyde, 2003). The harmful effects of the substance abuse on the mother may occasionally result in death by either an intentional or unintentional overdose (Hepburn, n. d.). Moreover, the prevalence rates of infectious diseases are increased due to needle sharing, abscess formation, endocarditis and HIV/hepatitis infection (Gillstrap & Little, 1999). Thus, maternal infection, neglect and malnourishment are partly responsible for the complications that the baby presents with. Nonetheless, the majority of opiate addicts are poly substance abusers. Behaviours that include smoking, drinking alcohol and taking other illicit drugs can all have a harmful effect on the baby (Fischer, 2000).

▪ Effects of substance misuse on the baby

Substance misuse during early pregnancy is associated with a poor pregnancy outcome (Sherwood, Keating, Kavvdia, Greenough & Peters 1999). According to Hepburn (n. d.) substance misuse during pregnancy increases the risks of:-

i. Having a premature or low birth weight baby
ii. The baby suffering symptoms of withdrawal from drugs used by the mother during pregnancy (neonatal abstinence syndrome is going to be discussed elsewhere)
iii. The death of the baby before or shortly after birth
iv. Sudden infant death syndrome (SIDS)
v. Physical and neurological damage to the baby before birth, particularly if violence accompanies parental use of drugs or alcohol

Similarly, Johnson, Gerada & Greenough (2003) proclaim that complications during pregnancy in the substance misuse mother include:-

i. premature rupture of the membranes
ii. meconium stained liquor
iii. fetal distress
iv. antepartum haemoorhage (opiates tend to increases the risk)

▪ The family and other children of the drug abuser

Families are usually the major providers of support for the drug abuser. It is recognized that psychological problems are common among families with a substance-abusing member (Lennox, Scott-Lennox & Holder, 1992). Most of the time, the drug abuser's family are viewed as 'pariahs'; they sometimes are even excluded from society because they have someone who take drugs in their family. This may be due to society's fear and ignorance on the subject. Hence, campaigns on this stigmatic subject should be done as it will be beneficial to help break the silence around drugs in families and counteract the usually negative presentation of the issues seen in the media. 'Flying blind', the family accompany the substance misuser throughout the days, weeks and sometimes months of abuse and withdrawal. Nonetheless, family members carry out this invaluable service for their loved ones at an enormous cost to themselves (Adfam, 2001).

Motherhood is often regarded as a women's destiny and ultimate fulfilment. If the mother is engaging in psychoactive drugs, this may result in a number of direct and indirect effects of her inebriation on the child's cognitive and psychosocial development (Klee et al, 2002). Children of drug dependent parents are an elevated risk of adverse development, social outcomes (Barnard & Barlow, 2003) and tend to perform less well academically (Keen & Alison, 2001). Most of the time these children are locked into a silence that they find difficult to unburden to anyone (Barnard & Barlow, 2003). Nonetheless, substance dependence among the parents has been related with child neglect and physical and sexual abuse. Hence child protection play an important role in ensuring that appropriate education is provided and if need be actions are taken, so as to ensure that children are properly assessed and safe from harm (Keen & Alison, 2001).

▪ Care and management

Forbes & Lyon (2006) state that when providing care to pregnant substance misusers; a holistic approach should be applied. This needs to address the physical, psychological, emotional, economic and social needs of the women and their families. Pregnant women with a significant drug use may have other social problems and their care should reflect this. Hence, a multi professional team approach to the management of substance use in pregnancy is essential ; which must include the mother and her support people, the midwife, physicians, obstetrician, paediatrician and also addiction and social services (Forbes & Lyon 2006, Hepburn n. d., British Columbia Reproductive Care Program 1999).

Midwives have a significant responsibility in providing the pregnant women and their babies with maternity care (Forbes & Lyon, 2006). Women with drug problems have potentially a high risk pregnancy (Gillstrap & Little, 1999); hence it is of utmost importance that the pregnant substance misuse woman seeks antenatal care early (Hepburn, n. d.). However, many a time this will be in the contrary and these women will present only at the time of delivery (Fischer, 2000). The woman may not seek antenatal care for several reasons such as a chaotic lifestyle and disinclination to be involved with social and health services. As drug abusing is illegal and is socially unacceptable, the woman may not wish to admit her problem to the midwife or other health professionals for various reasons such as being treated differently by the staff and losing custody of her child or children (Hepburn, n. d.).

The midwife and other health professionals that are providing care should ask the woman sensibly about the substances being misused which include also tobacco and alcohol. The woman will often admit to some use of a substance, however she will rarely admit that she have a problem with social or illicit substance use during pregnancy (Gillstrap & Little, 1999). The midwife should be trained on how to deal with these women. Moreover, the midwife should have enough knowledge and skills to identify substance misuse, assess its severity and refer the woman to specialist services. One should not exclude that the woman might also feel guilty and worried that her baby will be damaged or display withdrawal symptoms after birth (Hepburn, n. d.).

▪ Support and treatment

The skilled, trusted, non-judgemental midwife supports the mother and encourages her to attend to maternity and addiction services. Kelly (2004) states that rather than being criticised these women need to be provided with adequate care, reassured and encouraged. The woman must feel welcomed and accepted (British Columbia Reproductive Care Program, 1999). Antenatal care should include assessment of the extent of the woman's substance use, including the type of drugs being taken, level, frequency, pattern, method of administration and consider any potential risks to her unborn child from current or previous drug use (this is explained in more detail in appendix E). If the woman doesn't attend for maintenance therapy and/or doesn't have a social worker, the midwife will ideally ask the woman for consent to liaise with the local available services so as to enhance the outcome. There is a broad range of treatment options for heroin addiction, which include medication as well as behavioural therapies (U.S. Department of Health & Human Services, 2006).

Johnson et al (2003) claim that it is usually better to keep the pregnant women on maintenance treatment as insisting on abstinence will risk losing the mother from contact with the health system. In view of this, Fischer (2000) states that opiate dependent women who receive maintenance therapy during pregnancy are more stable both physically and psychologically, and receive more prenatal care than women who are not on treatment. Opiate withdrawal is risky for the fetus, hence the mother should never be advised to stop opiate use abruptly. An abrupt withdrawal from opiate use during pregnancy can lead to spontaneous abortion, miscarriage, premature labour and premature rupture of the membranes, abruption and stillbirth (British Columbia Reproductive Care Program, 1999). Substitution therapy is usually in the form of a synthetic narcotic analgesic called methadone (Couper, Chopra & Pierre-Louis 2005), which has been used for decades and is the most commonly prescribed opiate during pregnancy (Fischer, 2000).

Methadone is a long acting opiod receptor agonist with potent central analgesic, sedative and antiussive actions. It is available as an oral solution, tablets and dispersible tablets and as an injectable solution (Couper et al, 2005). Some side effects of oral methadone include drowsiness, weakness, headaches, sweating, flushings, stomach upsets, vomiting, constipation, loss of appetite, dry mouth, difficulty in urinating, mood changes, confusion, vision problems, difficulty falling asleep or staying asleep and decreased sexual desire or ability (Medline Plus, 2005). Larger doses of methadone may produce respiratory depression, hypotension and muscle rigidity (BNF, 2006).

Finnigan (1991) emphasizes that some advantages of methadone adaptation during pregnancy include improved prenatal care, improved nutrition, and decreased incidence of maternal opiod withdrawal, engagement of the woman into drug programs, decreased criminality and sex trade work and also decreased injection use, hence decreasing the risk of blood borne infections. On the other hand some disadvantages of methadone use during pregnancy include an increased risk of sudden infant death syndrome (methadone elevates the risk over heroin), maternal constipation, insomnia, increased sweating , decreased libido, a low birth weight baby together with a smaller head circumference and minor developmental delay (British Columbia Reproductive Care Program, 1999). Methadone crosses the placenta; hence there is a potential risk on the fetus for Neonatal abstinence syndrome (NAS) immediately after birth (Fischer, 2000). Further information on neonatal abstinence syndrome can be found in the appendix section.

Conclusion

The ultimate goal of substance abuse treatment during pregnancy is to decrease maternal and fetal/infant morbidity and mortality

(Gilstrap & Little, 1999). Pregnancy is a unique opportunity in a woman's life (Siney, 1999), hence getting the mother into treatment can be beneficial, because she can be maintained on medication and be monitored regularly (Fischer, 2000). Paradoxically, while substance misuse in pregnancy brings risks for mother and baby, pregnancy may also provide the motivation for women to make positive behaviour changes (Forbes & Lyon, 2006). The most important factor for long term success in breaking an addictive habit is a change in lifestyle (Siney, 1999). Maternity services should be sympathetic and honest with these women. (Hepburn, n. d). Nonetheless, whilst appropriate and effective prenatal care for substance using woman is crucial, equally crucial is an effective and well coordinated discharge plan (British Columbia Reproductive Care Program 1999, Siney 1999).

A pregnant woman can say NO to illicit drugs
But the fetus in the womb CANNOT

Heroin Info Facts

Heroin is an addictive drug that is processed from morphine. It is a naturally occurring substance that is extracted from the seedpod of the Asian poppy plant. Heroin usually appears as a brown or white powder. Street names for heroin include 'smack', 'H', 'skag' and 'junk'. Other names such as 'Mexican black tar' may refer to types of heroin produced in a specific geographical area (U.S. Department of Health & Human Services, 2006).

Heroin is usually injected, sniffed/snorted, or smoked. Typically, a heroin abuser up to four times a day. Intravenous injection provides the maximum intensity and most rapid onset of euphoria (7 to 8 seconds), while intramuscular injection produces a relatively slow onset of euphoria (5 to 8 minutes). When heroin is sniffed or smoked, peak effects are usually experienced within 10 to 15 minutes. Although smoking and sniffing heroin do not produce a 'rush' as quickly or as intensely as intravenous injection, researchers have confirmed that all three forms of heroin administration is highly addictive (Serenity Lane, 2005).

Heroin abuse is associated with severe health conditions, such as fatal overdose, spontaneous abortion, collapsed veins and also infectious diseases especially in those that inject the drug. The short term effects of heroin abuse appear soon after a single dose and disappear in a few hours. After injecting heroin, the user claim that he feels a surge of euphoria which is accompanied by a warm flushing of the skin, a dry mouth and heavy extremities. Following this euphoria the user then goes 'on the nod', that is an alternating wakeful and drowsy state. The function of the brain becomes clouded due to the depression of the central nervous system (U.S. Department of Health & Human Services, 2006). Opiates like heroin cause a release of dopamine in the brain's pleasure centre (the nucleus accumbens). It is this dopamine release that is largely responsible for the positive reinforcing effects (British Columbia Reproductive Care Program, 1999).

After repeated use of heroin, the long term effects will follow. Chronic users may develop collapsed veins, infection of the heart lining and valves, abscesses, cellulitis and also liver disease. Pulmonary complications may also follow which include various types of pneumonia. This can be due to the poor overall health condition of the abuser and also from the heroin's depressing effects on respiration. Nonetheless, when heroin is abused during pregnancy, this will result in adverse consequences, which is discussed in the next section.

Additionally, street heroin is rarely pure. Additives may be added to the heroin; which consequently results in clogging the blood vessels that lead to the lungs, liver, kidney or the brain. This outcome can lead to infection or even death of small patches of cells in vital organs.

Tolerance will develop with regular heroin use; hence the abuser must use more heroin to achieve the same effects. Physical dependence and addiction will gradually develop. With physical dependence, the body will get used to the presence of drugs and withdrawal symptoms will occur if heroin is reduced or withdrawn. Withdrawal effects may occur from as early as a few hours after the last administration. This is characterized by restlessness, muscle and bone pain, insomnia, diarrhoea, vomiting, cold flashes and other symptoms. Sudden withdrawal by heavily dependent users is usually fatal. Treatment options for heroin addiction will be discussed elsewhere (U.S. Department of Health & Human Services, 2006).

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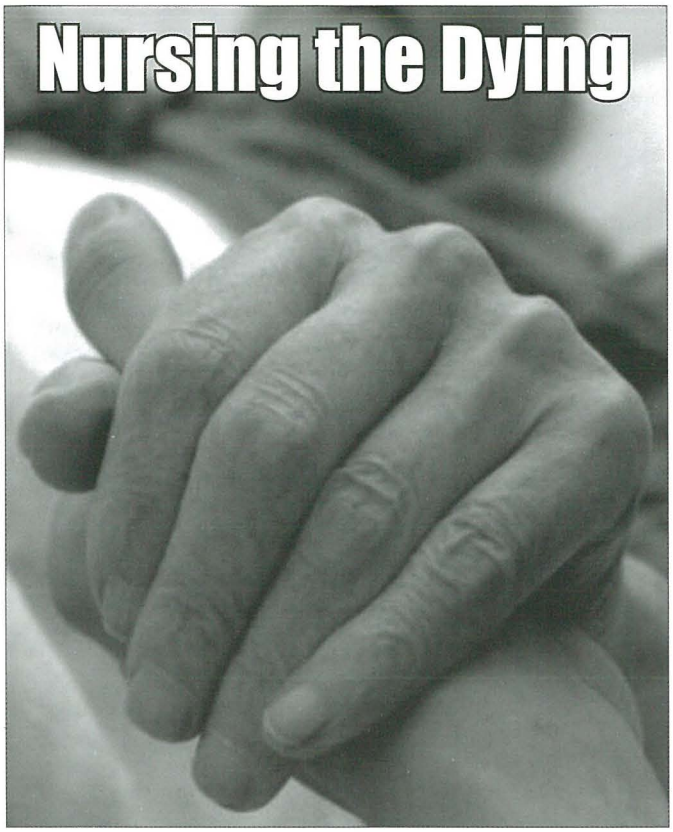


For most of human history, medicine could do little to prevent or cure illness or extend life, and living to an old age required considerable good fortune. Dying, like being born, was generally a family, communal and religious event.

Since many deaths occurred at home, people were more likely to care for dying relatives and thus to have a somewhat personal and direct experience of dying and death.

Since the Second World War, there have been two major changes in the handling of the dying. Death at home in the care of the family has been replaced by an institutional, professional and technological process of dying. That process, despite its positive aspects, has distanced the final stage of life from the rest of the living.

For many, the most common images of death are those presented on the media, which tend to focus on the sensational, violent or sentimental, and which often portray death as an event without much social or personal perspective.

Advances in public health and medical technology have extended the lives of those with chronic illness. This brought about an unintended consequence, namely the prolonging of the dying process. This often results after a long period of aggressive treatment, which is often burdensome on the patients, exhausting and expensive to the family, and demoralising to health carers.

End-of-life care is different from any nursing care, as it demands the nurses` full insight. However, nurses have a unique and primary responsibility to ensure that individuals at the end of their lives experience a peaceful death. When facing such responsibility, nurses often experience great difficulty in coping due to the emotional conflicts related to dying and death.

While limited importance has, in the past, been placed on death education in schools for health professions, the current status for death education support in nursing is somewhat encouraging. More emphasis on the health professions is placed on relating to the care of the dying and death, and it is anticipated that more positive attitudes towards dying patients become apparent when these students become qualified nurses. Death education should not only prove useful in coping with dying and death situations but can actually improve the quality of living.

Persons live until the moment of death and those at the last stage of life deserve attention that is as thorough, active and conscientious as that provided to those for whom disease prevention, diagnosis, cure or rehabilitation are still dominant goals. The nurse is in a key position to provide and promote excellent, compassionate, holistic care for the dying elderly.

Individual and system failure to care humanely for dying patients, including failure to use knowledge to prevent and relieve distress, should be viewed as clinical and ethical failures.

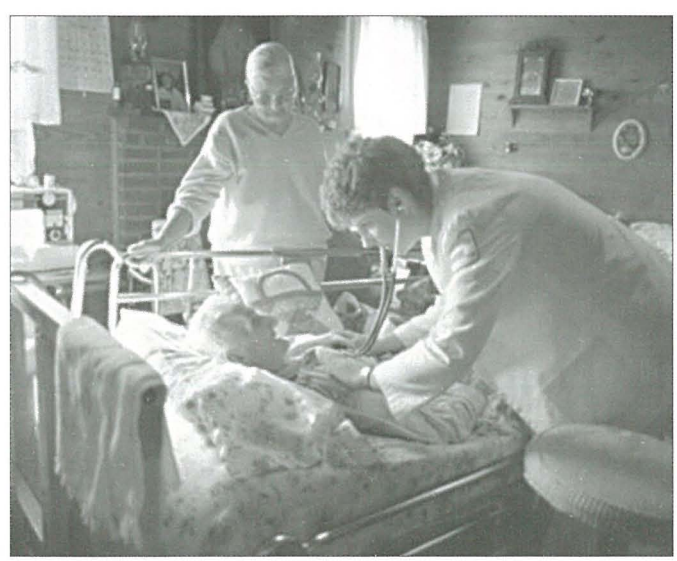
Death and Dying

The continuum of living includes dying and it is the denial of this inclusion of dying in living that causes so much distress. It is contended that the essential tasks in caring for the dying are the same in caring for the living.

The essential task is the creation of an environment that cares for the physical, psychological and spiritual well-being of all the residents, whatever their state of health. Consequently, understanding quality of dying and death is essential to provide quality care.

Of all events in life, dying can be the most stressful. People tend to fear the process of dying more than death itself. Dying is the process that happens to the physical body of the individual. However, the biological aspects of dying means less than the meaning placed on the events that take place during the dying process.

Death is a common incidence in residential homes for the elderly. Nurses who work with older persons often encounter the significant issues of loss, bereavement and care of the dying. Hence, knowledge about these topics and an understanding of their application through the nursing process is valuable.



The Nursing Process with the Dying Elderly

The nurse plays an important role in providing and providing exceptional, compassionate care for the dying. This can be achieved by providing holistic nursing care, which in turn, will contribute greatly to a dignified death both for the dying person as well as for family members.

The art for caring for the dying refers mainly to the period of the terminal illness and irrespective of the length of the terminal phase of an illness, control of the problems that may arise, is essential to achieve a good quality of life.

Good basic nursing with attention to needs such as nutrition, elimination, sleep, mobility, skin and mouth care, and pain management will provide significant comfort for dying persons and will show respect for the physical care of the dying.

The role of the nurse also includes assessment of the psychosocial and spiritual needs. Dying elderly may suffer from anxiety, ineffective denial, fear, impaired social interaction and spiritual distress. Skills and perceptiveness are essential in assessing such needs. It is important to acknowledge the uniqueness of each individual and hence needs vary from one person to another. It is the duty of both formal and informal carers to accept the patient`s needs and provide support and comfort.

An elderly`s view and feelings about death are subject to various influences, including education, culture, family, social support, positive and negative life experiences and personality. They think more about death than younger individuals and fear it less. Elderly who express fear are more concerned about the process of dying than about death itself.

Although each person reacts to the knowledge of impending death or to a loss in a unique way, there are relationships in the psychosocial responses to death and dying. These are usually described as having five phases beginning with denial, progressing to anger and bargaining and facing depression before final acceptance, although the stages may overlap and the duration of any stage may vary from a few hours to months.

1. Denial/Isolation: Denies the situation and may isolate self from reality.
2. Anger: Expresses rage and hostility. "Why me?" attitude.
3. Bargaining: Tries to negotiate for more time.
4. Depression: Goes through a period of grief before death. The person may feel numbness, sleeplessness and lack of appetite, self-care and self-worth. Anger and rage is replaced by a sense of loss.
5. Acceptance/Hope: Feelings of tranquillity and peace.

Integrity Vs Despair

Psychological learning experiences and stresses during formative years have long-lasting effects on behaviour in the adult years. According to Eriksson`s eight stages of psychological development, each stage is characterised by a different conflict that must be resolved by the individual. When the environment makes new demands on people, the conflicts arise and each person is faced with a choice between two ways of coping with each crisis, an adaptive and maladaptive way. The last stage, namely, 'old age', concentrates on adult life. Old age is seen to focus on resolving tensions between 'integrity' and 'despair'. The most important event at this stage is coming to accept one's whole life and reflecting on that life in a positive manner. Achieving a sense of integrity means fully accepting oneself and coming to terms with death.

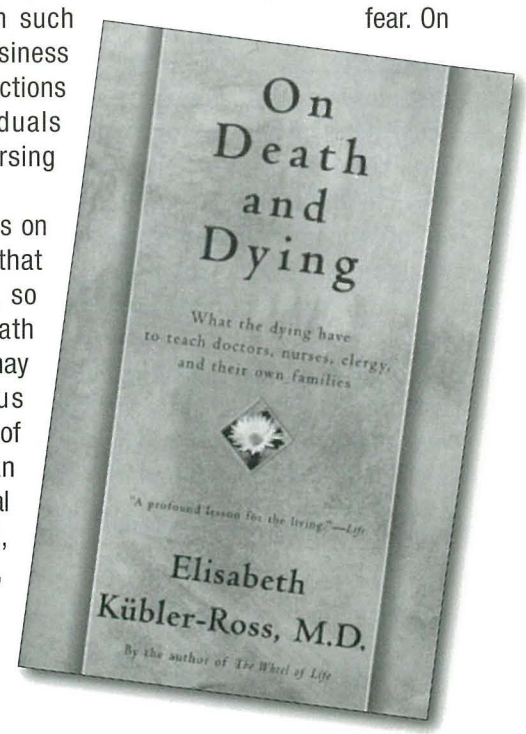
Reflecting and accepting responsibility for one's life and being able to undo the past and achieve satisfaction with oneself is essential. The inability to do this results in a feeling of despair and fear of death.

Effects of Death and Dying on Nurses

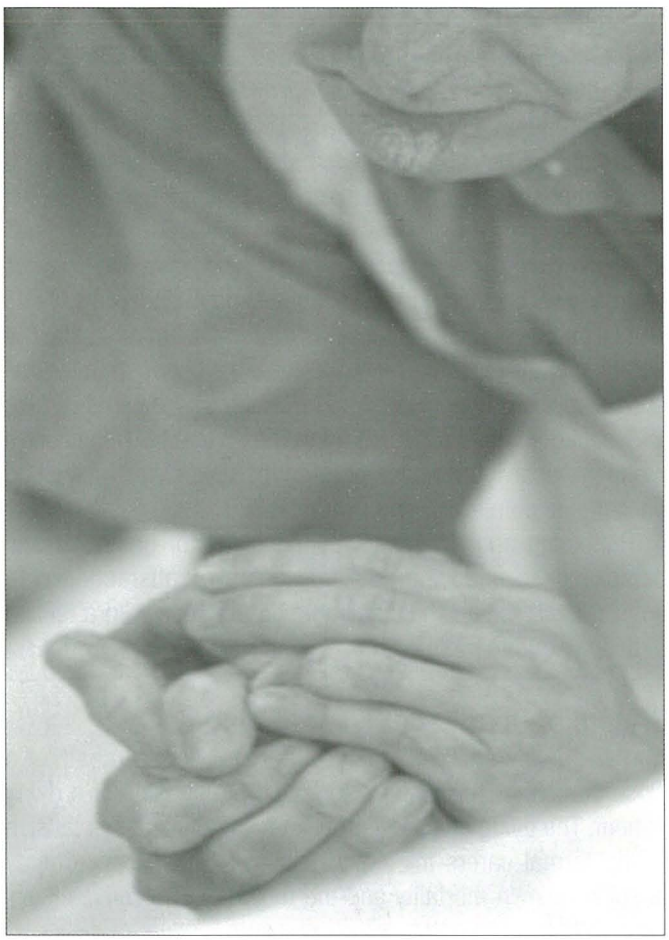
Nurses perceive their own fear of death or fear of death of a close person whenever they approach the bedside of a dying patient. The dying of a resident in an institution causes tension in the formal carers for many reasons. It raises uncertainty about their own mortality and the mortality of older relatives, especially their parents.

However, the fear must be challenged and resolved before they can help others experience a dignified death. The literature on nursing points out the great emotional and psychological turmoil the nurse has to cope with when caring for dying patients. Furthermore, nursing the dying patient is classified as one of the most distressing responsibilities.

A survey of over 15,000 nurses suggests that nurses` anxiety in caring for the dying is convincingly related to fear of their own death. Moreover, the study indicated that cumulative nursing experience was not a significant concern when dealing with such fear. On the contrary, uneasiness related with interactions with dying individuals increased with nursing experience.



Results of studies on nursing point out that as age increased, so did the fear of death among staff. This may be due to various features in the life of the nurse. One can mention the continual contact with frail, debilitated elderly, painful episodes, unpleasant illnesses and dying



and death itself. Possibly, these circumstances may influence the nurse into fearing death more than the passing of time.

Nurses must accept and confront their own reactions to death before they are able to help their own patients to do so. However, there is evidence that educating nurses to face personal death concerns will enhance the possibility that they will interact in a caring approach with dying patients. Moreover, nurses are often conscious of the needs of dying patients, particularly to confide in someone and to be with someone at such a critical phase.

Support

When caring for patients who are themselves experiencing high levels of stress, nurses should recognise and deal with their personal feelings of stress for their own peace of mind and mental health. Nurses often work long hours in situations they cannot walk away from; with people who are frightened and afraid of dying. To cope effectively with this work, nurses must have good support and supervision.

To nurse a dying patient in a way that enables him to die without pain and with dignity can be very fulfilling. When nurses have sufficient managerial, educational and emotional support, their work may not be harmfully stressful. However, when formal support does not exist, nursing can cause some degree of stress.

Many research studies identified 'talking things over with a colleague', as one of the most widely used and effective coping mechanisms. Furthermore, support groups can make a valuable contribution to support staff.

Caring Role at the End of Life

The last act of life is dying. Our vision as people should be the humanisation of death and its healing possibilities. Our mission as nurses should be competent, passionate and intensive caring.

Care for approaching death is an integral and important part of health care and should respect both patients and those close to them. As for all the patients, nurses need to consider dying patients in the context of their families and close relationships, and be sensitive to their culture, values, resources and other characteristics.

Good care at the end of life depends on a healthcare team with strong interpersonal skills, clinical knowledge, technical competence and respect for individuals and it should be informed by scientific evidence, values and personal and professional expertise.

Clinical excellence is important because the frail condition of dying residents leaves little margin to rectify errors. Systematic and clinical knowledge are important, but so are compassion, communication skills, experience and thoughtful reflection on the meaning of that experience.

As Elisabeth Kubler-Ross said: "Watching a peaceful death of a human being reminds us of a falling star: one of a million lights in a vast sky that flares up for a brief moment only to disappear into the endless night forever."

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From Mid-djarv tagħna...

1. When MUMN President and General Secretary attended the last European Federation Nurses Meeting in Cyprus they took the opportunity to visit Michelle Curmi, a Maltese Nurse working in Cyprus.
2. Ms Myriam Gomes, Director of Administration, International Council of Nurses and Ms Laetita Slottved, MCI (event organiser) visited MUMN offices to meet the MUMN Committee responsible for the preparations of the ICN Conference in Malta 2011
3. The ICN delegation together with MUMN Officials visiting the Health Minister, Mr John Dalli.
4. The same delegation visited the Malta Fair & Convention Center.
5. The ICN delegation met with the Health Division's organising committee and discussed the preparations for the ICN Conference in Malta 2011.
6. The same delagation met the President and Director of the Unsheduled Bus Service to discuss the transport facilities for the delegates during the 2011 Conference.
7. Ms. Gomes and Ms. Slottved visited the Mediterranean Conference Center as a proposed venue to welcome the ICN Conference in Malta.
8. MUMN celebrated its Christmas Dinner at the Le Meridean Hotel.
9. A Rally was organised by MUMN Council where Paul Pace, President gave out all the information about the dispute regarding Nurses' shortage and the lack of implimentation of certain clauses of the Agreement signed between the Government and MUMN.
10. An Extraoirdinary General Meeting was called for all members where the MUMN Council explained the financial situation of the Union and gave out details on the new premises and explained why certain industrial directives were given during the dispute with the Health authorities.


YOU CAN HELP PREVENT PNEUMOCOCCAL DISEASE
Children under five years of age are the most vulnerable to suffer serious consequences from pneumococcal disease including death or disability.
• Meningitis
• Septicaemia
• Pneumonia
The introduction of routine vaccination for all infants and of a catch up campaign for all children under the age of 2 years targets the age group who suffer the majority of this disease. PREVENAR, the pneumococcal conjugate vaccine, has been recommended by the World Health Organisation who also recommended that all countries should give priority to the inclusion of PREVENAR in national childhood immunization programs.
VACCINATE
HELP
STOP
IT
Wyeth
Prevenar
Pneumococcal Saccharide Conjugated Vaccine, Adsorbed
Pneumococcal saccharide conjugated vaccine, adsorbed. Presentation: Each 0.5ml dose of Prevenar contains 2 micrograms of each of the following saccharide serotypes: 4, 9V, 14, 18C, 19F, 23F and 4 micrograms of saccharide serotype 6B. Each saccharide is conjugated to the CRM197 carrier protein and adsorbed on aluminium phosphate. Indications: Immunisation against invasive disease (including sepsis, meningitis, bacteraemic pneumonia, bacteraemia) caused by Streptococcus pneumoniae serotypes 4, 6B, 9V, 14, 18C, 19F and 23F. Dosage and Administration: For intramuscular injection. Infants 2-6 months: Two doses with at least a 1 month interval between doses. A third dose is recommended in the second year of life. Infants 7-11 months: Two doses with at least a 1 month interval between doses. A third dose is recommended in the second year of life. Children 12-23 months: Two doses with at least a 2 month interval between doses. Children 24 months-5 years: one single dose. Contra-indications: Hypersensitivity to any component of the vaccine or to diphtheria toxoid. Warnings and Precautions: Do not administer intravenously. Appropriate treatment must be available in case of anaphylaxis. Impaired immune responsiveness may affect antibody levels. Prevenar does not replace 23-valent polysaccharide vaccine in at risk children ? 2 years of age. Prophylactic antipyretics recommended when vaccinating children with history of seizure disorders, or when vaccinating simultaneously with whole cell pertussis vaccines. Delay vaccination in acute moderate or severe febrile illness. Data are limited on vaccination of children in high-risk groups for invasive pneumococcal disease. Side Effects: Very common: Decreased appetite, vomiting, diarrhoea, injection site reactions (e.g. erythema, induration/swelling, pain/tenderness), fever equal to or over 38 degrees C, irritability, drowsiness, restless sleep. Common: Injection site swelling/induration and erythema larger than 2.4cm, tenderness interfering with movement, fever over 39 degrees C. Uncommon: rash/urticaria. Rare: Seizures including febrile seizures, hypotonic hyporesponsive episode, injection site hypersensitivity reactions (e.g. dermatitis, pruritus, urticaria), hypersensitivity reactions including face oedema, angioneurotic oedema, dyspnoea, bronchospasm, anaphylactic/anaphylactoid reaction including shock. Very rare: Lymphadenopathy localised to the region of the injection site, erythema multiforme. Legal Category: POM Package Quantities: Pack of 1 single-dose vial. Marketing Authorisation Numbers: Pack of 1 (vial): EU/1/00/167/001 Marketing Authorisation Holder: Wyeth-Lederle Vaccines S.A., Rue du Bosquet 15, B-1348 Louvain-la-Neuve, Belgium. For full prescribing information see the Summary of Product Characteristics. Further information may be obtained from: Wyeth (Malta) Sanitas Building, Tower Street, Msida MSD 1824. Telephone: 800 73102 Date of preparation: January 2008Prescribing

An Exploration of the Care-Giving Experiences of Maltese Co-resident Carers with Older People (part 2)

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For the purpose of this study, a community nursing association situated in Malta namely the Malta Memorial District Nursing Association (MMDNA) was approached. This association employs persons who provide physical assistance to 54 older people who reside with their spouse or relatives in their own home. An information sheet explaining the purpose of the study was distributed by the employees of the nursing association and given to the co-resident carers. Out of the study population of 54 co-resident carers, a total number of 20 co-resident carers accepted to participate.

Data was collected by the use of structured interviews. There are many reasons why interviews rather than questionnaires or solely observation was chosen as the best data collection method. A major advantage of an interview is that it normally results in high response rates. Another advantage as opposed to a questionnaire is that questions can be clarified to the participants. However, there are disadvantages related to interviews, one of them being the presence of the researcher. According to Polit and Beck (2006) participants may be more inclined to give socially desirable answers. Such a limitation was sought to be reduced by giving complete reassurance to the participants that the collected information will remain strictly confidential and their personal details will not be shared by anyone who is not involved in the study.

The study sample consisted of 13 female participants and 2 male participants. Although this is a small scale study and thus, no generalizations can be made, it gives an indication that in Malta, female informal carers outnumber male informal carers. According to Schulz and Martire (2004) this is in accordance with similar other studies conducted world-wide whereby adult daughters and daughters-in law are more likely than sons and sons-in law to provide assistance over long periods of time.

All participants replied that they entailed the caregiving role due to emotional bonds, with 13 participants further stating that it is a religious obligation to help others, especially the older persons, in need. The Maltese regard the Roman Catholic Church and its values as a very important part of their lives and derive great comfort from its spiritual and material support.

In this small scale study, 5 out of 15 participants marked caring as being 'a lot' stressful. Only 1 participant replied that that caregiving is not stressful. However, one needs to be aware that during the whole interview the older person was in the same room, and thus his presence may have

biased the participant's response. Inter and intra personal conflict was perceived by 10 participants as being the most negative aspect of the caregiving experience. Some carers complained that their social life suffered as a result of their having to provide full-time care. Several others remarked that caring affected their relationship with their significant others and friends, because they had to choose between spending time either with them or else with their older relative.

As regards to physical health, 5 out of 15 participants replied that their physical health has been affected ' a lot' due to their caring role. Lifting up and down the stairs, in and out of bed, bathing, special cooking, coping with incontinence and extra washing are some of the physical tasks of the carer. In this study, 7 participants stated that they suffered from chronic back pain while 8 participants commented that 'sometimes', they suffer from lack of sleep.

However, such findings cannot prove that caregiving is a risk factor for illness. Indeed, carers, due to their old age, may be in poor physical health prior to their caregiving experience. Vitaliano et al (2004) add that having a hostile disposition, co-existing medical conditions and poor health habits may be further attributes to a decline in health, rather than the caregiving experience per se. On the other hand, good coping skills, social support and income are generally predictive of better health.

Coping, defined by Connell et al (2001) as the cognitive and behavioral attempts to manage specific demands that are perceived as stressful, is an integral part of the stress process. Social support is fundamental in coping since it relieves stress and enhances a sense of self-worth. Interestingly, the study participants valued the support of the district nurses, who were seen as "*very helpful*" and as "*invaluable*" sources in giving them information regarding the physical condition of the older person. However, at the same time, they stated that support and information is not preceded by the nurse but is only given if they request it. "Having faith in God" was a positive coping strategy mentioned by 1 female participant. Interestingly enough, increased reliance on religious institutions especially amongst women is an approach for coping with caregiving stress and strain discovered in similar studies conducted by Neal et al (1997) and Picot et al (1997).

The finding that caregiving is still a family matter was further illustrated when participants were asked whether they have access to the support services namely the day care Centres, the Handyman Service, the Home Help Service, Incontinence Service, Meals on Wheels and Telecare. These specific services were mentioned since it was thought that they are the most familiar and widely used in the community.

However, none of the participants used the Handyman service or Meals on Wheels. Such needs were being effectively catered by the family members themselves. As regards to the day centers and the home help service, these were being used by only 3 and 2 participants respectively. It is possible that the main reasons for the informal carers not to seek help from these service providers stem mainly due to their, arguably wrong perception, that the use of formal services signify their own inadequacies as care givers.

Apart from the cultural expectation that family members should take care of their own family members, another possible barrier faced by carers in accessing support services could be due to lack of information being provided in the community regarding the available services. This is clearly illustrated when 4 participants did not know that a Handyman service existed in the community and were unsure whether they were entitled for it.

A major finding that emerged from the study was that 12 out of 15 participants are in favour of there being a register, with the main reason being that they believe they would be recognized and appreciated for their 'invisible informal' work. Indeed, not only there is not a national register but carer groups are scarce or practically inexistent in Malta. A national association for family carers could fulfill many purposes. Apart from providing basic support to the carers, it could be fundamental in helping them to become more aware of their own role and status in the community.

Although this has been a small scale with only 15 participants taking part, it has yielded several interesting findings; most particularly it has highlighted the fact that health care professionals need to focus more on the needs of the carers to ensure that the latter are able to maintain their physical and mental health to continue undertaking their invaluable role.

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ADDRESSING THE NURSING AND MIDWIFERY ISSUES CONCERNING PRESENT AND FUTURE SERVICES WITHIN THE HEALTH DIVISION

Introduction

MUMN has drafted this document highlighting the agenda for the next five years to improve the current health care services and address the nursing and midwifery challenges. The issues listed in this document are two fold.

The first part this document addresses the current scenario which is effecting the nursing and midwifery profession and subsequently affecting our service to our patients. The second part of this document takes into consideration the vision the government is proposing in this legislation and the challenges such a vision poses to the nursing and midwifery profession.

Shortage of Nurses and Midwives

The shortage of both nursing and midwifery staff present in every government institution is top on the MUMN's agenda. Lack of supporting staff is also considered by MUMN a top priority which needs to be resolved. The shortage of nursing and midwifery staff has been a long standing issue which has actually peaked last year with the opening of Mater Dei Hospital and the extension of Zammit Clapp Hospital at St. Luke's Hospital. The staff shortage is causing numerous problems but the main major issues attributed are the following:-

1) Stress and back injuries related to lack of proper staff compliment is effecting drastically our profession. Such stigma is also resulting from the lack of recruitment from the young generation prior entering university. MUMN has finalized various agreements with the health division on the number of nurses/ midwives that should be present per ward per hospital during these last four years. Such agreements were hardly implemented by the health division mainly due to lack of nurses and midwives available. Lack of relieve pools for nurses and midwives, the removal of day nurses and the lack of adherence to nurses to patient ratio in special units such as ITU and renal unit are all having an negative impact on the nurses and midwives with the result of numerous days of sick leave;
2) Cancellation of vacation leave - The cancellation of the vacation leave at SVPR has become the norm of the day. Nurses are having their leave cancelled for months in a row. This situation is also being spread to other hospitals but on a lesser degree. If shortage persists MUMN envisages that the situation will worsen and the scenario currently present in SVPR will also be effecting the other hospitals. Such scenario is unacceptable to this union in the light that that nurses are constrained to find their own replacement to avail from their legitimate leave. This is causing distress and anxiety, not to mention that nurses are constrained to work overtime just to benefit from their own leave;
3) Cancellation of study leave. - Various conferences, courses and other continuing professional development initiative are organized especially in the winter months. Nurses and midwives are entitled to attend to any type of education which can be utilized in his/her specialty. Unfortunately nurses and midwives who are willing to attend to such conference are not allowed to attend for further development since their replacement and lack of staff would bring their ward to a crisis;
4) Extension of health service - Mater Dei Hospital and the Primary Health Care are two government institutions were although the infrastructure and logistics are in place, lack of staff is constraining health care service. The situation in Zammit Clapp Hospital is even worst with two existing wards in Karen Grech hospital are being manned by overtime staff around the clock since no permanent staff is available. If such nurses decide not to attend overtime duties, such patients in these wards will have to remain unattended;
5) Burnout - Staff working especially in Mater Dei Hospital are in continuous pressure to actual accomplish the work load of a busy acute hospital. This in itself is a daunting challenge. Lack of proper compliment is resulting in demoralizing and demotivating and patients are not always treated

in an acceptable manner. The service has to be complimented with sufficient nursing staff to attain acceptable nursing standard levels and relatively good working conditions.

Manpower Plan

Highlighting some of the main issues provides a clear picture on the present situation effecting our two professions. The shortage of nurses and midwives is expected to worsen due that the number of students graduating from the Institute of Health Care this year is just 60 students (if no failures are registered). This figure hardly replaces the loss of staff accumulated during the year mainly due for retirement or maternity reasons. Such a poor turnout will definitely not permit any new services within the health division. It is clear that the vision of the present government which includes the increase in bed state in both the oncology hospital and the rehabilitation hospital, the full use of Mater Dei Hospital and the development of the Primary Health Care, shows clearly that the present number of recruiters will not allow any developments within the health care services. MUMN is therefore insisting that a manpower plan be devised by the health division as to have a clear picture on the present shortage and to be in a position to identify the required number of nurses and midwives needed in this legislature. The first step in the formulation of this manpower plan is to request each and every hospital manager to provide the present vacant posts present in each respective hospital. The second step of such plan is to then include all government projects regarding the new oncology hospital, the rehabilitation hospital and the primary care set up. All further heath services extensions including those at Mater Dei Hospital should be included. The third step in the manpower plan is to include all staff exceeding retirement age and an estimate of staff lost due to maternity leave and personal commitments.

After such exercise, the health division would be in a position to actual quantifying the number of nurses and midwives needed both in the short term and in the long term. Once the identification process on the actual number of nurses and midwives have been noted, the government should set up targets for the recruitment stage. The first priority is definitely the University of Malta. MUMN will be contributing significantly in this process since the government has provided funds to market the nursing/midwifery profession with the young generation. These government funds and the efforts of MUMN would be futile if the University of Malta persists in retaining either the numerous clauses or matriculation in the case of the BSc. Nursing course. All applications for the diploma and BSc. Nursing course which have attained all necessary qualifications issued by the university have to be accepted. All numerous clauses in the nursing and midwifery intake have to be removed and that the University of Malta through the Institute of Health Care (IHC) has to be in a position that from this years intake all applications with the required applications be accepted. The IHC should be in a position to address the nation's needs and provide all support to the government health vision by addressing its internal issues. The central government is to address this issue of recruitment and remove any parameters the IHC decides to impose to its convenience. Such a conduct will not be tolerated by MUMN. Other issues pertaining to the University of Malta are:-

a) Two intakes per year of nursing students has to be in place at the university;
b) Re-evaluation of the nursing course curriculum and that the diploma course should be consistent as with other universities and instead of 4 years be concise in 3 years.
c)

Part time lecturers should be engaged and more financial aid if needed be allocated to the Institute of Health Care. As described earlier in this report concerning the stress and the consequences suffered by the nursing and midwifery staff regarding to the shortage in numbers. MUMN cannot| accept any shortfalls from the University of Malta on this issue. Everyone has to carry the weight of his/her position within IHC but till this very day, it is only the nurses and midwives at the wards who are suffering to cope with workload while others set up projections to his/her benefit. MUMN will not allow any applications to be refused to either excuses if lack of resources or because tutors do not want more than 50 students in their class. If such issues are not addressed, MUMN would be left with no other option then to oppose to any new extension of services or the opening of any new ward or hospital within the health division.

The manpower plan should also include an estimate number of nurses and midwives recruited from other countries on a definite contract. Although MUMN accepted the health division to recruit foreign nurses as a short gap measure, the health division failed drastically in such an issue. Estimates were that by December 2007, 100 foreign nurses would have joined our work force. To this very day no foreign nurses were employed and that only 20 nurses are likely to be found acceptable. Foreign nurses will be accepted by MUMN if no refusals of applications into the nursing and midwifery courses do not occur by the University. The government should use all available resources to recruit nurses from E.U. Countries. Definite contracts have to be established and placements of such nurses in our wards should always be after all Maltese nurses have been placed according to their requests. Other countries not within the E.U. would most probably do not have the number of hours to work as nurses as stipulated under E.U. regulation and therefore might need further training to be given locally.

Once the manpower plan is finalized, this should be discussed with MUMN. This union expects that all vacant posts within the nursing and midwifery profession to be filled. Before any new extensions and services within the Primary Health Care or within a government institution, a human resources impact plan should be included especially in the light if drastic vacancies within the nursing and midwifery profession are persistent. The manpower plan should have a time frame for the next five years and should include this

year's intake of university since investment in human resources is considered a top priority to this union.

Support Staff at Mater Dei and SVPR

MUMN is requesting that all tenders for the recruitment of carers and porters within Mater Dei hospital and SVPR which have fallen short from the actual number requested in such tenders should be suffer heavy penalties or have the tender being re-issued. Such tenders in both Mater Dei hospital and SVPR could cause anger and suffering amongst the nursing staff since the requested support staff requested by the hospital management was not delivered by the contractor. This is not on exceptional circumstances but it is actually the norm of the day. Private contactors have caused numerous problems in the past to the nursing staff present in our wards since such contractors are offering miserable salaries to their employees, the recruitment of careers has become a daunting task. MUMN is proposing that such tenders have to be reviewed and valuated regularly and if such tenders fail to honor the contract then employment with the government under a definite contact has to be considered as one of the options to solve such crisis. Such support staff should have been in place prior the opening of Mater Dei hospital. Also the quality of such carers provided by the present contractor leave much to be desired especially of rumors that carers who are supposed to have an MCAST or ETC course are not capable of reading or writing. Vetting on the quality of such carers is not being done by the health division.

Midwifery Services

There is much ignorance and misunderstanding among the public and health professionals about the essential role of midwives in local modern maternity services. Thus, the general public must be educated of what the role and responsibilities of midwives are; giving importance of what the EU directive (no 185) stipulates about the activities of midwives. Midwives have always been with us - women in the community to whom other women can turn for support with women's problems.

The Government must strive to ensure that midwifery will be primary health care for women with a focus on reproductive health. Key elements of the midwifery model of care are normality, facilitation of natural processes with a minimal amount of evidence-based intervention, and the empowerment of the woman and the family. Midwifery must represents an alternative to the medical practice of obstetrics for the management of normal pregnancy and childbirth, emphasizing family involvement and the avoidance of unnecessary medical intervention.

Scientific evidence proves that: midwives are as safe or safer than doctors for primary maternity care; using midwives greatly reduces the rates of unnecessary obstetrical interventions; midwifery services lead to considerable cost savings; midwives have more success in reaching socially disadvantaged groups; women have more satisfaction with midwife-managed care. A maternity care system in which midwives provide primary care and obstetricians provide tertiary care has been proven scientifically to have less unnecessary interventions and, thus, be safer. This should be the local way forward of the Midwifery profession.

In nearly every industrialized country outside of Malta, midwives provide primary maternity care, and obstetricians, generally, are hospital-based specialists providing tertiary maternity care. In Scandinavia, the Netherlands, New Zealand and other countries, all prenatal, intra-partum and postpartum care for at least 70 percent of women is provided solely by midwives. These countries have much lower obstetrical intervention rates, and have maternal and prenatal mortality rates that rates well when compared with other counterpart providing different types of care. The national Caesarean section rate in Sweden is 11 percent. These countries have the lowest maternal and perinatal mortality rates in the world. Thus, our maternity model of care should be apar with the Scandinavian countries, as midwifery plays an essential role in a modern maternity care system. Having a system where local midwives are treated as professionals and thus practice independently will have by far many advantages. An important advantage of midwifery care which receives too little attention is the ability of 'user friendly' midwives successfully to reach the hard to reach, under-served, socially disadvantaged groups. Evidence based literature emphasize that there are many ways to improve utilization of prenatal care and thereby reduce low birth weight. Research findings emphasize that midwives have a key role and ability to reach low-income women, adolescents, minority groups, inner city and rural groups.

A final advantage of midwifery care, often disparaged by those following the medical model, is the woman's degree of personal satisfaction with her care. The midwifery model emphasizes the importance of women's satisfaction. The evidence in the literature is overwhelming: midwifery care is statistically significantly more satisfying to the woman and her family.

In order to ensure and provide primary maternity care, one must not forget to mention the importance to address the local shortage of midwives. Such problem can be tackled by removing the numerous clauses clause presently stipulated in the Course for Midwifery. Strategies need to be implemented in order to attract and retain midwives in the workforce. Decreasing shortage in the midwifery profession and having a full complement of midwives can again have another advantage which is cost savings. As no data can be found comparing costs of midwifery services with physician services in Malta, it is necessary to turn to data from other research findings carried out in other european countries. Not only do midwives have lower salaries and incomes than physicians, in addition, their proven lower intervention rates produce great cost savings. Although data about costs are difficult to apply across health care systems, it is reasonable for the moment to assume that costs will be in the same direction in Malta as in these other countries.

In 1993, the Malta Government and the Midwives' Union reached an agreement that Midwifery is a

separate profession, confirming the status of 1978; that of being an autonomous an independent practitioner (The Sunday Times, 1993). This agreement reflects the level of specialization Maltese trained midwives have obtained over the years. Meanwhile, their status is still the same, and reflects a different view from that of a what a professional status entails. Locally, the law establish midwifery as a professional profession, however, in prcatise local midwives practising within the state hospital are not given their rights to exercise their full potential as autonomous midwives. Thus, MUMN urges the Goverment to implement policies so that the midwifery profession re-identify its role in the care of normal pregnancies during all phases of pregnancy, particularly in the hospital setting, where the majority of deliveries in the Maltese islands occur.

An autonomous midwifery profession in equal standing with the medical profession is a key component of an optimal modern maternity care system. Options and trends must be implemented locally, so that midwifery will move towards to full autonomy. MUMN urges the present Government to implement research based innovations where autonomous midwives will have equal standing with doctors. The combining of the midwifery model with the medical model results in the most modern, optimal maternity care system and the best outcomes for women and babies.

In order to an optimal maternity care system MUMN suggest that there should be:

- No numerous clauses in the Midwifery course;
- Address the present shortage of midwives;
- Implement 'family-friendly' measures so that to retain midwives in the workforce;
- Midwives practice autonomously;
- Midwives regain their professional status as stipulated by the law and thus provide autonomous care in normal pregnancies;
- Midwives be primary care givers providing general women's health care, this also include pre-conception care;
- Midwives having an important task in health counseling and education, not only for the woman, but also within the family and community. This work should involve pre-conception care, antenatal education and preparation for parenthood and may extend to women's health, sexual or reproductive health and childcare.
- Specialist Midwifery Posts;
- More practice development midwives;
- More midwives in the community.

Specialist Nurses/Midwives and Practice Development Nurses/Midwives

In 2000 MUMN embarked on an agreement with the health division to establish the conditions, training and recruitment of the practice development nurses/ midwives and the specialist nurses/midwives. One of the established conditions agreed was that a definite contract will be in place to gauge the training and practices of such professionals have been achieved. The health division is to provide the necessary training for the specialization of such nurses/midwives. This agreement was continuously breached by the health division since only hand picked nurses without any call of application were sent to such courses. In fact MUMN is representing a number of specialist nurses in their plea for discrimination through the ombudsman. Not only existing specialist nurses and practice development nurses were not only offered any courses but a number of posts were issued unexpectedly prior the election. Such posts have different conditions from those agreed with MUMN in 2000. The obligation of providing training by the health division was utterly removed where no discussions with this union took place. Also the agreed managerial structure for specialist nurses was never implemented by the health division. Some posts issued by the health division prior the election are non existence as regards specialized post in nursing and therefore MUMN is requesting an investigation on the origin of such posts. Such posts have been issued for dubious reasons and not to the actual benefit of the health department. MUMN is therefore requesting an urgent meeting prior any interviews of such posts and such meetings should focus on:-

1) A frame work as agreed in the 2003 agreement for all specialist nurses and practice development nurses;
2) All posts are to be discussed with MUMN to evaluate the need and the service to provide to our patients;
3) All existing and future posts have to undergo training in their respective specialty. Such training is important since the service such nurses are to provide to our patients will be severely handicapped;
4) Posts which have been made vacant since contract, and had not been renewed, are to be issued prior venturing to further posts.

Such posts have to contribute to the development of a nursing and midwifery specialties in order to provide proper dedicated service to the patients. Such posts are not to be improvised to consultants' wishes and that such specialty truly exists within the nursing framework. In this country we still lack vital specialties such as nurses trained in intellectual impairment. Such nurses are needed in our society but a huge vacuum exists within the health care service. Such nurses did exist in the past but all have either retired or placed in management posts and consequently were never replaced. Also MUMN believes that a frame work should be in place were career development should be in place without the need to move in the management way stream. Nurses and Midwives should have the opportunities to advance in the careers without the need to move to managerial roles so as to retain nurses and midwives within the clinical setting. Meetings should be held as to setup the necessary framework for this career development.

Primary Health Care

The campaign for the development of the services in the Primary Health Care has finally been accepted by the government. MUMN had been consistent on lobbying for a reform in this service in last four years. The Mater Dei Hospital is a loop in part of a chain which includes the Primary Health Care (PHC), the elderly

and mental institutions and together will provide the proper health service to our nation. MDH or the elderly institutions would never be efficient as an entity on their own. MUMN is therefore proposing that any extension of these services within the PHC settings should be targeted:-

To address the needs of the elderly population by extending from the present services such as meals on wheels to a more rehabilitation support services. Nurses should be trained to those similarly to the Family Health Nurses within Germany and the U.K. to be able to provide a holistic service with the support of other health care professionals. Such nurses will be the fulcrum of the service and with the support of other members within this multi-disciplinary team would be in a position to provide an adequate health service in a home setting without the necessity that elderly people be admitted in a residential home or worse in an acute setting. Other incentives should also include the involvement of family members. The government should stop focusing on health centers as being the only care within the Primary Health Care. The second step should be the health promotion which could be used as the main driving force in preventing common illness afflicting mostly the very old generation. On this regard MUMN is proposing that a serous of meetings be organized on the proper use of human resources and discussing all possible solutions. All training programs for nurses have to be considered. This would not be an easy task to achieve especially with the lack of proper human resources within the health care professions. But MUMN believes that such an important field, challenges have to be addressed and all possible options be considered even to request an EU county to provide us with experts in this field.

Mental Health Care

Mental Health Care issues have a degree of diversity. The first proposal is the extension of the out-reach team to all patients. Financial and human resources should be invested as to provide a proper service for patients who are either discharged or sent out on temporary basis from the mental hospital. Mt. Carmel Hospital should be also in a position to resolve the shortage of beds present in such a hospital. Also wards should be made more specialized in their service and any mixture of patients afflicted with different disease should not be placed in the same wards. The shortage of nurses in such an institution is also effecting our service especially in the care of level one patients.

Oncology Care

It is planned that in the existing hospital will be moved to the present Zammit Clapp Hospital. Boffa Hospital, at the present moment, is very understaffed with only one nurse per shift in all wards. Such a staff compliment goes against the quality service charter since such patients who are heavily immune suppressed should have the nursing compliment of one patient to one nurse. Also palliative care as part of the oncology care does not exist within the government health service. Patients needing palliative care have to resort to the private sector or opt to with drew such treatment. Oncology care even as regards community care support is non existent with the result that the patient is either cared by his relatives or admitted to hospital. Oncology care lacks proper nursing from all aspects since no support facilities for patients or relatives who are either suffering from cancer or dying with cancer are provided with proper support from the government sector. It would be futile to build a state of the art hospital if investments in human resources with special training and specialization programmes are not part of such investment.

Promotions

MUMN is proposing to evaluate the primitive interview system used to fill the posts of Deputy Nursing Officers and Nursing Officers. The present system caused great pain, demoralization and demotivation amongst the nurses and midwives who are all after all providing an excellent service. The present system is also an insult to our profession since nurses and midwives with vast experience in management and in their specialty were utterly disappointed by the marks allotted to them during a ten minute interview.

The nursing and the midwifery profession have established into primarily a specialty role and therefore nurses and midwives are losing their great expertise when entering management roles by being transferred to a ward or hospital against their own choice.
Unless they do not accept the department request to be transferred, their promotion would not take place. The present system goes against the professional status of specialization and special units. Therefore MUMN is requesting meetings with the health division where a new and a fair system would be agreed and all specialties would be respected. Promotions should be grouped in various specialist ties while nurses and midwives will move into management but retaining their specialty area.

MUMN is proposing that a consultative approach leading to bi-lateral agreements will be in place in this legislature to avoid any dispute and that management by crisis which should not be the norm of the day.

MUMN is prepared to contribute and propose various options with different challenges. The depleting work force would be strengthened and not allowed to suffer more due mainly due to lack of planning. One has to keep in mind that our nursing and midwifery staff are so stretched in number that any decisions of extending the health care services without proper planning would not be accepted to this union.

MUMN has high lighted all major challenges and made it clear that objectives have to be met so to increase and improve our health care facilities. These challenges if tackled with the proposed initiatives would result in better services and care to our patients.

Paul Pace, *President*
Colin Galea, *General Secretary*

Ejjew Nieqfu ftit

Nursing Fun

Because laughter really is the best medicine

Humour in the Clinic

A Bad sunburn

A cowboy passed out on the Arizona desert for four hours, and got a horrible sunburn, specifically to the front of his legs above his knees. He went to the hospital, and was promptly admitted after being diagnosed with second degree burns.

With his skin already starting to blister, and the sever pain he was in, the doctor, prescribed continous intravenous feeding, a sedative and a Viagra pill every four hours. The nurse, who was rather astouned asked, "What good will Viagra do for him, doctor?" The doctor replied, " It won't do anything for his condition but it'll keep the sheets off his legs..."

"What luck! Just the doctor I was going to refer you to."

Ear infection:

They always ask at the doctor's office why you are there and you have to answer in front of others what's wrong. Sometimes it is embarrassing. There's nothing worse than a receptionist who insists you tell her what is wrong with you in a room full of other patients. I know most of us have experienced this, and I love the way this old guy handled it.

An 86-year-old man walked into a crowded waiting room and approached the desk... The receptionist said, 'Yes sir, what are you seeing the doctor for today?'

'There's something wrong with my dick,' he replied. The receptionist became irritated and said, 'You shouldn't come into a crowded waiting room and say things like that.' 'Why not? You asked me what was wrong and I told you,' he said.

The receptionist replied, 'You've caused some embarrassment in this room full of people. You should have said there is something wrong with your ear or something and discussed the problem further with the doctor in private.'

The man replied, 'You shouldn't ask people questions in a room full of strangers if the answer could embarrass anyone.

The man walked out, waited several minutes, and then re-entered.

The receptionist smiled smugly and asked, 'Yes?'

'There's something wrong with my ear,' he stated.

The receptionist nodded approvingly and smiled, knowing he had taken her advice.

'And what is wrong with your ear, sir?'

'I can't piss out of it,' he replied.

The waiting room erupted in laughter.

Developing the youth work approach: the importance of building relationships with young people

It is very important or more than that, it is crucial to understand that the globalisation of culture is perhaps nowhere more visible than in the changing nature of the relationship between the world's youth and their sense of identity. It has become common place to think of the world's youth as that part of the community who are most receptive, or, alternatively, susceptible to, foreign cultural practices. If childhood means acceptance, and adulthood means conservatism, youth means rebelliousness. Youth are seen as the part of society that is most likely to engage in a process of cultural borrowing that is disruptive of the reproduction of traditional cultural practices, from modes of dress to language, aesthetics and ideologies. From Japanese punk to Australian hip hop, youth subcultures are seen as being implicitly rebellious, born as much from a desire to reject the generation that went before them, as from an identification with what they have become. Exactly how accurate this widespread impression may be is difficult to assess. What is certain however, is that the age of globalization, more than any other age before it, is an age that has both exerted great effects upon, and been greatly affected by, young people.

And here is where youth work comes in... that is to work together with young people in today's world... in this era of globalization.

The idea of youth work differs from other education provision in its approach, the ways in which it is delivered, and the nature of the relationship it has with young people, which encourages their involvement in and ownership of the learning process. It provides less-formal learning processes designed to help young people to:

- develop greater self-awareness and acceptance through positive feedback

- explore the issues that affect them and to make responsible choices
- interact socially and to empathise with others
- develop the skills and knowledge needed for long-term health and employment
- move towards independent adulthood and autonomy.
- This highly skilled approach has a number of defining characteristics:
- It focuses on the interests of the young person and their motivation to learn.
- The learning takes place in accessible environments in which young people feel comfortable, safe and competent to learn.
- It focuses on each young person as an individual with the process centered on their learning and support needs, starting where the young people are not where we would like them to be.
- It is non-judgemental.
- It works with the whole young person, supporting their social, emotional, physical, spiritual and political development.
- Young people can learn flexibly at a time and pace that most suits them.
- Young people have ownership of the learning, it is set at their level, negotiated and undertaken in a participative and empowering way offering them respect as valued individuals.
- It focuses on the process of learning and the development of personal skills and attributes.
- Incidental learning en route is considered as important as the intended learning outcomes.
- It works through relationships built on trust, honesty, openness and caring.

It advocates on behalf of young people and helps to make their voices heard. Some young people have become disengaged at school, and many of these find themselves in the category of the most disadvantaged. To create the most effective environment for learning to take place there needs to be trust between the practitioner and the learner. This will take time to develop, depending on the individual and nature of the group. Young people who were consulted as part of the development of this framework expressed the importance of an informal or youth work approach, and valued the time to discuss issues, and to interact with each other and members of staff. Practitioners also recognise the need for this approach. The quality of the relationship can be more important than the setting itself.

- Practitioners working with young people need to be 'user-friendly': that is, aware of the types of issues young people may be facing, and approachable and non-judgmental in their advice and support. Most young people require a range of support to enable them to engage with learning, and it may be that this support has to come first. Young people also need to know that they can seek this support from staff, and that they will be listened to, and respected.
- Some learners, however, are more comfortable in formal settings, some like to work on their own whilst others are more comfortable in groups; it is also important to find the balance between challenge, discipline and security in learning, with clear boundaries and frameworks. Young people will also progress at different rates, and it is important that this is recognised and taken into consideration.

This short article was meant as food for taught about the way many people think about young people... Let us try to get closer not apart... let's build bridges instead of building walls.

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23 t'Ottubru 2008

- KONFERENZA STAMPA -

L-MUMN TIPPROTESTA MA L-GVERN DWAR DIVERSI NUQQASIJIET SERJI SABIEX JINDIRIZZA L-PROBLEMA TAN-NUQQAS TA' NURSES U MIDWIVES FIL-PAJJIŻ

Il-Malta Union of Midwives & Nurses qed issejjaħ din il-konferenza stampa sabiex tiġbed l-attenzjoni tal-pubbliku fuq is-sitwazzjoni li qegħdin fiha l-isptarijiet tagħna. Il-kura ġo kull sptar ma tiddependix biss fuq kemm ninvestu fil-bini u fl-apparat iżda tiddependi wkoll fuq ir-riżorsi umani. Dan il-Gvern, minkejja l-ħafna wedgħiet li għamel, abbanduna totalment kull inizjattiva li din il-Union issottomettiet lilu sabiex jaddotta miżuri u skemi sabiex ikollna aktar Nurses u Midwives f'pajjiżna. Dan il-fattur ta' nuqqas ta' Nurses qed jolqot mill-qrib lill-pubbliku inġenerali u l-MUMN tagħmilha ċara li l-kura għall-morda tagħna qed tiġi kompromessa.

L-ewwel miżura li ha l-Gvern f'dawn l-aħħar ġimgħat hija li mhux qed jaċċetta li jimpjega Nurses ġodda fuq bażi każwali kif ukoll Nurses li jridu jaħdmu fuq bażi partime. Fis-sitwazzjoni mwegħra li qegħdin fiha llum, kull Nurse tagħmel id-differenza. L-MUMN hija nfurmata li għadhom kemm għaddew b'suċċess 20 Nurse mill-Università u l-Gvern qed ikaxkar saqajh sabiex jimpjegħom b'detriment għall-kollegi tagħhom li kuljum qegħdin dejjem isibuha difficli sabiex ilaħqu mal-workload eżistenti li fl-aħħar mill-aħħar ser tirrifletti fuq il-kura mogħtija lill-pazjenti. Ma dawn hemm numru sostanzjali ta' Nurses li wasslu għal età ta' l-irtirar u lestu li jkomplu joffru s-servizz fl-isptarijiet, kif ukoll numru ta' Nurses li irtiraw f'dawn l-aħħar snin, u skond il-Ftehim li din il-Union lahqet ma l-Uffiċċju tal-Prim Ministru f'Ottubru tas-sena l-oġra, dawn lesti li jerġgħu jirritornaw lura fis-servizz. Il-Gvern lil dawn in-Nurses qed jagħlqilhom il-bibien f'wiċċhom. Kuntent li jimpjega Nurses barranin u fl-istess waqt qed jiċħad lin-Nurses Maltin. L-MUMN stqarret dawn il-prejokkupazzjonijiet tagħha quddiem l-awtoritajiet koncernati però sabet sitwazzjoni li kulħadd iwaħħal f'ħaddieħor. Min jgħid il-Management & Personnel Office fl-Uffiċċju tal-Prim Ministru, min jgħid id-Divizjoni tas-Saħħa jew inkella l-Ministeru tal-Finanzi. Din il-Union ma tistax tittolera din is-sitwazzjoni aktar. Dan huwa Gvern wieħed u jrid isolvi l-problema li għandu ta' nuqqas ta' kordinazjoni llum qabel għada jekk veru bis-serjetà għandu għal qalbu l-pazjenti u l-professjonisti li joffrulhom is-servizz.

Barra minn hekk fil-bidu ta' din il-legislatura, l-MUMN ppreżentat dokument lill-Gvern fejn fost affarjiet oħra qed jipproponi li jsir tibdil fis-sistema li biha jiġu ngaggjati n-Nurses kif ukoll tibdil fil-kors Universitarju tan-Nurses u fl-istess waqt nibqgħu nkunu qed nimxu mad-Direttivi ta' l-Unjoni Ewropeja. B'dan it-tibdil il-pajjiż ikollu aktar Nurses u fl-istess waqt ikollu Nurses aħjar u aktar ippreparati sabiex jagħtu servizz lill-pazjenti tagħna. Jidher ċar li l-Gvern poġġa dan id-dokument fuq l-ixkaffa għaliex s'issa għadu ma sar xejn. L-MUMN trid tgħin lill-Gvern sabiex jibda jsolvi din il-problema ta' nuqqas ta' Nurses u Midwives però b'dizzapunt nistqarru li l-Gvern irid jissupervja u jimxi għalih waħdu. Żgur li f'dawn iċ-ċirkostanzi l-islogan ta' 'flimkien kollox possibli' huma biss paroli fierha. Il-Gvern kuntent li jħaddem miegħu Nurses barranin mir-Rumanija flok jaddotta l-proposti tal-Union sabiex ikollna aktar żgħażagħ Maltin li jitħajjru jsiru Nurses u Nurses aħjar. Uhud mill-proposti li l-MUMN bagħtet lill-Gvern f'dak li jirrigwarda t-tibdil meħtieġ fil-kors

Universitarju kienu:-

1. Id-Diploma kors jinżel minn erba' snin għal tlett snin;
2. Jiġi eliminati għal kollox in-numerous clauses kemm għal-kors tan-Nurses kif ukoll għal dak tal-Midwives;
3. Titbaxxa l-età tal-maturity students għall- korsijiet tal-Nurses u Midwives;
4. Tingħata l-*minimum wage allowance* lill-istudenti ta' tielet sena fil-kors tad-Diploma u fit-tielet u r-raba sena fil-kors tad-*degree* filwaqt li, f'dawn l-istess snin li jingħataw il-*minimum wage allowance*, l-istudenti jiġu marbuta ma *shift* ta' *qualified Nurse* jew *Midwife* biex jieħdu ċertu responsabbilitajiet taħt supervżjoni u b'hekk ikunu aktar preparati għal meta jikkwalifikaw;
5. Terġa tinfetaħ il-*pre-vocational school*;
6. Il-kors jiftaħ dartejn fis-sena.

Meta din l-Union laħqet Ftehim ma l-Gvern sabiex jiġu ngaġġjati *Nurses* barranin dan kien sar fuq bażi temporarja sakemm il-Gvern jaddotta dawk il-miżuri neċessarji sabiex jerġa jagħti spinta lill-professjoni, liema spinta tkun intenzjonata sabiex tġalli riżultati posittivi fost iż-żgħażagħ Maltin sabiex jagħżlu l-karriera tagħhom fin-*Nursing* jew fil-*Midwifery*. Jekk dan il-Gvern mhux ser jimpennja ruħu bis-serjetà din l-Union mhux ser taċċetta li jiġu ngaġġati aktar *Nurses* barranin. Anki l-istess Ftehim li ntlaħaq ma l-Gvern f'Ottubru tas-sena l-oħra u li kien deskritt mill-Prim Ministru bħala wieħed storiku, kien intenzjonat sabiex iħajjar aktar żgħażagħ jidħlu fil-professjoni u fl-istess waqt jattira numru ta' Nurses biex jerġgħu jidħlu lura fil-professjoni. Għalkemm għaddiet sena minn meta ntlaħaq dan il-Ftehim, sa llum għad hemm klawsoli li mhux attwati għar-raġuni li l-Gvern għadu mhux kommess bil-fatti li jrid jattira u jżid in-*Nursing work force*. Eżempju ċar huwa l-ogħti tal-*Warrant* li sa llum wara tnax il-xagħar in-*Nurses* għadhom imċaħħda minnu. L-istess jista' jingħad għall-proċess tal-*bridging* fejn din il-Union kellha tħabbat wiċċha ma kull ostaklu sakemm dan ġie approvat. Sa llum stess l-MUMN għadha qed issib diffikultajiet kbar sabiex Nurses ikomplu jaħdmu meta dawn jaslu fis-sena ta' l-irtirar tagħhom. Problema oħra li din l-Union għanda pendenti hija li ż-żmien li n-*Nurses* u l-*Midwives* għamlu fuq bażi każwali mhux qed jiġi rikkonoxut mill-Gvern.

Fil-bidu tal-leġislatura ta' dan il-Gvern l-MUMN talbet li jsir *Man Power Plan* b'mod serju li jkun jirrifletti f' dawn il-5 snin li ġejjien kemm huwa n-numru eżatt ta' Nurses u Midwives li jaħdmu mas-servizz pubbliku u kemm dawn ser jiżdiedu biex b'hekk il-Gvern ikun f'pożizzjoni li jkun jaf jekk hux possibli li jiftaħ u jibda servizzi ġodda. Dan il-*Man Power Plan* għadu ma sarx u fin-nuqqas ta' dan l-MUMN mhux ser taċċetta li jibdew servizzi jew jinfethu swali ġodda. Bin-nuqqas ta' Nurses li hawn fil-pajjiż kull Ftehim dwar in-Nursing compliment qed jiġi miksur kontinwament u n-Nurses qed ikollhom jagħmlu sagrifiċċji kbar sabiex ilaħħqu max-xogħol liema xogħol qiegħed dejjem jiżdied. Eżempji ta' dan huwa li fl-Isptar Mater Dei, fl-*Intensive Care Unit* hemm nuqqas ta' 18 il-*Nurse*, fl-*Operating Theatres* hemm 20 Nurse nieqes u fir-*Renal Unit* hemm nieqsa 10 *Nurses* oħra. Il-Gvern mhux qed jagħti każ ta' dawn is-sagrifiċċji li qed jgħamlu l-membri ta' din il-*Union*. Nhar il-Ħadd li għadda waqt il-konferenza ġenerali tal-Partit Nazzjionalista smajna Dr Joe Cassar, Segretarju Parlamentari tas-Saħħa jiddikjara kemm żdiedu l-operazjonijiet fl-Isptar Mater Dei però dan naqqas milli jgħid x'konsegwenzi koroh din iż-żieda ħalliet fuq in-*Nurses* li jaħdmu fl-*Operating Theatres*. L-MUMN għandha l-istess oġġettiv bħal l-Gvern li titnaqqas il-*waiting list* però dan ma jistax jibqa' jsir għad-dannu ta' saħħet in-Nurses.

Biex il-Gvern ikompli jifrex il-melħ fuq il-ferità din il-Union hija nfurmata li d-Diviżjoni tas-Saħħa għaddeja bil-pjanijiet sabiex tintroduċi kategorija ta' ħaddiema ġodda fl-*operating theatres* biex jissostitwixxu *Nurses*. L-MUMN tiddikjara b'mod kategoriku li mhux ser taċċetta qatt dan il-fattur għar-raġuni ewlenija li minflok il-Gvern ha l-miżuri meħtieġa biex iżid in-*Nursing work force* ser jaddotta *short cuts* b'detriment kemm għall-istess *Nurses* kif ukoll għall-pazjenti fejn bl-intorduzzjoni ta' dawn il-ħaddiema ġodda ser tonqos drastikament il-livell ta' kura lill-pazjenti li jkunu qed jiġu operati. Kieku l-Gvern minflok jissupervja u jimxi għal rasu, jagħti widen lil din il-Union ikunu jistgħu jinstabu s-soluzzjonijiet meħtieġa sabiex tonqos il-*waiting list* u fl-istess waqt jitjiebu l-kundizzjonijiet tax-xogħol tan-*Nurses* li jaħdmu fl-*operating theatres*.

Għalhekk meta l-MUMN qed tara li l-Gvern mhux qed jieħu bis-serjetà li jsib soluzzjonijiet għan-nuqqas ta' *Nurses* u *Midwives*, l-MUMN mhux ser tippermetti aktar li l-membri tagħha jibqgħu jgħamlu s-sagrifiċċji li qed ikollhom jagħmlu kuljum minħabba dan in-nuqqas. Din hija primarjament responsabbilità tal-Gvern u mhux tal-Union li jieħu dawk il-passi kollha neċessarji sabiex tibda tiġi ndirizzata l-krizi ta' nuqqas ta' *Nurses* u *Midwives*. Minflokk qed naraw sitwazzjonijiet li l-MUMN, fuq bazi regolari, qed ikollha tieħu l-inizjattiva hija però qed isib lill-Gvern jgħalqilha l-bibien f'wiċċa. Din is-sitwazzjoni mhiex aktar aċċettabli.

Għaldaqstant l-MUMN tinforma l-pubbliku inġenerali li jekk sa nhar l-Erbgħa, 29 t'Ottubru 2008 il-Gvern mhux ser jinforma lil din il-Union li :-

a. Qed jaċċetta l-proposti dwar tibdil fil-kors ta' l-istudenti fin-*Nursing* u l-*Midwifery* mill-ewwel kors li jmiss is-sena d-dieħla;
b. Ikun lest il-*Man Power Plan* fuq medda ta' 5 snin;
c. Titneħħa l-burokrazzija kollha sabiex jiġi mplimentat il-Ftehim kollu t'Ottubru 2007;
d. Jiġu ngaġġati minnufih Nurses fuq bażi każwali u partime;

din il-Union ser tinforma lill-Gvern bid-direttivi industrijali mifruxa fuq l-isptarijiet u ċ-ċentri tas-saħħa kollha b'effett minn nhar il-Ħamis, 30 t'Ottubru 2008 sabiex in-*Nurses* u l-*Midwives* f'pajjiżna jiġu mistrieħa mis-sagrifiċċji żejda li qed jgħamlu fuq bażi regolari kapriċożament għall-attitudni negattiva tal-Gvern sabiex b'mod serju u bil-fatti jindirizza n-nuqqas ta' *Nurses* u *Midwives* f'pajjiżna.

Paul Pace, *President*
Colin Galea, *General Secretary*

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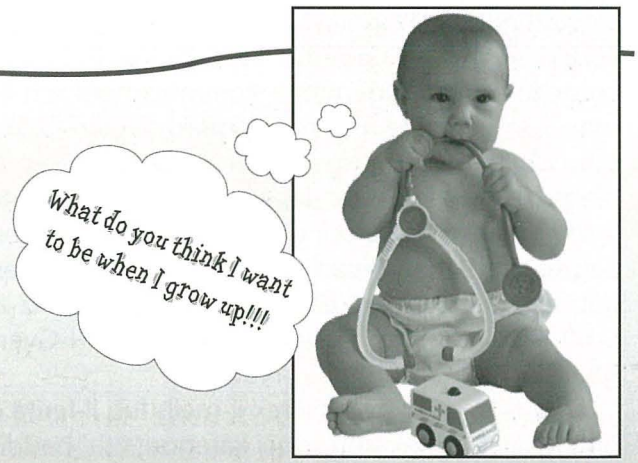
Ejjew Nieqfu ftit

"I can only give you one hour to live if you don't stop annoying the nurses."



"I think the doctor's trying to milk our insurance company. I only came in for a hang nail."

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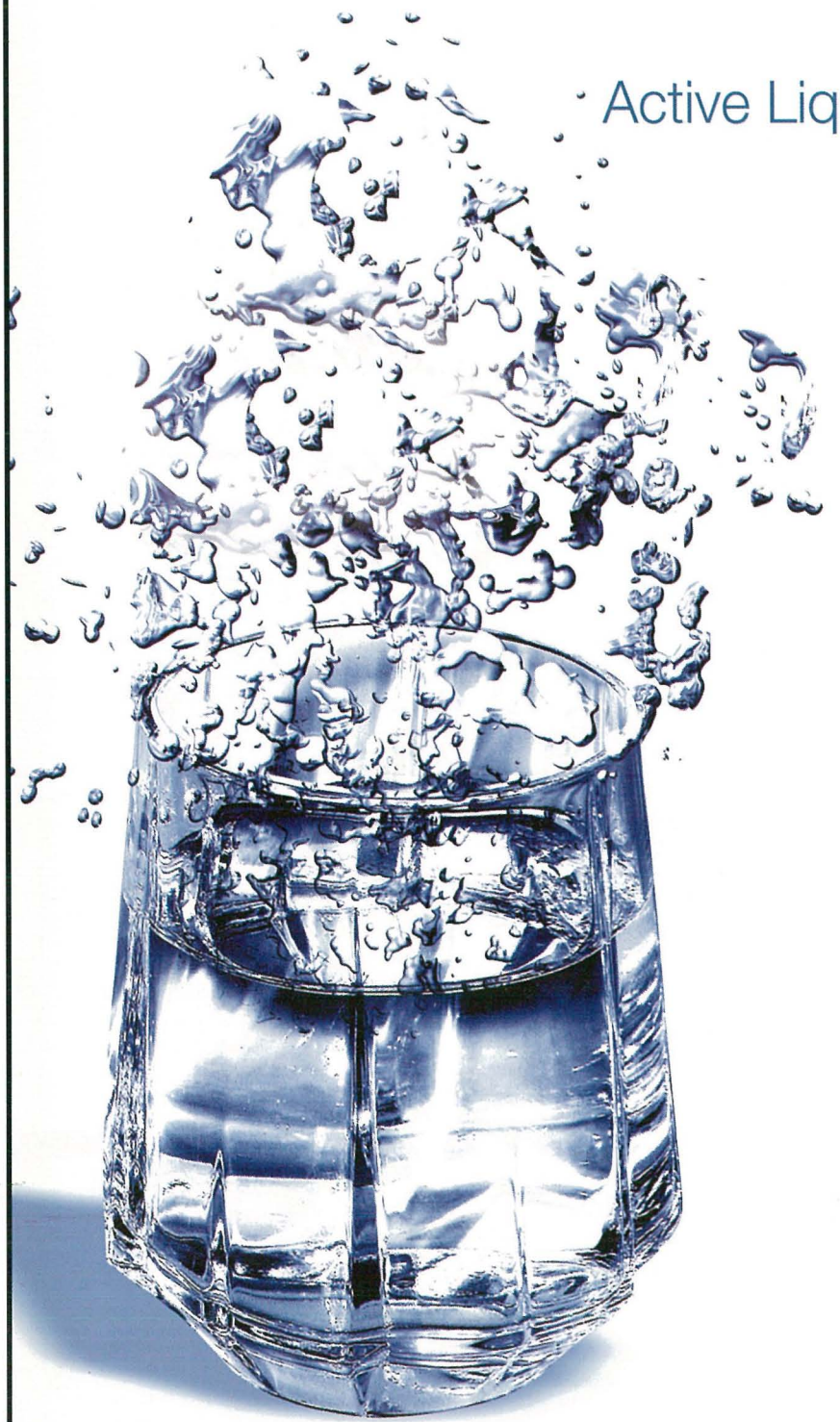

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