STÉRIMAR

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LABORATOIRES FUMOUZE
What makes a Health Care Professional a Hero?

Health Care Professionals risk their life constantly, exposing themselves to infectious diseases, violent patients, and constant over work and stress. Heroism is a “mindset” rather than a job description and until we begin to value the sacrifices we make, no one else will.

A heroic Health Care Professional is one who works on her or his critical thinking, job knowledge, team building, compassion, initiative, communication skills and so on.

When we think of heroism most think about those in the military, police officers, civil protection or anyone who makes a huge sacrifice or risk to help others. Most think that saving thousands of lives is just a Health Care Professional's job not heroism. But isn't working with very sick patients (especially dying people) heroic too?

Like the other emergency services, often nurses, midwives, social workers, physiotherapists and ECG technicians are running to horrifying accident scenes so no words can pay enough tribute to the skill and bravery of nurses and other healthcare professionals.

Nurses administer medications after checking the 8 rights, work long hours, stay late in exceptional circumstances, multitask, further their education and skills, be the patient's advocates and put up with unruly relatives and members of the public. Isn’t that heroism? These heroes and heroines among us simply do the right thing, with competence and consistency. Caring, endurance, and nurturing those who are the most vulnerable, and helping others make a nurse a hero. There is no media coverage about all the above.

Unfortunately, however, the sad reality is that for such heroic professions, the health care professionals seem to constantly be facing more than its fair share of administrative battles. It's also unacceptable that the healthcare professionals are not respected by all the relatives, which frequently happens in our hospitals.

The biggest challenges we are facing in our daily duties are workload, job duties and pay. Nurses cannot be expected to be competently taking care of excessive number of patients. Safe patient care ratios need to be agreed between MUMN and administrators and implemented; nurses are not expected to do anything beyond the scope of their job. Care assistants, porters and hospital security must be present in adequate numbers to do what they need to do and free up nurses; constant recognition of the vital work that nurses do. The medical world needs to support our nurses and treat them as what they are: the absolute heroes of frontline health care.

One hopes that our members haven't lost the most important value in health care profession: love for the suffering patient, a value that guides them to do heroic actions.
Dear Colleagues,

Here I am sitting down to write this edition’s note to you, and in doing so, I realised that another year is over, with many of us including myself preparing for the Christmas season. Yet again, despite being in the Christmas season, union matters keep popping up and we keep going full speed ahead with the work of the organisation. While preparing for this edition’s note, I reflected on our work and instantly decided that the theme for this edition will be ‘Reflection and Intention’. I can say that one of the skills and competences that taught me a lot about reflection and intention is driving. Those that know me, know that I always tried to shelve the idea of becoming a driver. It was something I never wanted to do; and I went for my driving lessons and for the driving test to keep a promise I did to my husband. During my very first driving lesson, my tutor taught me that while I am driving, I need to look back while also moving forward. While driving I need to do both to be successful and be crash free — check the rear-view mirror and keep my eyes on the road. I can say that our professions and our union are also about reflection and intention — looking at where we have been and where we need to go.

This is the perfect time of the year to stop and think about what has been accomplished and where we need to go next. This is the reflection part. As President of the MUMN, I am so proud of everything the MUMN has accomplished in 2017: the day to day running and administration of the union, the signing of a collective agreement, the signing of a sectoral agreement for the ECG technicians, the negotiation process of a sectoral agreement for nurses, midwives and physiotherapists, reaching an agreement on mentorship remuneration, working to improve practices within all organisations where we represent our members, provide evidence based training and so much more. Reflecting on the past months’ work, I reckon that we had accomplishments, projects in progress and work still needing attention.

“\"This is the perfect time of the year to stop and think about what has been accomplished and where we need to go next.\"”

The central themes of all this work include having targeted strategies for a solution-based approach to the health issues of the day, maximizing opportunities to advance the professions we represent, building on strengths, being responsible union officials and encouraging cohesiveness within the professions we represent. All the while, the MUMN has been providing examples and answers that support the sustainability of the health care system. These are just a few of the amazing things we together, and this means through your support and collaboration; have accomplished. I feel joy and pride as I write my last message for this year. I can report that my expectations have been met and exceeded. The MUMN has a visionary strategic plan that is anchored in health care. We have become an advocacy powerhouse in industrial relations work and closing the loop on the issues that are meaningful to the professions we represent. I am confident that these efforts will result in better care and a stronger health care system.

Back to the intention part; our eyes are on the road ahead — being practical and tactical — looking for opportunities and being strategic in advancing what needs to be done for a healthy nation and vibrant professions. I am optimistic about the future and about what the MUMN can accomplish. Our voice is important and meaningful, and we will ensure we keep our foot on the accelerator to move forward and give the rear-view mirror a check for safety and confirmation. On behalf of the MUMN Council, I look forward to welcoming the 2018 with enthusiasm so that together as a union we have another productive and successful year.

To close this edition’s note, I would like to extend a heartfelt thank you to all council members and the office administrators who are always enthused and dedicated to pushing the values of the MUMN. I also thank all our tireless group committee members who give so generously of their time.

During the Festive season more than ever, my thoughts turn gratefully to those who have made our progress possible, and that include you. And in this spirit, I say, simply but sincerely - thank you and best wishes. May this Christmas be bright and cheerful. May the New Year be blessed with peace, love and joy. Sending my heartfelt season wishes to all of you and your families.

Until next time,

Maria Cutajar
MUMN President
mis-Segretarju Generali


Bdejt bl-awguri għall-Mlied u Sena G’dida u se nagħlaq bl-istess nota. Fl-20 ta’ Diċembru se norganizzaw il-Christmas Dinner ġewwa il-be, Hotel f’Bay Street. Din is-seħna biddilna ftit l-ambjent peress li għal sentjejn wara xulxin organizzazjena din l-attività annwali fl-istess post. Napprezza hafna jekk inti tantendi biex filmikien niċċelebraw din is-seha stupenda li mxejna fiha filmikien u fl-istess waqt naghmu kuragg b’xulxin għall-ifsiċi li se ġġib maqgha Sena G’dida.

Tislijet mill-qalb,
Colin Galea
Segretarju Generali
Avoiding the Bitter Cocktail which could sour your Christmas

Written by Josianne Azzopardi - S.A.F.E. Programme Coordinator Agenzija Sedqa

Christmas is near and during this time of year one would be invited for a number of activities such as staff parties, dinners and dinner dances. A common factor that one comes across during these activities is alcohol.

One should remember that alcohol has two facets. On the positive side it could help a person to socialise. However, alcohol has a negative side, namely, one could harm himself and/or others as a consequence of alcohol such as by being involved in a traffic accident.

It is a known fact that a person who is driving under the influence of alcohol is at a higher risk (six times higher) of being involved in a traffic accident than a person who is sober. Even the smallest amount of alcohol intake can affect your driving skills and you would not be capable of judging distance and speed and your reaction time decreases. Although there are persons who boast that they drive better when under the influence of alcohol, the reality is different.

If a person is under the influence of alcohol, he/she will take longer to take decisions related to driving, for example he/she would take longer to decide to break in case he/she notices an obstacle on the road. This delayed reaction can cause a traffic accident, unfortunately at times even a fatal one.

It’s a pity that a person would allow alcohol to steal the joy of Christmas from him/her or from those he/she loves. Alcohol and driving form a deadly cocktail and it has ruined far too many lives. Therefore if you are going to drive it would be best if you do not drink any alcohol to avoid endangering yourself and/or others. If you drink alcohol do not drive. There are alternatives to celebrate Christmas in a healthy way:

1. Do not offer any alcoholic drinks to someone who will be driving. You can offer/drink alcohol free cocktails or non-alcoholic drinks.
2. If you are in a group, decide who will not drink alcohol (designated driver) so that this person could drive his/her friends home safely.
3. Never ride in a car driven by someone who has been drinking. Call a taxi, use public transport or ask a sober friend to drive you home.

Myths and facts

The Myths
I feel ok to drink and drive because:
• I had only a couple of drinks.
• I ate and had some milk before I drank.
• I mixed my alcoholic drink with mixers (soft drinks) or water.
• I am only going down the road.
• I drive slowly and carefully.
• I won’t get stopped by the police.
• I’ve been doing so for ages and I never had a traffic accident.

The facts
• Even one alcoholic drink can affect your driving abilities and performance.
• It does not matter if you eat before having an alcoholic beverage. Food only increases the time for alcohol to enter your body system but it does not decrease its effect on the brain. Your driving skills will be equally impaired.
• Mixing an alcoholic beverage with water, juices or soft drinks, does not dilute the effect of the drink. This only changes the taste and not the alcohol amount. Mixing alcoholic drinks with soft drinks makes alcohol reach your brain faster.
• A considerable number of alcohol-related accidents occur within 5km of the start of the journey.
• Alcohol is a depressant. It slows down your reflex actions and makes you less alert. Driving slowly under the influence of alcohol does not mean you are a safe driver.
• The police can ask you to take a breath test if they suspect you have been drinking, if you commit a traffic offence or if you get involved in an accident.
• It does not mean that if you have never been involved in an alcohol-related traffic accident, you will never be. Did you ever ask yourself if you have ever caused an accident while driving under the influence of alcohol?

Remember, alcohol and driving do not mix
On Tuesday 29 March 2016 I have had the joy of being cordially invited to take part in the International Conference organised by the Pastoral Care Commission for Health Caregivers. The theme of the Conference which continued the following day, Wednesday 30 March, was the subsequent: Ethics at the workplace calls for spiritual standing. The venue of this international conference was the Faculty of Health Sciences at Mater Dei Hospital.

Although I was only able to attend to the first day of the conference, due to the heavy working schedules we chaplains have at Mater Dei Hospital (MDH), I can say that I greatly benefitted from the output that it was abundantly presented to us. The pivotal question I made as a hospital chaplain while listening attentively to the relevant material that I was being exposed to was this: How this information would inform my way of being a chaplain and doing chaplaincy at MDH?

I want to start with the Eucharist which His Grace, Archbishop Charles J. Scicluna, celebrated. We, the chaplains of MDH, together with Fr Martin Micallef, Director of Dar tal-Providenza, had the privilege of concelebrating with him in this special Eucharist. The gospel of that day's liturgy gave me the first clue of what my pastoral profile as a chaplain should be. It was taken from John 20:11-18. It narrated the story when Mary Magdalene went to Jesus' tomb and stayed outside weeping.

In this gospel pericope we see Mary crying as part of the grieving process and completely out of shock for what had happened to Jesus. Even though her mourning was culturally expected, but she did not find what she expected to see. Instead of a body she would finish preparing for burial (remember she could not finish the rites due to the hasty entombment of Jesus), she found the tomb empty. So, she was asked twice, "Why are you weeping?" I still remember the Archbishop's comment: "To a woman who was enveloped in her grieving process Jesus addressed her by name". Why? Because behind that process there is a person involved. And here is my first challenge as a chaplain! Do I see the illness or the person who is suffering behind that illness? Is my pastoral approach personalistic or simply ritualistic?

After lunch the conference was officially opened by the President of the Pastoral Care Commission for Health Caregivers, Dr Josephine Attard. In her welcoming speech Dr Attard presented an interesting definition of who the patient is. According to the Malta Medical Council (MMC) definition "the patient/client is a unique person who is to be treated with respect and dignity irrespective of age, nationality, creed, gender orientation, political inclination or any other factor, ... [hence] recognise and respect the uniqueness of every patient/client and adapt the care given according to the patient's/client's biological, psychological, social and spiritual state and needs" [MMC Malta, 1997, pp 3].

This smart definition helped me to see if my spiritual care for patients is really embracing every person irrespective of his/her nationality, creed, gender orientation as well as political inclination. And, if it does, how am I doing that?

I was greatly enlightened in this soul-searching exercise as a chaplain by the opening speech of the conference which was delivered by Prof. Angela Xuereb, Dean of the Faculty of Health Sciences.
speech
Prof. Xuereb spoke the importance that health caregivers need to possess sufficient knowledge and skills in order to give them the right attitudes in dealing with their patients. She highlighted that among these attitudes health caregivers need to foster relationships based on collegiality and teamwork. Ongoing training is surely a must if a caregiver is to deliver an excellent service to the patients s/he is called to serve.

From Prof. Xuereb’s speech I learned that as a hospital chaplain I need to take into consideration the physical, psychological, and social aspects of every person I encounter with. The spiritual aspect can never be seen on its own when doing pastoral assessment of patients. Within the context of a social milieu which is becoming more and more multicultural as well as multifaith it is essential that as a chaplain I have to be more aware not only of the diversity of religious beliefs we have available in our country but also on how my Catholic faith can collaborate with adherents of different religions.

In her speech the President of Malta, H.E. Marie-Louise Coleiro Preca, accentuated that spirituality is an intrinsic aspect of being human. She said that spiritual patients tend to have a more positive outlook on their illness. These patients feel happier and less pain. Since spirituality, which may or may not be related to religion but expressed by beliefs, values and rituals, is important in our patients’ lives this equally means that I, as a chaplain, need to facilitate the growth of their spirituality. The President encouraged all of us, participants of the conference, to treasure the professional care we give to our patients. She augured that we deliver our care in a spirit of faith, hope and love. Is my pastoral care animated by these three core values which Saint Paul mentions in his First Letter to the Corinthians? Am I facilitating enough the spiritual values, beliefs and rituals of the patients I daily serve at the hospital?

The keynote speech of the first day of the conference was delivered by Prof. Bart Cusveller, from the Center for Bioethics & Human Dignity of the Netherlands. The title of his speech was Humanising care to patient and family. Prof. Cusveller mentioned four professional virtues which are pivotal in providing a sound spiritual care. The first virtue is attentiveness. In other words, paying attention to the person’s situation. The second virtue is accountability or moving into action. The patient needs to feel that I, as a chaplain, thanks to the way I am attending to him or her I am being committed to him or her. The third virtue is competence. Here practical involvement is decisive. It is not enough that I have listened and recognized my pastoral responsibility. I need to conduct the pastoral conversation in a way that the patient feel empowered to do something about his situation. The fourth virtue is responsiveness. My active listening should enlighten the patient to make some practical decisions in order to take more control of his or her situation.

Prof. Cusveller speech helped me understand that as a chaplain I need to refrain myself from indulging in omission or prescribing certain spiritual beliefs or, worse, proselytising. The two extremes in fact go against the patient’s integrity. Instead, Prof. Cusveller proposed 6 professional norms that are worth exploring and interiorizing. First, do not...
What does it mean to be a “good nurse”?

I’ve been very blessed in my short career as a nurse. I have worked at some amazing hospitals, and have had some even more astounding co-workers. I’ve worked in various areas of different hospitals, and through that, I think I have discovered what it means to be a good nurse.

There is something about a good nurse. Having a nursing license and job doesn’t make you a good nurse. Working for 30 years doesn’t make you a good nurse. It’s not about being a good IV starter or being best friends with all of the physicians.

It’s so much less defined and measurable than that. It isn’t measured in letters after your name, certifications, professional affiliations or by climbing the clinical ladder.

It’s something you feel when you see a good nurse care for their patients. It’s that security you see in their patient’s eyes when they come in to care for them. It’s that nurse whose patient’s family member will finally go home to sleep and shower because they know their loved one is cared for with that nurse.

Good nurses breathe instinct. They breathe discernment. Good nurses can pick out seemingly insignificant things about a patient, interpret an intricate clinical picture, somehow predict a poor outcome and bring it to the doctor’s attention, literally saving someone’s life.

And then there’s that heart knowledge that good nurses have that blows me away even more.

There are those nurses who always know the right thing to say. They know how to calm an apprehensive and scared mother enough to let them take care of her son.

They know how to re-explain the worst news a husband is ever going to hear because it didn’t quite make sense when the doctor said it 15 minutes ago. And they know how to comfort and reassure him when they see it click in his mind that his wife is forever gone.

They know how to convey urgency, not terror. They somehow make you feel safe when someone’s life is literally a breath away.

Those nurses are my heroes. They’re who I aspire to be every time I put my badge on in the morning. They’re who I hope I have been when I clock out. They’re the good nurses.
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Reference:
Endurance Exercise, High-Impact Activity and Resistance Training to Promote Bone Health in Postmenopausal Women

Osteoporosis is characterised by a decline in bone mass associated with the weakening of the microarchitectural component of bone tissue resulting in increased fragility and fracture risk (Rizzoli, 2005). Increased bone fragility and osteoporotic fractures entail considerable amount of pain, compromise quality of life and may cause disability amongst sufferers (Ivergard et al., 2013). The International Osteoporosis Foundation (2015) reported that beyond the age of fifty, one in three women will experience an osteoporotic fracture, translating to 8.9 million fractures globally, a third of which occurring in Europe (Hernlund et al., 2013). In the EU27 in 2010 and beyond, 26.7 million men and women between 50 and 84 years were diagnosed with osteoporosis. 3.5 million Europeans suffered osteoporotic fractures summing up a €37 billion economic burden (Svedbom et al., 2013). In Malta, 20,000 men and women over 50 were diagnosed with osteoporosis and 2,600 fractures linked to this silent disease. This took up €17 million of the total healthcare budget to treat fractures and to provide pharmacological prevention. Hip and vertebral fractures were the most common. The EU27 report predicts that a 25% increase in expenses is expected in the next decade (Ivergard et al., 2013).

Women over the age of 50 are the worse effected by osteoporosis, following onset of menopause which is the major risk factor (Ivergard et al., 2013). Demir et al. (2008) reported a 2% loss in cortical bone and 5% reduction in trabecular bone per year in the first 5 to 8 years post-onset of menopause. This is attributed to the reduction of oestrogen concentrations decreasing osteoblastic activity and allowing for increasing osteoclastic bone resorption activity resulting in a deficiency in bone deposition as compared to that resorbed (Hadjidakis, 2003).

Bone tissue can undergo remodelling and osteogenesis throughout one’s lifetime making osteoporosis and osteopenia modifiable conditions if adequate loading exercise is performed by those effected. This is based on Wolff’s Law and Frost’s mechanostat theory, stating that bone is adaptable to the mechanical load placed upon it and bone strength adaptable to the load applied (Lyne, Nelson, 1999; Frost, 1987). Consequently, there seems to be enough evidence relating to the positive effect of exercise in terms of osteogenesis and maintenance of bone health throughout the postmenopausal stage in women. However, the optimal physical activity type, frequency, intensity, outcomes and strategies are still unclear due to the varied results within numerous studies and guidelines providing varied recommendations.

The American College of Sports Medicine (ACSM) (1995) issued a position statement stating the main role of physical activity to combat osteoporosis. The main aim of exercise is to increase bone mass and strength and secondly to improve balance decreasing risk of falls. ACSM recommends a combination of weight-bearing endurance, high impact and resistance training for those at risk of osteoporosis (Kohrt, et al. 2004), whilst those with higher fracture risk are recommended to omit high impact exercises (Pescatello et al., 2014).

Endurance activity including both high impact and low impact

* continued on page 16
exercise together with resistance training are beneficial in boosting or maintaining BMD at specific sites as noted by Howe et al. (2011) in their Cochrane review, implying that combination training is the best choice for an overall BMD enhancement in postmenopausal women. In this Cochrane review, spine BMD is mostly responsive to low impact weight bearing exercise and high force resistance exercise. Conversely high impact, weight bearing exercise such as multidirectional jumping activity was found to favourably affect hip BMD (Howe et al., 2011; Palombaro et al., 2013).

The Erlangen Fitness Osteoporosis Prevention Study is a strong supporting evidence with regards to the benefits and anti-fracture properties of combination training, in which results showed gains in bone mass within the first year till the fourth year of the study and BMD losses were constantly lessened till the end of study in an exercising group when compared to the inactive control group after 12 years (Kemmler 2003-2016).

There seems to be no single dose when prescribing exercise in relation to enhancing bone health in a postmenopausal population. Resistance training protocols seem to be the most constant with the use of 60 to 90% 1RM for a maximum of 3 sets of each exercise covering various major muscle groups and carried out 3 times weekly. Other forms of activity also seem to follow the frequency of 3 times weekly to allow adequate rests between each exercise session. Most studies shorter than 1 year have shown ineffective results, which links the idea that DEXA scans should be carried at least 12 months after the initiation of a training program to allow adequate time for osteogenesis to occur.

In conclusion, exercise is an inexpensive, relatively safe and a modifiable form of intervention which may be adapted to the individual needs of postmenopausal women at risk or those suffering from osteoporosis. Such intervention aims to improve the quality of life and reduce fracture risk and suffering caused by this silent condition. A combination of safe exercise together with recommended medication may reduce the economic burden in relation to healthcare costs linked with the treatment of osteoporotic fractures namely hip and vertebral fractures.

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Consequently, there seems to be enough evidence relating to the positive effect of exercise in terms of osteogenesis and maintenance of bone health throughout the postmenopausal stage in women.
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The Women’s and Men’s Health Physiotherapy service provides physiotherapy care for women and men with pelvic floor issues such as urinary and bowel incontinence, pelvic organ prolapse and pelvic floor dysfunction and pain. Women are also cared for throughout pregnancy and in the post natal period in cases of back pain, symphysis pubis dysfunction and diastasis recti. Men are also followed up pre operatively and post operatively when they undergo total prostate surgery to minimize the impact of incontinence on their lives. The physiotherapy team also looks after patients in the urology, gynaecology and obstetrics wards. On the inpatient wards physiotherapists provide treatment and advice for women after 3rd or 4th degree tear and forceps/ventouse delivery. Physiotherapists also treat women following gynaecology surgeries upon doctor’s referral.

The service at Mater Dei Hospital is gradually evolving and expanding with the physiotherapists undergoing training and improving their knowledge and skills in assessment and management techniques of patients with continence problems. The physiotherapy team is composed of three physiotherapists who work closely with the obstetricians, gynaecologists, urologists, gastroenterologists, colorectal surgeons, midwifery and nursing staff to ensure a holistic approach to continence and obstetric care.

Incontinence is the unwanted and involuntary leakage of urine or stool. Incontinence is a sensitive condition that affects an estimated 400 million people across the world. Urinary and bowel incontinence are major public health problems impacting on the quality of life of affected women and men, with resultant loss of self-esteem and considerable social and economic impact. Continence care, both preventative and management is at the centre of the physiotherapy service. Historically, conditions affecting the bladder and bowel have often been uncomfortable or "taboo" subjects and accordingly these medical disorders have been underreported and under-diagnosed. Surveys have shown that fewer than 40% of persons with urinary incontinence mention their problem to a doctor or nurse and this figure is even higher for those with bowel incontinence. People might also think that these symptoms are an inevitable sequelae of childbirth and/or ageing and that they would need to live with the symptoms. It is the role of all health care professionals to break this taboo cycle and set the message across that incontinence symptoms should not be simply accepted and that management is possible. These conditions have been inadequately treated and poorly addressed by medical professionals, despite the substantial impact on individual health, self-esteem and quality of life.

Health care professionals need to be aware of how to identify patients who are at risk and ask directly if they have incontinence issues and guide their patients accordingly. In order to raise awareness about continence issues and care the women’s and Men’s Health physiotherapists participated in World continence week 2017 between the 19-25th June. World Continence Week (WCW) is an annual initiative managed and run by the World Federation of Incontinence Patients (WFIP) and the primary aim is to raise awareness of incontinence related issues and works to give sufferers the confidence to seek help and improve their quality of life. A event was organized at Mater Dei Foyer were physiotherapists were available throughout the day with informative materials to answer questions related to continence issues. A stand set up in the main foyer together with educational videos, had the aim to educate the public on conservative management which should always be the first line of treatment in continence care. The other aim was also to inform that such conservative management is possible and available at Mater Dei Hospital upon a doctor’s referral. Awareness was also raised with article in local newspapers and magazines to reach a wider section of the population.

We as health care professionals have an important role to break the silence over continence issues and give the confidence and support to our patients to speak up about the issues and seek necessary help to manage effectively.

Carolyn Sultana
Senior Allied Health Professional - Physiotherapist
The MUMN SVP Group Committee organised another activity at SVP involving the National Blood Transfusion Centre. During this activity the On. Parliamentary Secretary for Active Ageing & Community Services paid a visit to encourage staff to donate blood.

MUMN started attending in schools to market the nursing profession addressing different levels of students.

MUMN organised a brilliant ceremony in collaboration with VGH on the occasion of the International Days of Nurses and Midwives. H.E. President of Malta accepted MUMN’s request to organise this ceremony near the National Monument for Health Care Professionals at her Presidential Palace.

Mr. Claudio Grech MP attended MUMN office to inform us about a law that was presented in Parliament regarding liability for public service employees whenever they intervene in accidents occurring in public places.

The MUMN SVP Group Committee organised another activity in Gozo where the number of attendees from one activity to another is always on the rise.

A group of Maltese Nurses attended an interesting nursing conference in Rome.

The Learning Institute for Health Care Professionals organised the first ever conference organised by MUMN in Gozo.
The First 1000 Days
- a crucial time for a baby's development

From conception to the age of two, the first 1000 days of a baby's life are crucial. What happens during this time can have a major impact on a baby's future health.

Making the right decisions now can help deliver lifelong benefits. The endocrine, immune system, and even appetite are believed to be programmed for life by what happens in the first 1000 days.

Breast feeding is recognised as the gold standard of infant nutrition by the World Health Organisation and the Ministry of Health (Malta). Breast milk adjusts according to the infants needs and so the right amounts and quality of nutrients are given instantaneously which infant formula is not able to mimic. Children who are breastfed have a lower chance of developing obesity and other non-communicable diseases later in life.

If a mother chooses not to breastfeed infant formula milk is a recommended substitute. At SMA we strive to continually improve the quality of our formula. Over the past 90 years, SMA Nutrition has invested in early life nutrition research. As a result, SMA PRO represents some of our most advanced formulas yet.

SMA PRO Follow On Milk will meet the nutritional milk needs of babies aged between 6 to 12 months. It is used as part of a weaning diet and is fortified with important nutrients such as iron, vitamin D, calcium, omega 3 & 6 which are very important in the development of infants. ESPGHAN 2014 recommends that all infants from the age of 6 months should receive iron rich foods or iron-fortified foods. The amount of protein has been reduced to 1.30g/100ml to reduce risk of excessive intake. SMA PRO Follow On Milk is available in 400g and 800g tins.

SMA PRO Progress Kids is used as part of a healthy balanced diet in toddlers aged 1 to 3 years. It has been designed to complement the toddlers diet, providing important nutrients shown to be at risk in toddler diets. The amount of protein has been reduced to 1.5g / 100ml and the amount of Vitamin D increased. It is important to remember that any toddler milk should not replace a meal and be part of a balanced diet. No more than 3 servings daily should be given to toddlers.

IMPORTANT NOTICE: Breast milk is best for babies and breastfeeding should continue for as long as possible. Good maternal nutrition is important for the preparation and maintenance of breastfeeding. Introducing partial bottle-feeding may have a negative effect on breastfeeding and reversing a decision not to breastfeed is difficult. A caregiver should always seek the advice of a doctor, midwife, health visitor, public health nurse, dietitian or pharmacist on the need for and proper method of use of infant formulae and on all matters of infant feeding. Social and financial implications should be considered when selecting a method of infant feeding. Infant formulae should always be prepared and used as directed. Inappropriate foods or feeding methods, or improper use of infant formula, may present a health hazard.

Information for Medical Professionals Only.
Breast Is Best for Babies.

This article has been brought to you by SMA Nutrition. For more information and to receive the references please contact: info@viviancorp.com
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Made with SMA® Nutrition’s exclusive protein process

Contains Omega 3 & 6 LCPs and GOS/FOS**

We’ve responded to expert opinion about proteins in SMA® PRO First Infant Milk

"Protein intakes of infants are generally well above the requirements, so protein content of Infant Formula and Follow-on Formula could be decreased”

European Food Safety Authority 2014

SMA PRO First Infant Milk has the lowest protein content, 1.25g*/100ml (1.87g*/100kcal)³

*Powder only, liquids will vary

"The breast milk content of amino acids as the best estimate of amino acid requirements for this age group”

WHO/FAO/UNU 2017

SMA PRO First Infant Milk has an essential amino acid profile closer to that of breast milk²

"Of the essential amino acids, branched chain amino acids have been shown, when supplied in excess, to be more associated with increased release of insulin. This may trigger a cascade of reactions in the body which may result in faster growth”²

European Childhood Obesity Trial Study Group 2015

SMA PRO First Infant Milk has an improved amino acids profile for healthy growth and weight gain ⁷

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IMPORTANT NOTICE: Breast milk is best for babies and breastfeeding should continue for as long as possible. Infant milk should only be used on the advice of a doctor, midwife, health visitor, public health nurse, dietitian or pharmacist, or other professionals responsible for maternal and child care.


*When bottle feeding is considered
**In powder formulation only: GOS/FOS = Galacto-oligosaccharides/Fructo-oligosaccharides
³Registered trademark
Some people think investments are complex. We can help you better understand and choose the right investment strategy that fits your personal risk tolerance.

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ignore. Make the availability of spiritual care explicit. Second, do not pressure. Provide spiritual care in the interest of the patient. Third, bring up your own spirituality only with the patient’s consent. Fourth, communicate transparently regarding spiritual care provided. Fifth, provide considerations on which spiritual care is based. And, finally, provide spiritual care in a step by step process.

The next item on the programme was the family Umanah’s experience, called Experience teaches us! (X’jaf min ma garrabx!). This experience dealt with a family who was having the mother with critical illness. Thanks to this experience I came to realize that faith seeks understanding. Faith is purified and consolidated through spiritual wars and battles which sickness surely provides. Miracles do happen. In fact the husband openly asserted that his wife remained alive thanks to the prayers that were prayed for her. Her husband was courageous enough to pray with his wife in her right ear. Am I praying enough not only for patients but, and most of all, with patients? Do I realize that the patients and their relatives may appreciate more such a caring pastoral intervention?

The penultimate item was a discussion conducted by Prof. Emanuel Agius, Prof. Donna Mead and Prof. Bart Cusveller. The title of this discussion was Ethical issues and the spiritual dimensions of care and relationships. I was deeply touched by what Prof. Agius was saying, namely that faith brings a broader horizon to our suffering experiences. This is so since spirituality is a person’s consistent search for meaning. Hence, as a chaplain, ethics has the power to help me become more and more a fellow traveller with our patients. The main question which I derive from Prof. Agius’ contribution is the following: If God is a fellow sufferer who understands the person who is suffering, and as a chaplain I am called to put on his character, how can I become God’s faithful representative? Is this not the same invitation that we find in Saint Paul’s letter to the Romans: “Rejoice with those who rejoice, weep with those who weep” (Rom 12:15)?

The final contribution of this conference which I was able to attend for its first day, was the speech by Prof. Ggfrill Haugan, which had as its heading Caregivers’ Interaction with clients – A core aspect of spiritual care. When I adapted what she was saying to my vocation as a hospital chaplain the main thrust of Prof. Haugan’s argument was that if chaplaincy is the art of nurturing a soul then an effective pastoral care needs to take into consideration the patient’s hopes, meaning in life, self-transcendence, anxiety and depression.

Being a chaplain is an ongoing journey, with its ups and downs. Thus, the chaplain’s pastoral profile is never fixed or fully completed but it is always evolving and open to change, while of course, keeps being faithful to its fundamental tenets. To use a common quote which Pope Francis uses for the Church, what hospital chaplaincy “needs most today is the ability to heal wounds and to warm the hearts of the [patients]; it needs nearness, proximity. I see [hospital chaplaincy] as a field hospital after battle. It is useless to ask a seriously injured person if he has high cholesterol and about the level of his blood sugars! You have to heal his wounds. Then we can talk about everything else. Heal the wounds, heal the wounds. .... And you have to start from the ground up”.

Drawing periodically a chaplain’s pastoral profile through education in connection with experience surely helps developing and interiorising more the much-needed art of spiritual care.

Fr Mario Attard OFM Cap
Breastfeeding is one of the most effective investments a country can make to ensure a smarter, healthier population. It protects children from a myriad of illnesses, increases IQ, and promotes a strong bond between mother and infant. It is a powerful practice, and one that has huge implications for a country's future prosperity.

This scorecard analyzes indicators that influence breastfeeding (see following page). Worldwide, performance on recommended policies and programmes for breastfeeding is poor. No country is highly compliant on all indicators, illustrating that substantial progress on all fronts is needed.

WHO and UNICEF have established recommendations for breastfeeding practices. Although every mother decides how to feed her child, this decision is strongly influenced by economic, environmental, social, and political factors. Unfortunately, countries are not adequately protecting, promoting, or supporting breastfeeding through funding or policies. As a result, most children in the world do not meet these breastfeeding recommendations.

In recognition of this, the Global Breastfeeding Collective (Collective), a partnership led by UNICEF and WHO, has set targets for all of the indicators listed below, as well as four critical breastfeeding practices, to be met by 2030. The Global Breastfeeding Scorecard stands as an urgent call to action for policy makers worldwide. Hundreds of thousands of lives could be saved each year and numerous health conditions prevented if countries committed to changing their policies and providing greater funding to support breastfeeding. In addition, societies could ensure a healthier, smarter workforce by investing in this one simple practice.

BREASTFEEDING SHOULD BE:
Initiated within ONE HOUR of birth
Continued exclusively for SIX MONTHS
Continued with complementary foods to TWO YEARS of age or beyond

COUNTRIES LOSE MORE THAN $300 BILLION ANNUALLY BECAUSE OF LOW RATES OF BREASTFEEDING. THAT IS 0.49 PERCENT OF GNI.
Global Breastfeeding Collective

Call to Action Priorities:

1. **FUNDING**: Increase investment in programmes and policies that promote, protect and support breastfeeding

2. **THE INTERNATIONAL CODE OF MARKETING OF BREASTMILK SUBSTITUTES**: Fully implement the Code with legislation and effective enforcement

3. **MATERNITY PROTECTION IN THE WORKPLACE**: Enact paid family leave and workplace breastfeeding policies

4. **BABY-FRIENDLY HOSPITAL INITIATIVE**: Implement the Ten Steps to Successful Breastfeeding in maternity facilities

5. **BREASTFEEDING COUNSELLING AND TRAINING**: Improve access to skilled breastfeeding counselling in healthcare facilities

6. **COMMUNITY SUPPORT PROGRAMMES**: Encourage networks that protect, promote, and support breastfeeding

7. **MONITORING SYSTEMS**: Track progress on policies, programmes, and funding

**CURRENT RATES AND TARGETS OF INDICATORS:**

- Donors contribute at least $5 per newborn to support
  - Current Percentage: 6%
  - 2030 Target

- Fully implements the Code of Marketing of Breast-milk
  - Current Percentage: 21%
  - 2030 Target

- Provides recommended maternity leave
  - Current Percentage: 12%
  - 2030 Target

- Over half of births are in Baby-friendly facilities
  - Current Percentage: 14%
  - 2030 Target

- Most primary healthcare facilities provide IYCF
  - Current Percentage: 61%
  - 2030 Target

- Most districts have community IYCF Programmes
  - Current Percentage: 50%
  - 2030 Target

- Breastfeeding programme assessed in the last 5 years
  - Current Percentage: 40%
  - 2030 Target

- Breastfeeding data collected in the last 5 years
  - Current Percentage: 48%
  - 2030 Target

**CURRENT RATES AND TARGETS OF BREASTFEEDING PRACTICES:**

- % of babies breastfed within an hour of birth
  - Current Rate
  - Target by 2030

- % of babies under 6 months old exclusively breastfed
  - Current Rate
  - Target by 2030

- % of children still breastfed at 1 year of age
  - Current Rate
  - Target by 2030

- % of children still breastfed at 2 year of age
  - Current Rate
  - Target by 2030

United Nations Children's Fund (UNICEF)
3 United Nations Plaza
New York, NY 10017, USA

World Health Organization (WHO)
Avenue Appia 20
1202 Genève, Switzerland

For more information and to join the collective:
www.unicef.org/breastfeeding
email: breastfeeding@unicef.org
www.unicef.org
www.who.int/en

Society of Hospital Pharmacists

Don't rush to crush

Pharmacists have a role in educating patients and other healthcare staff on the dangers of altering solid dosage forms.

"I am struggling to swallow my tablets, is it OK to crush them?"

As pharmacists, we are asked variations on this question frequently. Many patients are elderly, taking multiple medicines. Some are unable to eat normally and have enteral feeding tubes. So, we can expect these questions to continue, from both patients and healthcare staff.

This means pharmacists need to be proactive because many people who alter medicines either don’t seek alternatives or advice— we should be asking how they are managing their medicines.

There are a number of dangers inherent in altering solid dosage forms.

From a medico-legal stance, altering solid dosage forms to administer in a form not intended by the manufacturer is classified as “off label” use, with greater liability falling on front-line practitioners. It is important that solid dosage forms are only altered when this is the only available option, the risk and benefit have been thoroughly assessed and documented, the prescriber is aware, and the patient consents. Altering the dosage form may reduce stability, efficacy and palatability, and increase toxicity. Administering crushed medicine via an enteral tube also risks blockage of the tube. Off label use is not an exercise to be undertaken lightly. So what should we do?

Start with treatment review. Liaise with prescribers to minimise current medicines. Consider substitution with more suitable formulations or alternative drugs, taking into account PBS availability and affordability of potential options. Use of liquids, dispersible tablets, rectal or transdermal preparations may avoid the problem.

For the remaining medicines there are a number of issues to consider before altering the dosage form.

First, consider the release characteristics of the formulation. Only immediate release preparations should be crushed. If the solid dosage form is formulated as a sustained release product, designed to release the drug over an extended period of time, crushing it or opening up the capsule and chewing the granules may result in “dose dumping” — a tablet designed to release the drug over a 24-hour period, may release the whole dose over 30 minutes. This has the potential for serious toxicity and indeed deaths have been reported.

Of course drug coating is not always about prolonging release, enteric coating is designed to prevent the medicine being released in the stomach. This avoids destruction of the drug by stomach acid, or local adverse effects in the stomach. Crushing therefore results in either reduced efficacy or increased side effects, neither of which are desirable.

Liquids are often suitable for patients with tubes or swallowing difficulty, but may need diluting to aid administration or reduce intolerance due to high osmolality, or thickening in patients at risk of aspiration.

Second, consider side effects. If the drug is irritant, crushing may increase erosion in the mouth or oesophagus.

Finally, assess occupational safety.

Altering dosage forms exposes the handler to powdered drug that puts them at increased risk of toxic effects via inhalation and skin exposure. This is particularly a concern with cytotoxic agents, but also other agents such as hormones and antibiotics.

When dispersing or crushing, safe practices for administration should be adhered to. Always use oral dispensers, never syringes intended for parenteral use, due to the risk of administration error. Dispersing, if appropriate, may be preferable to crushing with less occupational safety issues and dosage loss.

Fortunately, there are excellent sources of information available to help us deal with these questions. The first edition of the SHPA’s Don’t Rush to Crush was released in 2008. A second edition is expected shortly, also available in electronic and mobile formats. It is an excellent source of information for medical, nursing and allied health staff on the suitability of Australian medicines for patients with swallowing difficulty or enteral tubes, and gives comprehensive guidance on correct administration procedures.

Pharmacists have a role in educating other healthcare staff on the dangers of altering solid dosage forms and the sources of information available to help manage these issues. Encourage staff and patients to ask for your advice, and consider altering solid dosage forms only when it is absolutely necessary and safe to do so.

References available on request.

Written by Carol Simmons, medicines information pharmacist, Fremantle Hospital and Health Service, WA
Help hearts run smoothly

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- May slow down recovery from illness
- May cause overdose

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Ethics & Health Care Beneficence

Beneficence is important to our understanding of the professional obligations health professionals have once a relationship is established with a patient, where a minimal duty to treat is set. Beneficence requires that the health professional acknowledges their duty to help others achieve their interests.

That said, under the principle of beneficence, the health professional must prevent harm, remove harm, do and/or promote good. In essence, the principle of beneficence is about doing good. As a result, Beauchamp and Childress identify several rules that fall under the principle of beneficence. These include: protect and defend the rights of others; prevent harm from occurring to others; remove conditions that will cause harm to others; help persons with disabilities; and rescue persons in danger.

Beauchamp and Childress make a distinction between general beneficence and specific beneficence. General beneficence does not refer to any specific relationship but encourages people to do good and help others with whom they are not in a special relationship. General beneficence is also referred to as ideal beneficence. Specific beneficence is obligatory beneficence. It refers to the positive duties to act health professionals have to further the patients important and legitimate interests. As health professionals, we owe a duty of specific beneficence to our patients, with whom we are in a special relationship, the therapeutic relationship. This means that as health professionals we must act in their best health and medical interests.

The question is who decides what is in the best interests of another person? The principle of beneficence has a long history that is rooted back to Hippocrates and the teachings of medical ethics. This led to what is called paternalistic beneficence, where it is assumed that the health professional knows what is best for the patient and therefore has the right to decide what they should do and what should be done because of their education and experience. Whatever the scenario, the health professional must always consider the wishes and wants of the patient. The duty of beneficence must be reasonable and acted upon in the context of duty to respect the autonomy of others. Health professionals should provide patients with the necessary information in order to be able to decide and act on the basis of reason.

This can potentially create two areas of conflict. The health professional, as the holder of the information, can determine what to share and withhold from the patient. Alternatively, the patient, after receiving the required information to decide based on reason, decides to act in a way that the health professional believes is not to be in their best interest. In this case, ethicists tend to agree that the act of interference is often justified, and the principle of beneficence can take precedence over the principle of respect for autonomy. This is an ethical dilemma that merits much more discussion and consideration.

In the healthcare setting we rarely care for patients remotely and therefore the good of one patient cannot be considered in isolation. As health professionals, while we have a duty to do good for each of our patients, we also need to be sure that in doing so we do not cause harm to other patients. In health care, the duty to do good, beneficence, is a duty to do good to all patients. This is where many may find a dilemma. The health professional may ask how can we do what is best for every person, without doing less good for another person? If patients have equal rights how can these be safeguarded, ensuring that each person is able to exercise their rights fully? In fact, the rights of one person may be restricted by the rights of another person.

In this scenario, the health professional must make the distinction of how to apply beneficence... 

Benficence... an ethical principle that addresses the idea that a nurse's actions should promote good

* continued on page 33
SECLUSION OF PATIENTS

1. When the seclusion of a patient becomes necessary, he or she shall be placed in one of the rooms specially provided for that purpose.

2. Seclusion shall be resorted to only when patients are in such a state of excitement as to be dangerous to themselves or to others.

3. No patient shall be taken into, or out of the seclusion room without the permission of the Superintendent, who shall initial each entry made in the return mentioned in Rule 91. This Rule states “A record shall be kept in the prescribed form in each division of all patients who have been placed in the seclusion room. The return shall be drawn up by the chief nurse, or the matron, and taken daily to the Superintendent who will place them before the Visiting Physician on each of his visits”.

4. The chief nurse or matron shall be present when a patient is placed in a seclusion room; and shall pay frequent visits to the patient in order to ascertain when he or she can be safely released.

5. In cases when the patients become suddenly violent, they may be placed in seclusion room at once; but the circumstances shall be reported without delay to the Superintendent.

6. Patients kept in seclusion shall be under the continuous surveillance of a nurse by day and night. The patient, however, is not to be disturbed in his sleep. No nurse shall enter the seclusion room unless he or she is accompanied by another nurse.

7. Nurses in charge of patients in the seclusion rooms shall exercise special care not to leave therein any article that might be dangerous to the patients.
Salvatore Borg Olivier Minister for Public Health who approved the Regulations for the Chambray Mental Hospital on 7th September 1933 for the Office of the Charitable Institutions who were responsible to administer the hospital.

7. A record shall be kept in the prescribed form in each division of all patients who have been placed in the seclusion room. The return shall be drawn up by the chief nurse, or the matron, and taken daily to the Superintendent who will place them before the Visiting Physician on each of his visits.

8. The regulations regarding the seclusion of patients shall be read to the nurses by the Superintendent, when they are first appointed and once a quarter; and the Superintendent shall occasionally test their knowledge of the regulations.

It is interesting to note that from 1933 to 1983 Fort Chambray was used as the first Gozitan Mental Hospital. This hospital was intended to accommodate persons both male and female who are affected with mental disease. Then it was transferred to the place where there is today the University of Malta – Gozo Centre and later in 1994 as a unit within the Gozo General hospital.

Ethics & Health Care Beneficence

Beneficence in the therapeutic relationship, and when considering their course of action towards a group of patients. The therapeutic relationship is the perfect climate for the health professional to implement the principle of beneficence. However, when dealing with a group of patients this becomes more challenging. In this case, the health professional must take the course of action that will be of benefit to the group of patients. This may require not fulfilling what one patient needs. Herein lays the challenge, as the health professional may feel that they are not fulfilling their duty of doing well for their patient. This requires an understanding of the relationship between the principle of beneficence and non-maleficence, which will be looked at more closely in the following issue.

Beneficence is a core value that is featured in the therapeutic relationship. Simply put, the duty of beneficence establishes a positive duty not to abandon the patient and to treat those in need. It needs to be acknowledged that these cannot be applied in a general sense even in terms of the therapeutic relationship and therefore a deeper understanding of this principle is warranted.

Marisa Vella

Please contact Marisa Vella on marisalvella@gmail.com for references and information related to this article. Join the group Ethically Speaking on Facebook.
Healthy skin is very important in our general well-being, since it acts as a means of protection against external influences on the body and prevents excess moisture loss. During incontinence, the skin is exposed to additional stress due to several factors which affect its normal functions. A moist skin environment, often caused by the use of occlusive incontinence products, leads to swelling and maceration of the stratum corneum. Additionally, the formation of highly alkaline ammonia also attacks the acid protection mantle, thereby further weakening the skin's barrier functions. Faeces containing traces of digestive enzymes, can also attack the skin. Frequent and thorough cleansing with standard detergents, or normal soaps, further damage and leave a longer-lasting negative effect on the skin. Alkaline detergents modify the acid content within the skin, weakening the regeneration function of the acid protection mantle. Such detergents also wash off valuable epidermal lipids, natural moisturising agents which support the elasticity and barrier function of the stratum corneum and the prevention of internal moisture loss.

Specially designed skin care systems, that are effective in maintaining elderly skin integrity, have been developed. It is estimated that about two thirds of skin irritations and problems in elderly, can be avoided by the use of suitable cleansing, caring, and protection products. The University of Iowa Hospitals and Clinics recommend that care for elderly skin requires the use of special care products designed to provide protection and help replenish lost moisture. The Agency for Health Care Policy and Research (AHCPR) guidelines advise the use of non-alkalinic, mild cleansing agents to minimize irritation and dryness and to better maintain the skin's protective acid mantle. The use of moisturisers, such as lotions and creams, in order to maintain the skin's suppleness and pliability is essential. Proper barrier preparations should be used to protect the skin against irritation, such as during incontinence. The use of powders for this purpose is not recommended since they will be washed away with the next incontinent episode. It is therefore necessary to protect the skin by using specifically designed barrier products which form a protective layer on the skin whilst also not interfere with the absorption of fluids of incontinence devices, such as diapers, being used concurrently. This formulation constraint is very important, since certain barrier formulations tend to deposit onto the top layer of incontinence absorbent devices, blocking the passage of fluids into the central core, thus lengthening the time of exposure of the skin to the excretory products.
Specially designed professional skin care formulae usually include the use of components such as:

- **Panthenol**, which restores oils, transports moisture into the skin and ensures that it is bound within the skin.
- **Creatine**, which stimulates the energy exchange rate of skin that declines with age, thereby supporting the skin's natural functional mechanisms. It also forms a protective film around the skin cells and protects them from external attack.

Such skin care formulae should ideally have a skin-balanced pH value of 5.5 and be dermatologically tested. In the elderly, the skin easily dries out and becomes less elastic since the ability to produce moisture-storing epidermal lipids is reduced. The skin’s acid protection mantle, an important defense against bacteria and germs, becomes increasingly unstable and a longer recovery period is necessary. Therefore, ideally a good quality formula should also contain nutritive components in order to aid the skin to regenerate and recover from injuries. Such components often include:

- **Essential fatty acids**, essential nutrients for skin cells; important for the skin barrier
- **Amino acids**, important precursors of the “natural moisturizing factor”
- **Almond oil**, a rich source of natural essential fatty acids which also has emollient properties

**Therefore, the main 3 challenges**, to be addressed in order to maintain skin integrity, and their solutions are:

**Challenge 1: How to limit chemical stress of frequent washing**

**Solution:** By using specifically designed formulations which provide thorough but mild cleansing. Such products include: Cleansing Foams, Cleansing wipes, Wash/bath lotions, and shampoo.

**Challenge 2: How to fight attacks of urine and faeces on the skin**

**Solution:** By using specifically designed barrier formulations which provide uncompromising and active skin protection. Such products involve barrier creams and barrier foams.

**Challenge 3: How to meet elderly skin’s need for moisture and lipids**

**Solution:** By using specifically designed formulations which provide moisturising and lipid-replenishment. Such products include: Body Lotions, Hand Creams, Massage Gels and Skin Care Oils.

Preservation of skin integrity in elderly persons is a continuous challenge, especially during incontinence. The use of professionally developed continence absorption products is essential but often not enough on its own. This is where specially designed skin care products can complement the use of good quality diapers/pull-ups/pads in supporting skin integrity. When developing an individualised care plan, it is very important to consider factors such as present skin condition and integrity, ease of product application and removal, and cost. Hence, selecting a “universal” preparation for cleansing, moisturising and barrier protection is not an ideal solution. Recent research and the clinical practice guidelines published by the Agency for Health Care Policy and Research (AHCPR), recommend proper selection of topical agents, i.e., cleansers, moisturizers and topical barriers; to assist caregivers in developing a comprehensive approach to elderly skin care.

**Going further for Health**

**Because elderly skin needs special care... Active skin protection**

Tanya Carabott, P.Q.Dip.HSc (Mgmt)

For more information and to receive the references please contact: tcarabott@alfredgera.com
L-Ewwel Parti - JOE CAMILLERI, CN

“Ejjew ghad-dieta”


Kien żmien meta n-nurses ma kienux jghidu “dan mhux xogholna”, anzi bil-maqlub, kien parti ntegrali minn xogholna. Kien żmien meta n-nurses ma kienux jghidu “qegqassam it-treatment”. M’hemmx skużi, it-tqassim u tmigh tal-ikel kien xogholna wkoll. Ma rridx inkun polemikuż imma donnu dawn id-dmirijiet báziċi lejn il-marid qed niskartawhom. Back to basics?


U min ma jiftakarx il-breakfast? Bajd mgħoll, bajd iebeż, hobż tal-Malti jew tal-Franċiż, butir u ġobon, bela’ tæjba jew kafė. Ma kienx għadu daħal il-comflakes u l-wheatabix. Anke l-ghasir tal-laring għall-habta tal-10.00a.m. donnu spićċa. Il-juices tal-laring sarp aktar konvenjenti. It-tæ u l-kafė ta’ waranofsinhar (kulant b’xi biċċa cake) u fil-ghaxija ma kienx jonqos lanqas. F’xi sjuf fis-swali, fl-eqqel ta’ ġranet shan jaqlu l-ankri kien anke jitqassam
I-ilma kiesan bis-silg, kultant imnallat bl-orange. Ta’ qabilna kienu jemmnu wkoll fiI-famuz egg-flip; 1=talib, bajda jew tnejn, zokkor u kultant whisky jew brandy, li kien jinghata “ghal min ghandu bzonn isostni ruħu” (anzjani, dawk xipiċi eċċ). "Il-ktieb tad-dieta" kien registru fejn konna nniżlu min se jiekol x’hiex, jekk hux dijabetiku, liquidised eċċ. Kien jinżamm b’mod metikoluż għalkemm ma kienx jidhol f’xi dettal partikolari dwar il-konsistenza tal-ikel u x-xorb. Anke l-Istudenti dak iż-żmien konna nduru l-pazjenti u nsaqsuhom xi jridu.


M’ghandniex xi nghidu, dejjem bil-permess tat-tabib. Xi kultant anke l-Gran Mastro nnifsu kien imur is-Sacra Infermerija “biex iservi l-morda biex jonora id-dmir tieghu bħala Ospedaller Religjuż u biex jagħti eżempiu tajjeb lill-ohrajn”. U dan mhux biss, l-ikel kien jiġi servut fi platti tal-fidda!

Fil-harġa li jmiss, it-Tieni Parti tal-artiklu jitratta t-tmigħ tal-marid skont l-ewwel manwal tan-Nursing f’Malta miktub mit-Tabib Galizia fl-1904.

Għal aktar informazzjoni u biex tirċievi r-riferenzi kkuntattja lil: mumn@maltanet.net
Social Security Benefits in Malta in 2017

TAPERING OF BENEFITS(UAT)

Social Assistance Beneficiaries who find employment can opt for the Tapering of Benefit scheme if they earn at least the National Minimum Wage or more and if they have been in receipt of assistance for at least two years in the last three. This is also applicable in the case of spouses of beneficiaries who find employment. In this case the Social Assistance of the beneficiary will be tapered accordingly.

Yet Single parents with children under 23 years of age, can get Tapering of Benefits as long as they work at least ten hours of work at the National Minimum Wage rate per hour. They also do not need to have two years assistance in the last three years.

As another measure in the last Budget 2015, single mothers who marries or enter into a civil union and whose spouse is employed and earning at least the National Minimum Wage or over, will get their social assistance tapered as well.

If a person qualifies for Tapering of Benefit, he will get 65% of the benefit for the first year, 45% for the second and 25% for the third. The employer will also qualify for 25% for the three year duration if employment is on full time basis and 12.5% if part time. This is a one time measure, yet a person who is made redundant after a year and applies again and qualifies for assistance can opt to continue the two years left as tapering if he is employed again.

MEDICAL AIDS GRANT (KNOWN AS THE PINK FORM)

The capital means test is now the same as that of Social Assistance and Age Pension.

- Single person must have less than €14000 capital
- Married couple must have less than €23300 capital

There are two different income tests following the capital means test namely for employed and non employed.

- Persons in receipt of Age Pension, all types of Social Assistance and Carer's Pensions are given the Pink Form automatically if they present a medical prescription from a GP.

The means test for employed persons is done by adding the weekly wage/s less the National Insurance Contribution to any other income. If this is over €151.13 in the case of a single person and €159.28 in case of a couple then request will be rejected. If there are children in the household, we add €8.15 to the single rate.

The means test for non employed persons is done by adding the pension, maintenance and all other income. If the person is single and amount is more than €158.84 the request will be rejected. If the household consists of a couple, the amount must not exceed €182.75. For every child in the household who is not employed we add another €8.15 to the respective rate.

SCHEDULE 5 (YELLOWCARD)

The department of social security does not cater for the issue of the yellow card. It is prescribed by the Specialist mainly from Mater Dei when a patient is diagnosed with a chronic illness and need to take medication all life long. The card is issued and renewed by the Health Department.

SICKNESS ASSISTANCE (SKA)

Persons who suffer from chronic diseases which are mentioned in the Social Security Act and satisfy the means test similar to that of Social Assistance will be awarded this benefit after being assessed by a Medical Panel.

Persons who are in receipt of a Non Contributory Benefit will qualify automatically if he qualifies medically.

In case of pensioners, a person must not exceed the amount of €21.66 in the case of a single person. The access over the National Minimum Pension only is considered plus all other income. The same capital threshold of €14000 (single) and €23300 (married) applies.

Weekly rate for one person €25.63.
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