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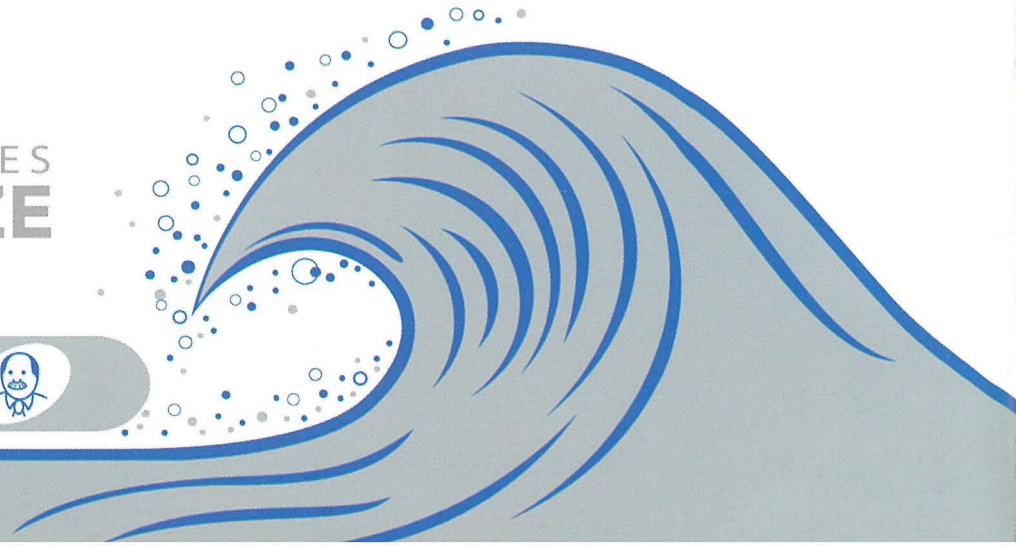
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L-MUMN ma tistax tinzamm responsabbli għal xi f'sara jew konsegwenzi oħra li jiġu kkwazati meta tintuża informazzjoni minn dan il-ġurnal.

L-ebda parti mill-ġurnal ma tista' tiġi riprodotta minghajr il-permess bil-miktub tal-MUMN.

Ċirkulazzjoni: 4,000 kopja.

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

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Disruptive patient behaviour

Hospitals are presently overwhelmed with disruptive patient behaviour, with escalation to violence becoming an increasing concern. The A&E Department, Admissions Units and Medical wards are particularly high-risk area.

Every day nurses and healthcare providers are victims of verbal and physical violence. But disruptive behavior occurs in nearly every practice setting. This is because there are growing problems including deteriorating social controls, patient feelings of entitlement, patient impairment (drugs, alcohol, psychiatric), stress of illness, treatment waits and delays, and strained medical environments. Alcohol withdrawal, confusion, agitation and delirium are also other examples.

Excessive drinking or some form of abuse is also another concern as at present A&E staff are inundated and overwhelmed by 'patients' in need of treatment either due to alcohol or drug abuse. Particularly such patients are drunk or manifest erratic behaviour during or after a wild night out.

It is important that we establish a therapeutic relationship from the initial contact with such patients, as this can help avoid disruptive behaviour. We should address any issues as soon as possible and offer a blameless apology. Disruptive patient behaviour is on a continuum from irritation to violence. The nurse or any healthcare provider needs to de-escalate patients and/or families' behaviours early before they progress to violence.

We should identify what is unacceptable, to avoid the "normalcy of deviancy". For instance, allowing screaming or threatening staff gives the impression that this behaviour is acceptable. If a patient progresses to a level of aggression, safety is our key concern.

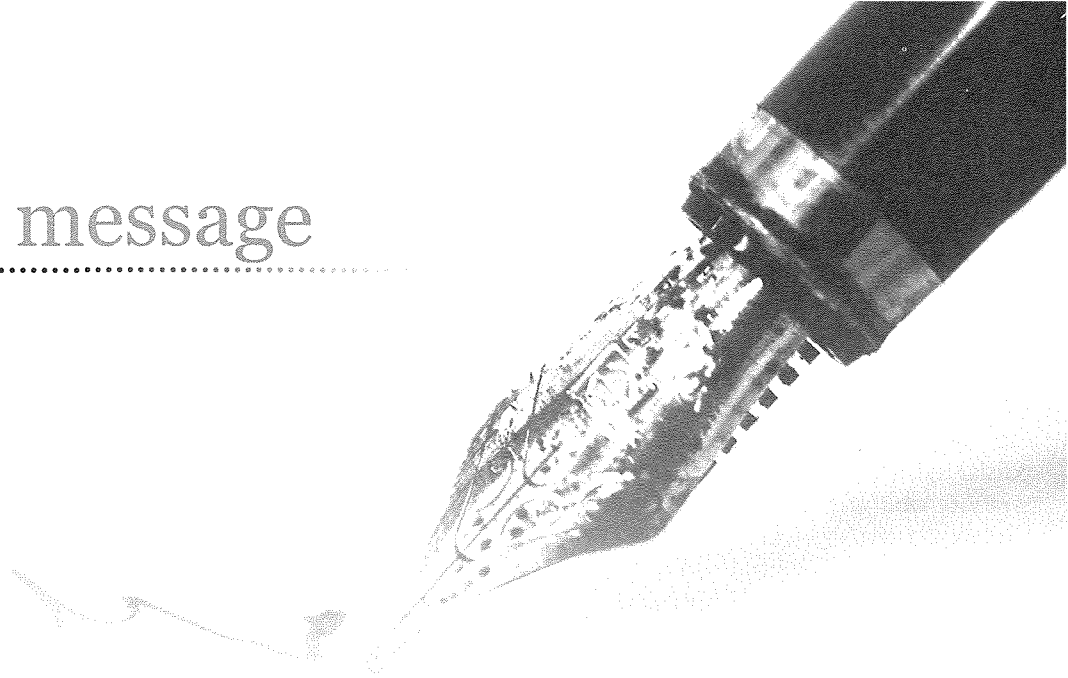
Some examples of disruptive behavior are verbal abuse such as name-calling, racial or ethnic epithets, sexual harassments, loud or profane language, threats, possession of weapons and excessive emotions.

All staff must be trained in customer service. One must watch for signals that may be associated with impending violence such as body language, signs of alcohol and anger. Staff must also be aware of the Hospital Violence Policy, Gender Equality and Harassment Policy, Constant Watch policy, the use of the panic button, alerting hospital security, alerting the police and incident reporting.

Guidelines must be clear, simplified, sensible and with no bureaucracy. The interpretation of policies is sometimes unclear and different entities interpret the policy differently or set up their internal guidelines which are in conflict of the policy. This should stop.



President's message



Dear Colleagues,

Welcome to the September edition of 'Il-Musbieh'. Wow! Time has flown by! I hope everyone had a great summer and enjoyed some time with families and friends. As I write this message, I realize that this has been another summer full of challenges; and as such this edition will feature some insightful updates of our work during the past few months.

To me September often brings energy to gear up and start routines back up again, while Autumn, is a season for reflection and introspection. September signals a shift for nearly all MUMN members in one way or another; as the new academic year begins. Most obvious, members who have children (or grandchildren) in school will be affected by the change in schedule and the hectic life attributed to this. Similarly, members who teach in an academic setting will be organising and preparing lectures.

Moreover, the academic calendar will affect our members who are in the clinical setting as health care professional students will have their clinical placements. During these experiences, we as professionals will have the opportunity to help students optimize their educational experience, while assisting them to socialize into a disciplinary culture. These clinical experiences will provide us healthcare professionals with opportunities to reflect on our own practice and to develop a network

of enabling relationships – so do make the best of these professional opportunities.

As a midwife, I believe that reflective practice is a key skill for healthcare professionals and it can make a difference in each respective clinical setting. As I sat down to write this edition's message, I quietly reflected on the work done by the MUMN during the last 3 months. I was overwhelmed by the work we did; and while reflecting I could feel that there were times with chaotic moments.

.....

The MUMN ongoingly is investing heavily on different approaches to analyse the current staffing levels, define staffing requirements, while at the same time we're determining the future staffing needs. In many cases where we conducted staffing levels studies, we asked respective members of the MUMN to support us.

.....

In June there was a breakdown of negotiations on the sectoral agreement for nurses and midwives. Thus, the MUMN has issued a series of directives; which were followed by nurses and midwives. During

this time, we asked you as MUMN members to respond to calls for action and as always, our voice was heard. On reflection I can proudly say that the MUMN could not function well without its group committees, whose members contribute their time, talents, expertise and energy to these important activities. I am also proud to see that the MUMN has many hardworking prodigious members whose efforts contribute to the greater good of our union.

On behalf of the MUMN council members and group committee members allow me the opportunity to humbly thank each one of you for all the support and collaboration. Following the directives issued in relation to the sectoral agreement for nurses and midwives, the MUMN officials had a series of meetings with the Administration which resulted in effective negotiations. We are now waiting for the Administration to give us the draft of the sectoral agreement so that after it will be reviewed by the council members, an extraordinary meeting for nurses and midwives will be called.

As a union we continued with our day-to-day trade union work and we look forward to continuing the negotiations of the Sectoral agreement for the physiotherapists; while at the same time kick start the draft proposals for the social workers. Our industrial relations' work is a work in progress and the

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Kelmtejn mis-Segretarju Ġenerali

Dieħlin fl-aħħar tlett xhur tas-sena fejn jidher li ser ikunu x-xhur li se jissigjillaw is-snin ta' preparazzjoni, diskussjonijiet u thejijiet li saru sabiex nilhqu qbil mal-Gvern fuq Ftehim Settorali ġdid.

Għalkemm il-Ftehim isir mal-Gvern fuq in-Nurses u l-Midwives li jaħdmu fis-Servizz Pubbliku, awtomatikament jibbenefikaw minnu wkoll dawk in-Nurses u Midwives li jaħdmu fis-Settur Pubbliku u dawk tal-PPP kif ukoll, indirettament, dawk in-Nurses u l-Midwives li jaħdmu fis-Settur Privat. Dan peress li minħabba li hawn nuqqas ta' Nurses, is-settur privat ikun irid jattira l-aqwa Nurses u jzomm li għandu, u għalhekk il-kundizzjonijiet tax-xogħol u s-salarju jkunu jirriflettu dawk tal-Ftehim il-ġdid.

Sakemm qed nikteb dan l-artiklu, konna għadna qed nistennew it-*text* uffiċjali min-naħa tal-Gvern biex dak li ftehmna fuqu waqt in-negozjati, ikun rifless f'dokument uffiċjali. Naturalment, hekk kif nircievu dan id-dokument, il-Kunsill tal-Union jiltaqa' mill-ewwel biex janalizza l-kontenut tad-dokument. Jekk ikun hemm xi punti li jkun differenti minn dak li ftehmna fuqu waqt il-laqqgħat, ikun hemm il-ħtieġa li ssir laqgħa oħra ta' kjarifikazzjoni però jekk kolloxx ikun sew, allura jibdew mill-ewwel il-preparamenti biex tissejjaħ Konferenza Ġenerali Straordinarja sabiex il-kontenut jiġi spjegat lill-membri u jivvutaw fuqu.

Fil-mument li jiġi konkluż il-Ftehim tan-Nurses u l-Midwives, il-Gvern ikompli d-diskussjonijiet fuq il-Ftehim li hemm involuti il-Physiotherapists. F'dawn l-aħħar 11-il sena dejjem hekk sar u din id-darba mhux ser tkun eċċezzjoni.

Fil-mument l-MUMN għaddejja wkoll bil-preparamenti tagħha biex tissottometti d-dokument għall-Ftehim Settorali ġdid tas-Social Workers. Wara li l-Gvern laħaq Ftehim mas-Social Workers ta' l-Appoġġ, issa

jmiss li jintlaħaq Ftehim mas-Social Workers tas-Servizz Pubbliku.

Dan ix-xahar reġa' kellna s-so-disfazzjon li niltaqgħu ma' ħafna min-Nurses il-ġodda. Tieħu gost tara l-uċuh ferħana li rnexxielhom jagħmluha u herqana sabiex jibdew issa jaħdmu mal-pazjenti, mhux aktar ta' studenti imma ta' Nurses. F'isem l-MUMN nixtieq nawguralthom kull suċċess fil-karriera tagħhom.

Dan ix-xahar ukoll intlaħaq Ftehim mal-Gvern sabiex dawk in-Nurses li jkun *mentors* tan-Nurses barranin li jiġu allokatu mill-Council, jibdew jithallsu tal-*mentorship* tagħhom. Dan il-Ftehim wasal wara numru ta' laqqgħat li l-MUMN kellna mal-Kunsill Regolatarju u se jkun qed jikkumplementa l-Ftehim li lhaqna aktar kmieni din is-sena dwar il-*mentorship* tal-istudenti ma' l-Università ta' Malta u l-Università ta' Northumbria. Kif qed insemmi dan il-punt nixtieq nieħu l-opportunità sabiex ninfurmakom li ftit tal-granet ilu kellna laqgħa pożittiva ħafna ma' dawn iż-żewġ universitajiet u reġa' ġie kkonfermat il-Ftehim li ntlahaq ftit tax-xhur ilu fejn il-ħlas huwa ta' €1000 għal massimu ta' 4 studenti u li l-ħlas ser isir f'Diċembru li ġej.

F'Novembru li ġej, il-Florence Nightingale Benevolent Fund ser jorganizza ċ-ċerimonja annwali ta' apprezzament, gratitudni u ħajr lil dawk il-membri ta' dan il-Fond li jkunu irtiraw mix-xogħol. Din iċ-ċerimonja ssir fil-Palazz ta' San Anton fejn l-E.T. President ta' Malta b'ġenerożità kbira mhux biss taċċetta li norganizzaw din iċ-ċerimoja u l-quddies fil-Palazz, iżda wkoll tagħtina l-lok li nużaw l-apparat necessarju u thejijna bibita apposta għall-okkażjoni.

U hawn ukoll tkun tista' tara s-sodisfazzjon fuq wiċċ dawn il-membri li jkun irnaxxielhom jaslu f'din il-fażi ta' ħajjithom, liema fażi kienet tidher 'il bogħod ħafna meta bdew

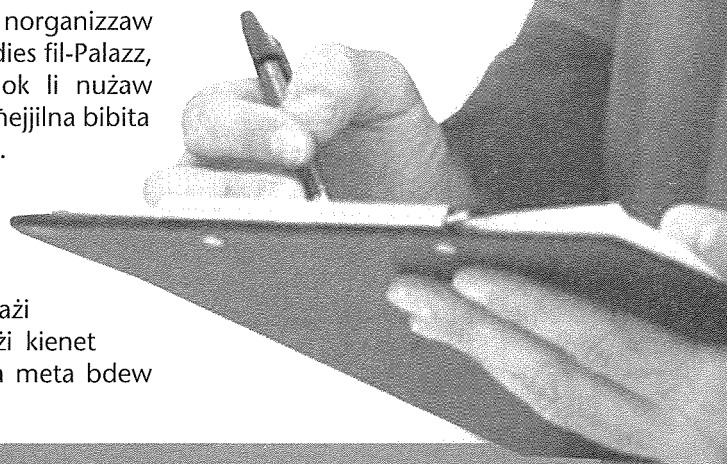
il-karriera tagħhom.

Għalkemm kull sena jilhqu ammont ta' Nurses ġodda, xorta għandna nuqqas kbir. L-ammont li jilhqu jkopru dawk li jirtiraw filwaqt li s-servizzi ġodda jkomplu jzidu n-nuqqas. Bħal ma tistgħu tapprezzaw l-MUMN ma tistax tipprovi n-Nurses peress li aħna m'aħniex il-Management imma Union però nistgħu nħarsu s-saħħa u s-sigurtà tiegħek billi taħdem b'*safe practice*. Dan isir billi nagħmlu analiżi tal-prattiċi tiegħek u nieħdu dawk id-deċiżjonijiet meħtieġa kif diġà sar f'ħafna okkażjonijiet.

Għal din il-ħarġa ser nieqaf hawn għaliex għedna biżżejjed. Nixtieq ninfurmakom li l-Christmas Dinner ser isir fil-15 ta' Diċembru ġewwa ix-Xagħra Lodge fir-Rabat peress li kellna talba ġenerali biex nerġgħu norganizzaw l-attività tal-Milied f'dan il-post.

Napprezzaw jekk tagħmlu nota biex tat-tendu anki biex niċ-ċelebraw flimkien il-Ftehim Settorali l-ġdid. Min ikun irid jibbukkja bħala sala jew *unit*, tistgħu wkoll għaliex nirservavalkom mejda apposta għalikom.

Colin Galea
Segretarju Ġenerali





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council members together with the industrial executive committee will strive to be a sustainable, member-led organisation with the capacity to deliver our mission effectively, efficiently and in accordance with our values and core objectives.

And this leads me to the next insight I would like to share with you. As we informed you on several occasions, the MUMN ongoingly is investing heavily on different approaches to analyse the current staffing levels, define staffing requirements, while at the same time we're determining the future staffing needs. In many cases where we conducted staffing levels studies, we asked respective members of the MUMN to support us. As their tasks are completed, I would like to take this opportunity to publicly acknowledge the impressive work conducted by these members. On this regard I cannot thank you enough for your tremendous support while compiling the data. With the help of these members, till present day we compiled data from wards at KGH, GGH and MDH.

We can proudly say that we have the first finalised report on one of the wards at MDH. Data compiled on this ward indicate that there is shortage of staff and lack of skill mix. We look forward to publish the reports of the other wards in the coming weeks. The MUMN will continue to advocate for adequate staffing levels as adequate staffing levels can reduce workplace stress and burnout, improve employee morale and satisfaction, lower employees' turnover and increase customers' satisfaction. For years, the MUMN has been urging governments and health administrators to heed existing evidence that links appropriate staffing to better patient outcomes as well as balanced budgets.

On another note as we regularly update you, the Institute of Health Care Professionals (IHCP) within the MUMN from time to time launches new learning opportunities. As you might be aware, the IHCP develop significant relationships

with our members, and strive to make continuous professional development and education more fully accessible. Another recent milestone and accomplishment made by the IHCP is that during the past few months it organised a 4-ECTS course accredited by the University of Malta. I can proudly say that the participants who attended this course excelled both in their assignments and their presentations. This course will be organised again in Gozo next October. May I also take the opportunity to remind you that in October we will be having our conference 'Death and Dying: Supporting the Journey', and that currently there is a call for abstracts for the Commonwealth Nurses and Midwives Federation Regional Conference to be held in Malta next March. I look forward to seeing even more of our members at our upcoming events!

As I sat down to write this edition's message, I quietly reflected on the work done by the MUMN during the last 3 months. I was overwhelmed by the work we did; and while reflecting I could feel that there were times with chaotic moments.

Before I conclude, I would like to say congratulations to all the students who finished their studies, and best wishes goes for those who enrolled for pre – or post-graduate courses. Best of luck goes to the newly graduates who started a career in the healthcare professions - may they have an exciting and rewarding career.

In closing, I am extremely thankful for the wonderful work you do. Until next time.

Warmest regards,

Maria Cutajar
MUMN, President

My pectoral cross

Some time ago, after a very hectic night at work where I could hardly recollect myself in peace, I had at least a chance to have a good look at my hospital tag. Strange as it may sound the first word that crossed my mind while watching it was pectoral cross.

The wikipedia entry on the subject made me more enthusiastic in engaging myself in this query. My search gave the following result: "A pectoral cross or pectorale (from the Latin pectoralis, 'of the chest') is a cross that is worn on the chest, usually suspended from the neck by a cord or chain. In ancient and medieval times pectoral crosses were worn by both clergy and laity, but by the end of the Middle Ages the pectoral cross came to be a special indicator of position worn by bishops, and the wearing of a pectoral cross is now restricted to popes, cardinals, bishops and abbots".

Obviously, I am neither an abbot, nor a bishop, a cardinal or, much and much less, a pope. However, the tag I wear as a hospital chaplain, as a clergy man that is working within a lay context, does yes conduct me to the reality of the pectoral cross. Or else, to that identification which, in a hospital milieau, is not simply an identification but, and not to my worth as much as to the worth of the institution I lovingly represent, the identification.

In my hospital tag there are three aspects which made me reflect more thoroughly regarding the great significance of my pectoral cross. These three dimensions are: Mater Dei (the Hospital I work in), my name (Fr Mario Attard) as representing the Franciscan Capuchin Brothers, and, lastly, the hospital chaplaincy profession.

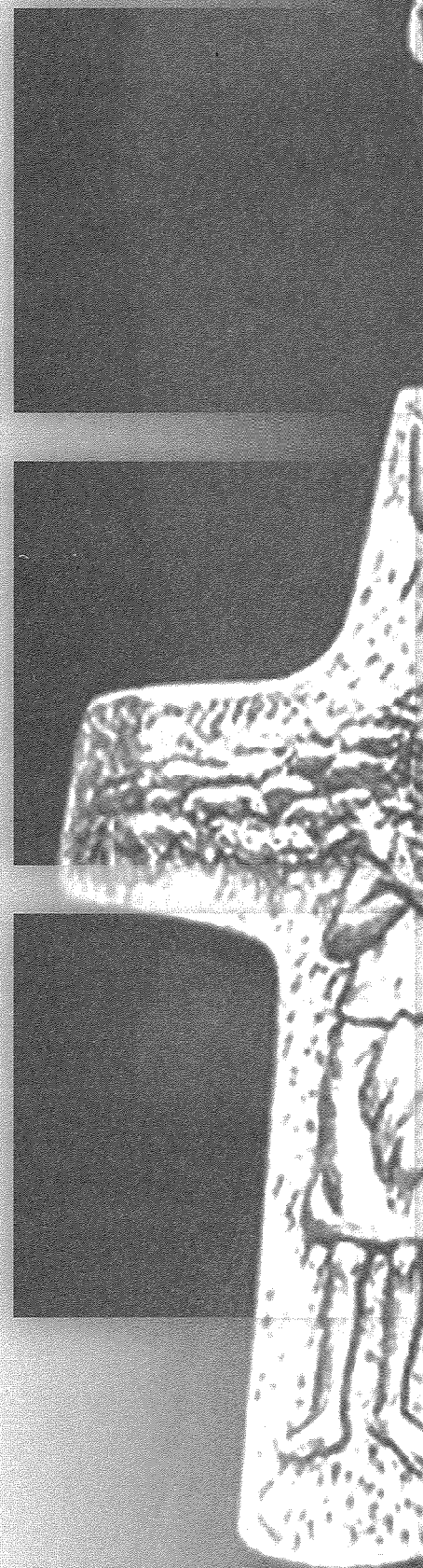
One of the titles given to Our Lady Mary, Mater Dei, the Mother of God, is to be found in the famous Litany of Loreto. Here Our Lady is revered as Health of the Sick. Her humble and faithful cooperation with God's saving plan to redeem us humanity, brought her to fulfil her duty as daughter, wife and mother. In each of these relationships Mary did indeed serve as an Angel of God's Mercy.

In fact Mary took good care of

her parents, Saint Joachim as well as Saint Anne. She sat by their sick-bed while holding their hands at the our of their passing from this world to the next. Mary was an Angel of God's Mercy even more so with Joseph. The latter had the grace of having Jesus and Mary sitting by his death-bed. No wonder than that he earned the mission of being Patron of the Dying. Mary stayed by Joseph till his very last breath. She caringly wet his parched lips, smoothed his pillow, kept vigil through the night, folded his hands, and closed his eyes when he passed away. In memory of her faithful love towards her husband Joseph to the grave Mary is honourably remembered as "Health of the Sick".

As the Mother of the World's Redeemer Mary was consecrated as "Health of the Sick." Even if Jesus was immune to sickness and death, but, for us and for our salvation, He willingly let himself be struck as a leper, and He was put to death, who can really fathom the source of strength Mary was to Her Son Jesus in His dereliction, in His scourging, in His crowning with thorns, in His way of the Cross, and ultimately, in the three-hour passion and death? It is interesting to note that each and every line of the Stabat Mater stands as a commentary on Her title – "Health of the Sick," with its concluding prayer for a happy death, applying to us: "Christ when Thou shalt call me hence, be Thy Mother my defense; be Thy Cross my victory. While my body here decays, may my soul Thy goodness praise, safe in Paradise with Thee." Let us also consider that "Health of the Sick" (Salus Infirmorum) primarily signifies our eternal health, our eternal salvation— for salus implies not merely "health," but "salvation."

In this regard suffices to mention what Saint Thomas More wrote, in his book *The Dialogue of Comfort Against Tribulation*, whilst he was





in prison awaiting for his eventual execution: "How many men attain health of body, that were better for their souls' health their bodies were sick still". Thus, fully conscious of the eternal benefit that our souls get when they are saved, Mary is rightly concerned with what is profitable for the soul's salvation. Yes, Mary desires our bodily health. Otherwise what sort of Mother will she be for us? However she takes care of our full integral healing. In other words, her maternal love drives her to will and do everything possible for her to see us healed spiritually. That is why that great French abbot and the primary reformer of the Cistercian order who had a special devotion to the Virgin Mary, Saint Bernard of Clairvaux, ardently wrote to Mary in one of his beautiful tributes to Her: "O Mother of God, Thou dost not disdain a sinner, however loathsome he may be: if he send up his sighs to Thee, Thou wilt deliver him with Thine own hand from despair."

Finally, Saint John Paul II's Prayer to Mary, Health of the Sick, written within the context of the Great Jubilee of the year 2000, highlights this integral healing of both the physical and the spiritual, thanks of course to Mary's powerful and maternal intercession.

"O Virgin Mary, 'Health of the sick', you who accompanied Jesus on the way to Calvary and remained near the cross on which your Son died, participating intimately in his suffering, take our suffering and unite them with His, so that the seeds sown during the Jubilee continue to produce abundant fruits in the coming years. Most tender Mother, we turn to you with confidence. Obtain from your Son the strength to return soon, completely restored, to our duties, so that we be useful to our neighbour through our work. Meanwhile stay with us at the moment of trial and help us to repeat everyday with you our yes, sure that God will bring out from every evil a greater goodness. Immaculate Virgin, may the fruits of the Jubilee Year be for us and for our dear ones a pledge of renewed vigour in Christian life, so that in the contemplation of the Face of the Risen Christ we will find the abundance of the mercy of God and the joy of a more complete union with the brethren, the beginning of the joy

without end in heaven. Amen".

Mary's continued intercession is pivotal for us to persevere in what is good and true. So we eagerly pray this ancient prayer: "Holy Mary, Mother of God, pray for us sinners now and at the hour of our death. Amen".

The second element which emerged from my hospital tag was my name. As I said already I work as a hospital chaplain not on my own account. I have been sent here by the obedience given and reconfirmed to me by my superiors. The Franciscan Capuchin Order has a long-standing tradition of working with the sick. It is enough if one mentions the example of Saint Francis, our Founder. In his Testament, which scholars consider it as being dictated by the Saint and served only as a "remembrance" or "admonition" to the future brothers of the Order, our Seraphic Father Francis thus confides: "The Lord granted me, Brother Francis, to begin to do penance in this way: While I was in sin, it seemed very bitter to me to see lepers. And the Lord Himself led me among them and I had mercy upon them. And when I left them that which seemed bitter to me was changed into sweetness of soul and body; and afterward I lingered a little and left the world". Therefore, for Francis, meeting the sick (the lepers) meant brought in him an inner transformation.

In the VI Plenary Council of the Capuchin Order, which dealt with the theme Living Poverty in Brotherhood, its fifth proposal read the following: "Within the Franciscan movement the Capuchins have placed particular emphasis on austere simplicity in their manner of living poverty and closeness to the people in practicing minority (preaching to the people, serving the sick and plague victims, questing...). These values, when they are lived in brotherhood, renewed and encultured, are a powerful witness to the gospel and a stimulus for the advancement of the weakest people". Throughout our Capuchin history, people like Fra Matteo da Bascio, Fra Mattia da Salo, Fra Bernardino Ochino, Saint Felix of Cantalice, Fra Anselmo da Pietramolara, Fra Paolo da Salo, Frère Eusebe d'Embrun, Fra Giuseppe da

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Ferno, Fra Serafino da Montegranaro, Frère Jean-Baptiste de Sillery, and, practically in our times, Saint Pio of Pietrelcina, all displayed an outstanding loving service for the sick. One of the greatest spiritual counsels given by Saint Pio, which personally builds me up as a Capuchin Hospital Chaplain whenever I reflect upon it, runs as follows: "Giving the benefit of your charity to all without distinction, from the most well-off to the poorest, administering to all, in generous measure..."

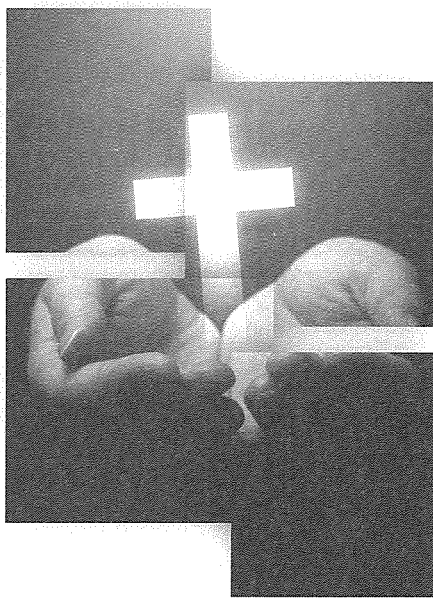
Again, in the VII Plenary Council of the Capuchin Order, which reflected on the Capuchin Fraternal Life in Minority, in proposal 38 we find again an insistence on working as a hospital chaplains as a vivid expression of our Gospel Franciscan minority and a credible sign of obedience to Mother Church.

"As a lesser brother, Francis always sought to combine obedience to the gospel with obedience to the Church, the community of the baptized. His insight was to understand that the gospel was inspired and born in the Christian community (cf. Circular Letter 22, 'The Courage to be Minors'). In this sense it was an earnest response to the invitation of the crucified: 'Francis, go and repair my Church, which as you see is falling into ruin' (LMj,II). In the Testament of Siena he states: 'Let them always be faithful and submissive to the prelates and to all the clerics of Holy Mother Church'. We recognize as an essential expression of our minority heartfelt, co-responsible obedience to the Church and her ministers. Indeed, we express our belonging to the Church in a tangible way when, inspired by the gospel, we make ourselves available to serve the entire People of God.

In this way let us remain sincerely available to serve the local and universal Church, working in harmony with its pastors (Test 8-10). We should give priority to ministries that are more in keeping with our vocation as minors, assuming pastoral commitments on the boundaries, especially ministries that are least sought after in the Church, where we can more easily manifest compassion and closeness to people, whether in out-of-town parishes, hospital chaplaincies and

ministry to the sick or marginalized who suffer poverty in forms old and new".

The Spirit of God showed Francis that charity begins at home. God's Word is crystal clear about this. "And let us not grow weary in well-doing, for in due season we shall reap, if we do not lose heart. So then, as we have opportunity, let us do good to all men, and especially to those who are of the household of faith" (Gal 6:9-10). The Capuchin brothers' heroic love towards the sick has to be an outward expression of their mutual caring especially when one of them falls sick. In fact, in its sixth chapter concerning the sick brothers within the fraternity Saint Francis makes the subsequent exhortation: "And wherever brothers meet one another, let them act like members of a common family. And let them securely make their needs known to one another, for if a mother loves and cares for her carnal son, how much more should one love and care for his spiritual son? And if one of them should become ill, let the other brothers serve him as they themselves would like to be served".



Fully attentive to Saint Francis' undying words in his rule the VIII Plenary Council of the Order of Capuchin Friars Minor on The Grace of Working, says in proposal 43 and 44:

"One of the most marginalized groups in our society is the sick. We recognize the value of the presence of sick brothers in our fraternities.

With their silent witness, in patience and in prayer, they collaborate in the building up of the fraternity. Let us recognize also the work of the brothers who take care of them in the fraternity, accompanying them generously and with love and deep respect. Love and responsibility for our senior and sick brothers requires that the fraternity give them special care and attention. Let the fraternity ensure medical care and assistance, adapt work to their capacities, and encourage their gradual withdrawal from responsibility, service, and ministry, helping them in this transition since it is often a source of interior distress".

This simple reflection regarding 'my pectoral cross' helped me understand that wearing on my chest that hospital tag as a hospital chaplain simply means serving generously. And, most of all, serving on the example of Jesus, who, by "empty[ing] himself, taking the form of a servant" (Phil 2:7), transformed power into service. As my fellow Capuchin brother and Pontifical Household preacher, Father Raniero Cantalamessa OFM Cap, rightly put it: "Service [is] a power for others, not over others! ... Service confers something more, authority that means respect, esteem, a true ascendancy over others".

Whenever I see 'my pectoral cross', my hospital tag, spontaneously comes into my mind the Prayer before the Crucifix at San Damiano prayed by Saint Francis, which I momentarily pray with faith:

Most High, glorious God, enlighten the darkness of my heart and give me true faith, certain hope and perfect charity, sense and knowledge, Lord, that I may carry out Your holy and true command.

Encouraged by Martin Smith's Lyrics of the Praise he has written, Thank you for Saving Me, I would like to turn to Jesus for the second time and humbly pray to Him:

Lord, thank you for the Cross, your mighty Cross. Everyday I am changed into your image, more and more. Because Lord, by your Cross, I am being transformed. Thank you for saving me at such a cost. I am so amazed. That is why I am giving you praise: for the power of your Cross in me. Amen.

Fr Mario Attard OFM Cap

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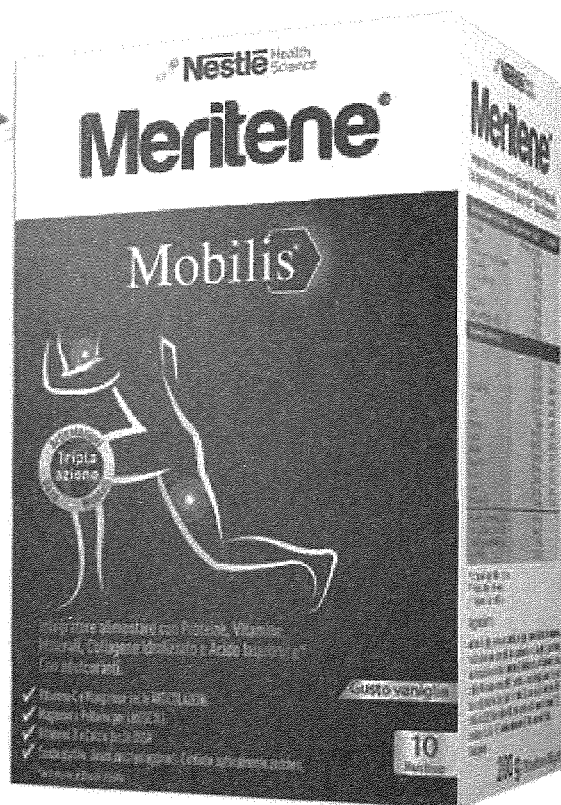
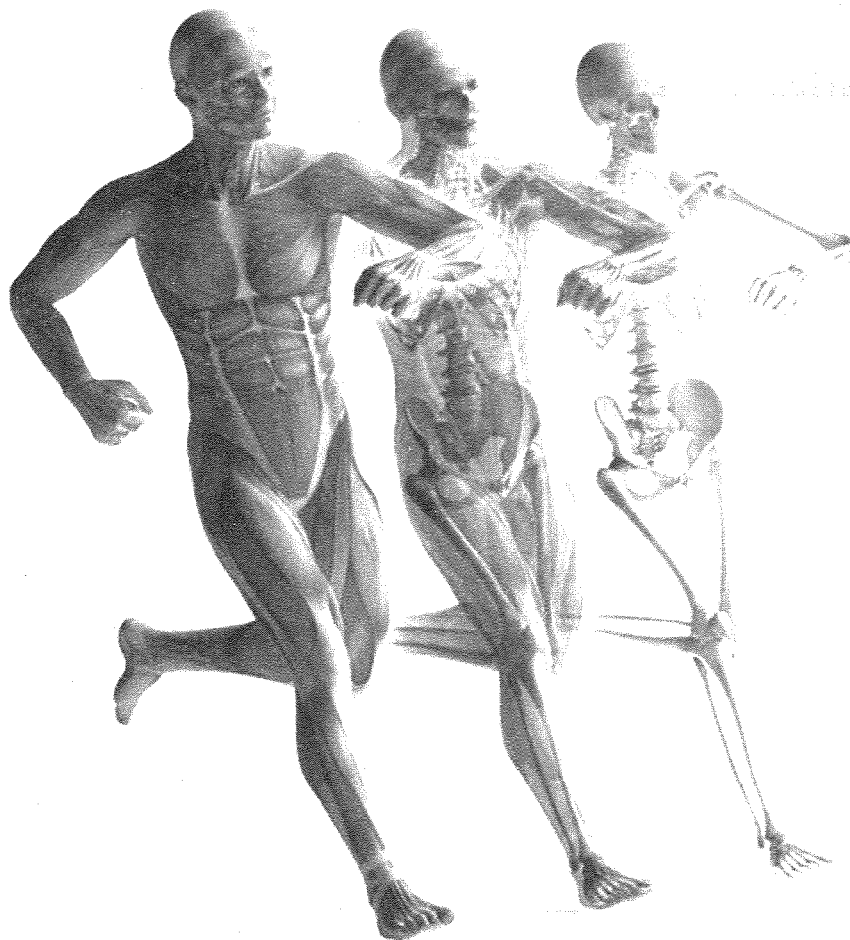
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Protein intake in adults for muscle and bone health

The aging process is frequently characterized by an involuntary loss of muscle (sarcopenia) and bone (osteoporosis) mass. This loss of bone and muscle results in significant morbidity and a decreased quality of life for the individual. Preventing and attenuating osteoporosis and sarcopenia is an important public health goal and evidence suggests that protein plays a role in this process since dietary protein is crucial for development of bone and muscle. Most population-based observational studies suggest that greater dietary protein intake is associated with higher bone mineral density values in middle-aged and older adults. Dietary protein affects bone and muscle mass in several ways and there is evidence demonstrating that increased essential amino acid or protein availability can enhance muscle protein synthesis and anabolism, as well as improve bone homeostasis in older subjects. Furthermore, protein also increases circulating insulin-like growth factor,

which has anabolic effects on muscle and bone.

A healthy lifestyle together with exercise intervention are known to exert positive effects on overall health. To promote and maintain health, adults need moderate intensity exercise for about half an hour several times a week. The balance between exercise and nutrition plays a pivotal role in the regulation of skeletal and muscle mass. Muscle protein metabolism is dependent on the adequate intake of dietary-derived nutrients and a protein rich in glycine, proline, arginine, and hydroxyproline is known to help the body to build and maintain protein structures. A protein compound rich in these amino acids is collagen. 'Hydrolyzed collagen' is a specially-processed form that creates shortened peptide structures which are more easily absorbed by the body. In fact, collagen peptides are absorbed into the bloodstream almost immediately after ingestion, making them ideal for nutritional

replenishment. An innovative product by Nestlé health science was recently launched locally offering collagen in its Hydrolysed form. Meritene Mobilis meets protein demands for active adults that want to maintain or prevent loss of bone and muscle mass. This product provides protein, contributing to the maintenance of muscle mass, as well as Magnesium and Potassium for normal muscle function. Meritene Mobilis also provides 1.2g of Hydrolyzed Collagen, a critical structural protein as well as 54mg Hyaluronic Acid which forms part of the synovial fluid lubricating the joints. Normal bone development is also targeted through the addition of Calcium, Vitamin D, Phosphorus and Zinc.

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Commonwealth Nurses
and Midwives Federation

13th European Conference of The Commonwealth Nurses' & Midwives Federation

MALTA 8th & 9th March 2019

The MUMN is pleased to announce the call for abstracts for the 13th Commonwealth Nurses and Midwives Conference to be held in Malta on the 8th & 9th March 2019. The organising board invites abstract / poster submissions from midwives and nurses, who would like to share their knowledge and enhance nursing skills around the globe.

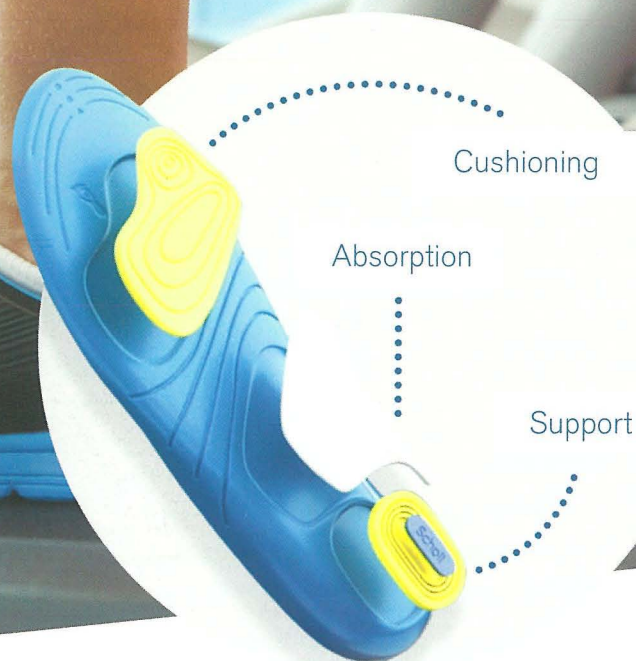
The conference would be a great occasion for nurses and midwives from the European Commonwealth region and beyond to share their experience with and learn from each other; to meet new and former friends and to establish international connections. The call for abstracts closes on the 30th November 2018.

Abstract Themes for this conference include:

- Nursing/Midwifery Education*
- Psychiatric and Mental Health Nursing*
- Nursing/ Midwifery Care and Patient Satisfaction*
- Midwifery and Women's Health*
- Nursing/Midwifery Teaching Technologies*
- Nursing/Midwifery Research*
- Clinical Nursing and Practice*
- Cancer care and Oncology Nursing*
- Cardiovascular Nursing*
- Critical Care Nursing & Emergency Nursing*
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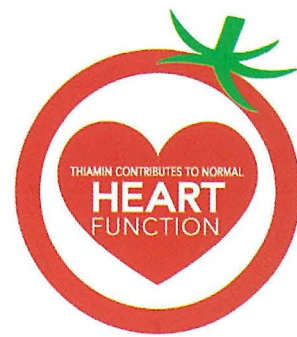
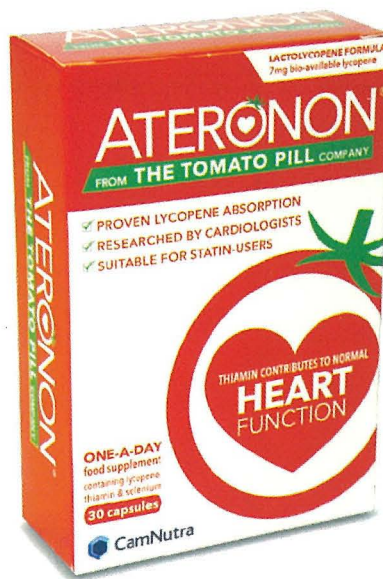


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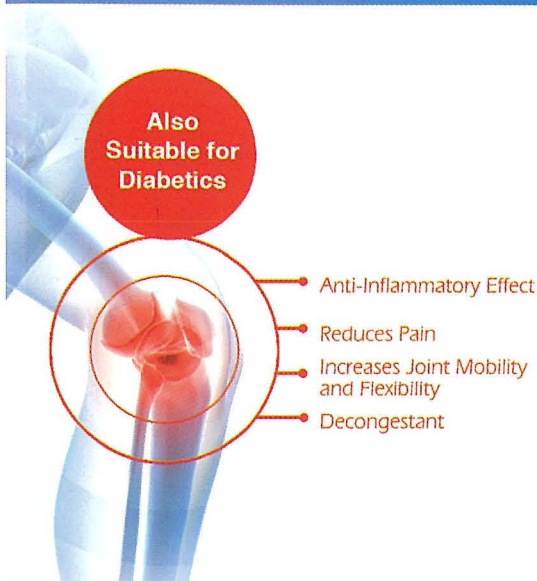
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Scientists develop new material for controversial vaginal mesh implants

Scientists believe they have come up with an alternative to the material used in vaginal mesh implants which prompted a huge number of women to complain they had been left in severe pain.

Mesh treatment has been offered in cases of pelvic organ prolapse and incontinence after childbirth, but sparked controversy after many women said they felt discomfort and had difficulty walking or having sex after undergoing the surgery.

Scientists at the University of Sheffield said they have now come up with a better material following seven years of research, suggesting the use of polyurethane rather than polypropylene.

The research group said polyure-

thane is more suitable because it has more elasticity and a likeness to human tissue.

They also inserted oestrogen into the new mesh in a bid to speed up the healing process after treatment.

The research, published in the *Journal of Neurology and Urodynamics*, said: "We believe that we have developed a new biomaterial that will avoid complications due to a better mechanical match with the native tissues."

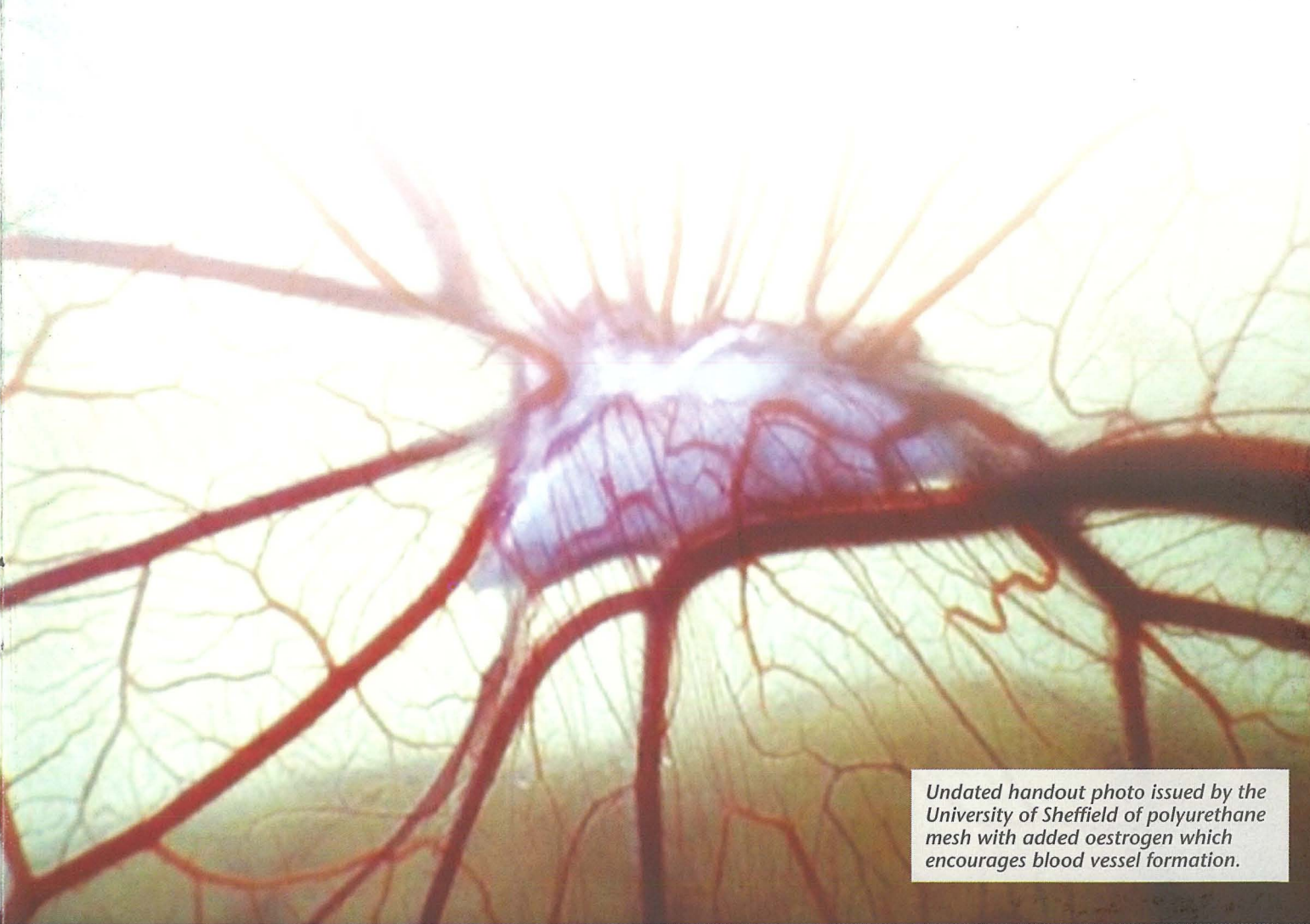
Professor Sheila MacNeil, professor of tissue engineering in the department of materials science and engineering at the university, said they began their research "because it was clear that the polypropylene mesh was not fit for use in the pelvic

floor".

She said: "Over the last seven years, we have investigated a range of materials and for the past few years, we have focused our efforts on polyurethane, using the method of electrospinning to create a fine mesh which we have fabricated in layers to mimic the structure of human tissue.

"We have shown through our research that it does not provoke inflammation and retains its strength and elasticity. The addition of oestrogen is a major breakthrough as we have proved its beneficial effects in regenerating pelvic tissue."

The scientists recognised their research "now needs to be further evaluated in suitable preclinical animal models".

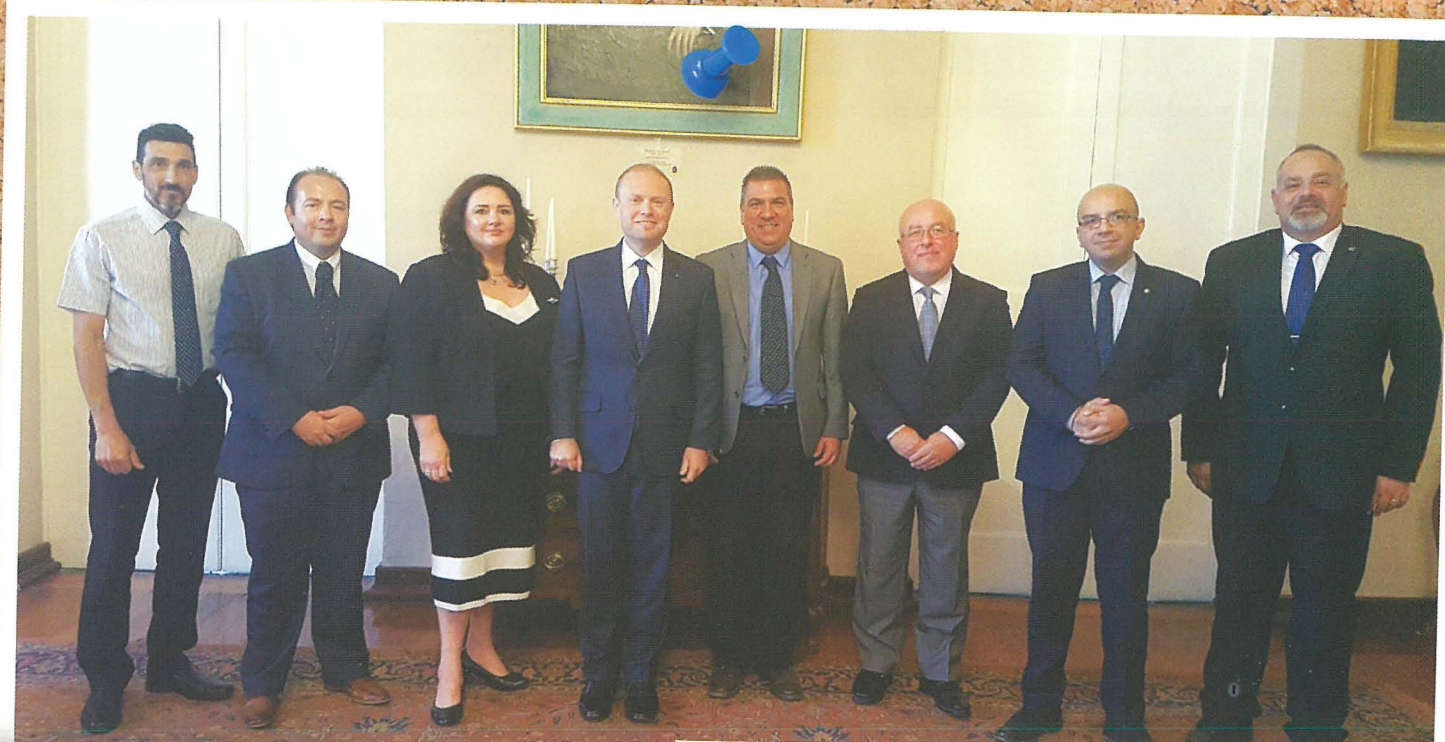


Undated handout photo issued by the University of Sheffield of polyurethane mesh with added oestrogen which encourages blood vessel formation.

from our diary



MUMN's Learning Institute for Health Care Professionals attends in schools to market the Nursing profession



The Executive Council of the Forum Unions Maltn met with the Hon. Prime Minister, Hon. Minister for European Affairs and Equality and the Principal Permanent Secretary



The Learning Institute for Health Care Professionals organise several courses at the MUMN's Head Quarters



MUMN organised a press conference to announce nationwide industrial directives regarding the new Sectoral Agreement for Nurses and Midwives



The FNB Group Committee organises the Annual Ceremony to express MUMN's gratitude to those Members who retire from work. This ceremony is organised under the Patronage of H.E. President of Malta



MUMN organised a press conference in front of the PSC Office to protest against the delay in issuing the results of the Deputy Charge Nurses



The Administration Committee of the For.U.M. met with MUMN's Council to discuss the way forward in the interest of its members.



Why Screen for Colorectal Cancer?

Introduction

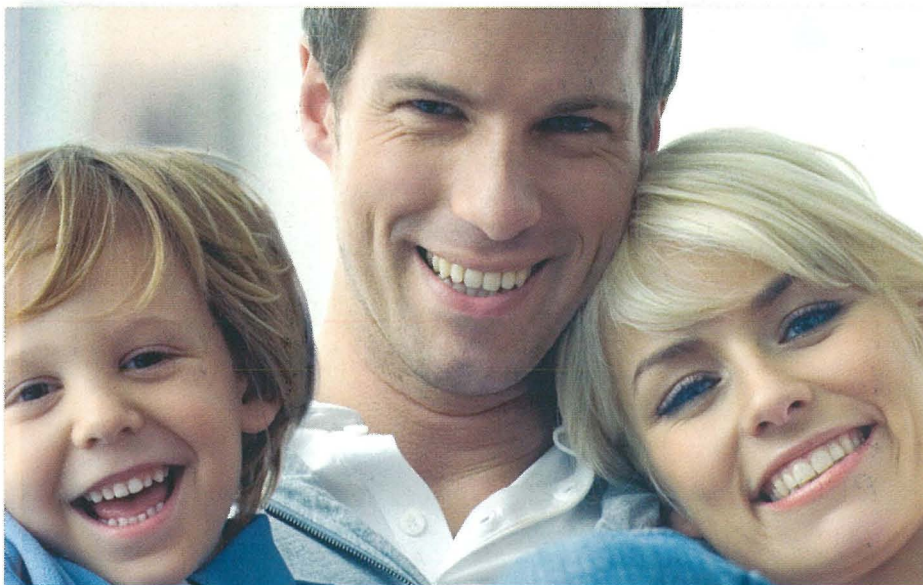
Colorectal cancer is a major public health challenge which can be prevented if individuals participate in a population-based screening programme. As suggested by World Health Organisation (WHO 2016), in the European code against cancer one of the recommendations is regular screening screening for breast, colon and cervical screening. Colorectal cancer presents a problem in Malta as well.

Cancer Data in Malta

Malta 2015	Incidence of colon cancer	Mortality of colon cancer
Males	170	67
Females	124	55

Note. Retrieved from: Department of Health Information and Research, 2018

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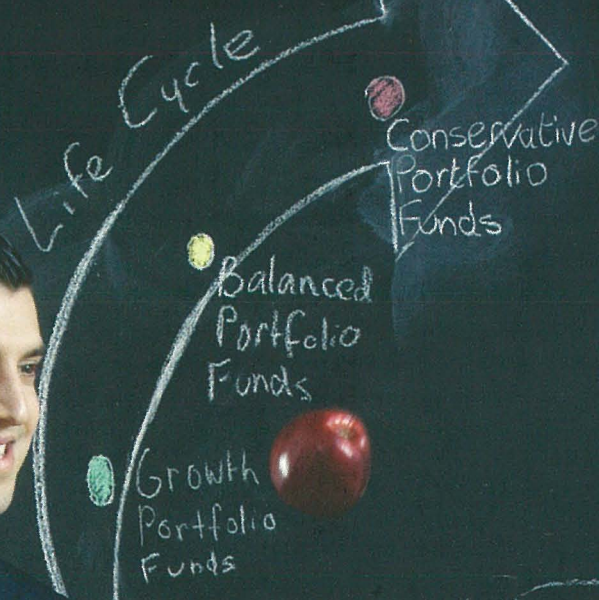
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Promoting physical activity in Cancer Care and Prevention: World Cancer Day 2018

Physiotherapy Department – Sir Anthony Mamo Oncology Centre

For the second consecutive year, the Physiotherapy Department at Sir Anthony Mamo Oncology Centre (SAMOC) was invited to participate in the World Cancer Day event organised by the National Cancer Platform.

Physiotherapists have an important role in promoting the benefits of physical activity both as a preventive and rehabilitative approach in cancer care. On the day, we were carrying out fitness tests (Queen's College Step Test) and spirometry. A range of leaflets related to physical activity and services offered by the department as well as a promotional video of the cancer survivors exercise class available at our department were also available.

Over a hundred fitness tests and spirometry tests were performed in four hours. These tests offered the public the opportunity to discuss their lifestyle and to get practical tips on how to include physical activity in their day. There were a number

of physically active participants who wanted reassurance that their efforts were paying off in terms of cardiovascular and pulmonary fitness. The public was also interested in getting to know about the role of physiotherapy in managing their physical ailments and how to access the services. A number of cancer patients and relatives were interested in the services offered at SAMOC. This interaction led to empowering patients to get referred to physiotherapy and even to the

exercise class.

The response of the public to the presence of physiotherapists, and other health care professionals, at such an event sends a strong message. There is a great interest from the general public to be informed and educated about aspects of health and wellbeing. Such events offer a great opportunity to interact with the general public outside of a hospital setting, promoting the profession and its role not only in oncology but in all aspects of health.



Benefits of Exercise during /after Cancer

Improves cardiovascular fitness

Improves muscle strength

Improves body composition (percentage of fat, water, bone and muscle); obesity linked to increase risk of recurrence and poor survival rates

Improves bone strength

Supports fatigue management

Addresses Co-morbidities

Supports management of Anxiety/ depression; promotes psychological well-being

Enhances self-esteem/ body image

Better overall quality of life

Lowers risk of cancer recurrence and improved survival in specific cancers

Physiotherapy in Oncology can help with:

Mobility issues

Symptom management: Lymphoedema; Pain; Fatigue & Breathlessness

Deconditioning (muscular and exercise tolerance) due to disease and treatment

Joint range impairments

Post-radiation fibrosis

Survivorship: Managing side effects of treatment and promoting well being

Advanced disease: support regards handling, positioning and home care advice

The physiotherapy department at Sir Anthony Mamo Oncology Centre may be reached on 2545 2300



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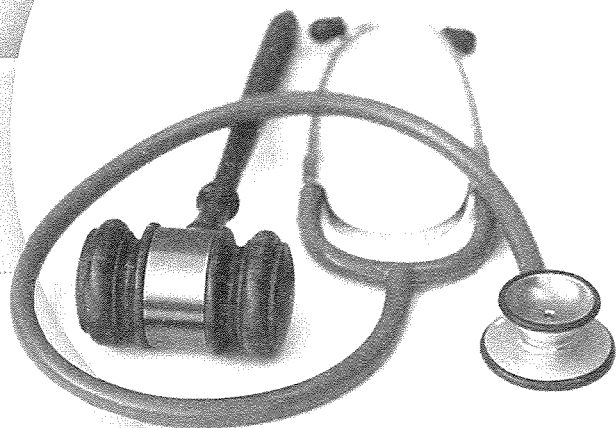
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Ethics, Industrial Action and Nurses



When looking into ethical issues and health care the focus is commonly on the rights of the patient and the duties of the health care professional. The rights and responsibilities of nurses for instance, are typically considered in the context of therapeutic and professional relationships as well as clinical scenarios.

However, nurses are also employees in a demanding and fast paced industry, and have the right to fair terms of employment, a right to fair working conditions, progression and compensation. When nurses decide to revert to industrial action several ethical dilemmas emerge. Unfortunately, nurses are sometimes seen as displaying unprofessional behaviour and not prioritising patient needs when they strike. This often leads nurses to hesitate and be reluctant to follow industrial action. Nurses are entitled to voice the terms of their employment; however, nurses provide an essential service as patients rely on the 24/7

care nurses only can provide. So, do nurses have a right to strike?

Nurses form the largest professional workforce within the health care setting and know that by joining forces they are a powerful voice for both the profession and the service. Collective bargaining is becoming an increasingly sought approach as a solution to the quality of care issues, high patient to nurse ratios, limited decision-making opportunities, progression and professional development (Schraeder & Friedman, 2002). In a survey carried out by Fitzpatrick (2001) nurses identified the following reasons why nurses feel they need to be unionised:

- inadequate staffing, obligatory overtime, man-

datory deployment, unfair wages, lack of recognition, intimidation, feeling unsupported, and being undervalued. Nurse dissatisfaction is also inked with high union activity (Steltzer, 2001).

Being unionised, offers nurses the opportunity to strike through their union. It must be clear that nurses need to remain grounded and fulfil their responsibilities to patients, for strike activity to be implemented. At no time can there be any risk of patient abandonment. This requires that nurses and the representing union follow the appropriate guidelines for a strike, and the entity is given enough time to ensure patient care provisions. Nurses can refer to their professional code of ethics, scope of professional practice, and code of conduct to be fully aware of their responsibilities towards patients, colleagues and the service. From an ethical perspective, there are various approaches to determine how a nurse and representing union can approach industrial action. Some examples of these approaches are virtue ethics, deontological ethics and a utilitarian perspective.

Focusing on virtue ethics, the purpose of industrial action would need to keep the patients' best interests at the centre. Kemp (2013) divides these into two broad categories, "hard" and "soft" benefits. Issues centred on high patient to nurse ratios, obligatory overtime with nurses being overworked and burnt out result in the goal of negotiations leading to "hard" benefits for patients.

Contact Marisa on marisalvella@gmail.com for references and further information related to this article



Negotiating better wages, allowances and progression where nurses would be happier is typically a "soft" benefit for patients. Some of these goals can be subjective in nature, therefore it is important to have reliable statistics in place on clinical outcomes and nurse-patient ratios, so that adequacy and levels can be objectively determined. It can be argued that to resolve a conflict by focusing on the patients' interests, striking and not striking are both in the patients' interests. Many times, it falls squarely on making a choice between protecting patient interests in the short-term and in the long-term (Chadwick & Tadd, 1992). This is not an easy decision to make and identifying different ethical approaches to analyse the situation is highly recommended. Union regulations and activities should strive for productive goals that result in enhanced working conditions for nurses that will improve patient care and nurse satisfaction.

The benefit of having a large group of professionals with a shared voice should not be underestimated. Most nurses who unionise, do so because they seek safe workplace environments, fair treatment and wages, respect, and patient safety as they are advocating for themselves and their patients. Recent trends indicate that unionised nurses have had a positive impact on addressing issues such as obligatory overtime and nurse to patient ratios (Bosek & Savage, 2007). Ultimately the appropriate course of action will depend on variables such as specific circumstances and whether the benefit to be gained by the strike will outweigh the harm done. While a strike should remain a last resort, Chadwick & Tadd (1992) state that "after other channels of complaint have been used, to say that a nurses' strike can never be justified is hardly a tenable position as such a policy encourages exploitation of nurses and provides little or no incentive to improve conditions and resources for either staff or patients."

Marisa Vella



Advice from a patient

This may be a normal day at work for you
But it's a big day in my life.

The look on your face and the
tone of your voice can change
my entire view of the world.

Remember, I'm not usually
this needy or scared.

I am here because I trust you,
help me stay confident.

I may look like I'm out of it,
but I can hear your conversations.

I'm not used to being naked around strangers.
Keep that in mind.

I'm impatient because
I want to get the heck out of here.
Nothing personal.

I don't speak your language well.
You're going to do what to my what?

I may only be here for four days,
but I'll remember you the rest of my life.

Your patients need your patience.

• continued from page 22

PRINCIPLES OF SCREENING

Colorectal cancer can be detected in early stages, where in this stage treatment could be adequate and efficient. Endoscopic removal of the adenomas prevent the progression of precursor lesions to cancer, consequently reducing the incidence of colorectal cancer. The Council of Europe recommends faecal occult blood screening for colorectal cancer in men and women aged 50–74 at a 2-year interval in organised screening programmes.

COLORECTAL CANCER SCREENING IN MALTA

A screening programme should at least include individuals of 60 to 64 years of age, in an environment where colon cancer incidence and mortality are high, and life expectancy is still substantial (Council of the European Union, 2003). In Malta, colorectal cancer screening was introduced in 2013 where individuals born between 1949 and 1953 were invited in the first 2 years. As this is a roll out programme which repeats itself every 2 years, clients born between 1949 and 1959 were invited the following 2 years. The programme kept on expanding to reach the current cohorts, that is those born between 1949 and 1963. These will eventually be called by the end of 2018. In Malta, the immunochemical faecal occult blood test (FIT) was adopted as it has a superior detection rate and positive predictive value without any dietary or medications restrictions required. The FIT results in higher detection rates of adenomas with 22% reduction in colorectal cancer-related deaths when compared to no screening (Schreuders et al. 2015). After a positive immunochemical faecal occult blood test, clients are invited for a pre-assessment and referred for a direct colonoscopy.

COLORECTAL CANCER

Precursor lesions that often present as polyps develop into colorectal cancer, which are resected during colonoscopy (Ijspeert et al. 2016). Colorectal polyps can be categorised into non-neoplastic or neoplastic polyps. Non-neoplastic polyps are hyperplastic polyps which are benign, asymptomatic and lack the ability for progression to colorectal cancer (Fua, Yua, Linb, & Chai Chi-Chang Chenc, 2014). Neoplastic polyps are adenomatous polyps which are strongly associated with colorectal cancer with a variable degree of dysplasia ranging from low grade to high grade, relating to malignancy potential. The World Health Organisation (WHO) subdivided colonic polyps into hyperplastic, sessile serrated adenomas/polyps and traditional serrated adenomas, which has been suggested to cause approximately 15- 30% of all colorectal cancers (Ijspeert et al.). Polyps can be asymptomatic in the average risk population. Therefore it is essential that all detected polyps be radically resected during colonoscopy (Ijspeert et al.). Early diagnosis achieves lower morbidity and mortality. In localised cases, there is a survival rate of 90% (Atkin et al. 2010).

Only 5% of colorectal cancer is inherited, with diet being the most ex-

ogenous factor currently known. An increase of colorectal cancer by 19% is due to obesity (Baena, & Salinas, 2015). Conversely, regular physical activity reduces the risk of colorectal cancer by 24% (Baena, & Salinas).

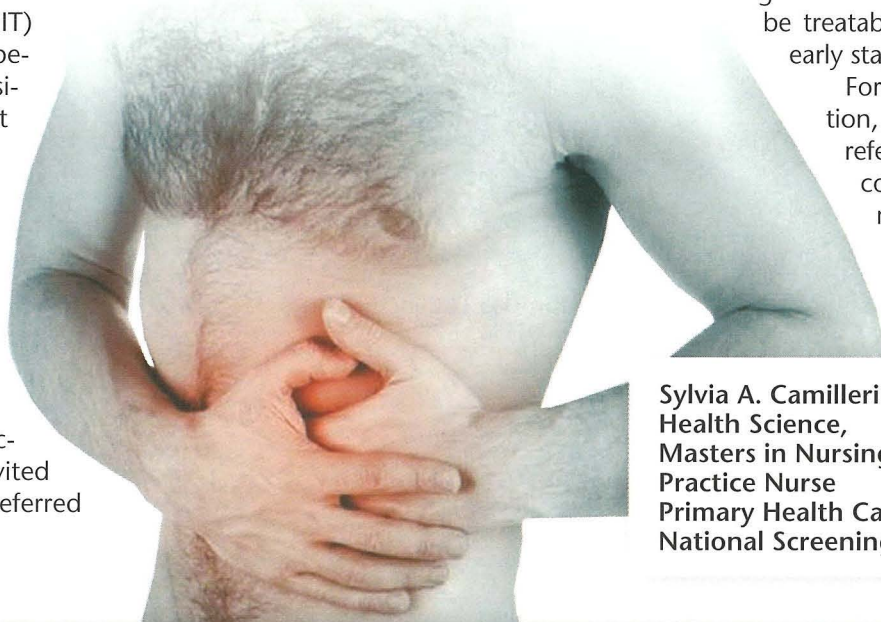
While moderate amounts of alcohol (25–30 g/day), and both red meat consumption and its frequency influence the risk of colorectal cancer conversely fish consumption decreases the risk. Fibre intake of more than 20 grammes per day is associated with a 25% reduction in colorectal cancer risk, and 525 ml of milk reduces colon cancer risk by 26% in men (Baena, & Salinas).

ROLE OF HEALTH PROFESSIONALS IN PROMOTING SCREENING

Low participation would render the service unworthy. Economic balance should always be taken into consideration, as an early intervention will probably reduce treatment costs and is more beneficial. While public education should be widely promoted on the access of the programme, this should not incorporate any moral pressure.

The minimum acceptable participation rate should be at least 45%, although it is highly recommended to aim for a rate of 65% (Keighley, O' Morain, & Giacosa, 2004). It should not be tolerable that colorectal cancer go undiagnosed and causes high mortality where it can be treatable if detected in early stage by screening.

For further information, clarification and references, please contact Ms. Camilleri on sylvia.camilleri@gov.mt



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Health Science,
Masters in Nursing
Practice Nurse
Primary Health Care
National Screening Programme

Evidence shows nurses save lives, reduce costs and improve patient outcomes



International Council of Nurses
The global voice of nursing



ICN new safe staffing position calls for investment in nursing and no substitution of RNs

The International Council of Nurses (ICN) has released a new position statement on Evidence-based safe nurse staffing which calls for increased investment in safe, effective and needs-based nurse staffing levels in order to improve patient outcomes and create positive practice environments.

"There is clear evidence of the importance of safe nurse staffing in relation to patient safety in all healthcare sectors. Inadequate or insufficient nurse staffing levels increase the risk of care being compromised, adverse events for patients, inferior clinical outcomes, in-patient death in hospitals and poorer patient experience of care," said Howard Catton, Director of Nursing and Health Policy at ICN. "ICN recognizes that safe staffing is a key priority and major issue of concern for many of our members and the nurses they represent."

Research shows an increase of one Registered Nurse (RN) per 10 beds is associated with an 11-28% reduction in death 30 days following a stroke and with an 8-12% reduction one year following the stroke.ⁱ Evidence further demonstrates that hospitals with higher proportions of baccalaureate prepared RNs have better patient outcomes and lower mortality rates.ⁱⁱ

i) Myint PK, Bachmann MO, Loke YK, Musgrave SD, Price GM, Hale R, et al. (2017). Important factors in predicting mortality outcome from stroke: findings from the Anglia Stroke. Age Ageing [Internet]. 2017 Jan [cited 2018 Apr 20];46(1):83-90. Available from: DOI: 10.1093/ageing/afw175

ii) Aiken LH, Sloane DM, Bruyneel L, Van den Heede K, Griffiths P, Reinhard B, et al. (2014). Nurse staffing and education and hospital mortality in nine European countries: a retrospective observational study. Lancet [Internet]. 2014 May [cited 2018 Apr 20];383(9931):1824-30. Available from: DOI: 10.1016/S0140-6736(13)62631-8

In addition, inadequate staffing levels can lead to lower job satisfaction, increased levels of stress, staff burnout, a higher inclination to leave and increased staff turnover. This also has resource implications which a number of studies have shown are very significant. The substitution of healthcare support workers for RNs and the development of new non-RN roles have been implemented in some countries as a possible solution to address a shortage of RNs and to reduce the wage bill. However, research shows that substituting RNs for less qualified cadres of workers may worsen patient outcomes and may not be cost-effective.

"Patient safety and the health of the nursing workforce are two sides of the same coin," said Catton. "Many nursing associations are concerned that staffing decisions are being driven by financial considerations rather than improved patient outcomes and practice environments. In order to deliver quality, patient-centred care, there is a real need for positive practice environments with an adequate number of staff, manageable workloads, managerial support, high quality leadership and the ability of nurses to work at

their full scope of practice."

The position statement, which was developed with the input of international experts and in consultation with ICN's members associations, sets out both principles and key elements of approaches to ensuring safe staffing which is intended to help and support all those involved in determining staffing levels and ensure there is clear nursing leadership on this vital issue.

It calls for:

- establishment and implementation of safe nurse staffing systems based on real-time patient information
- sufficient healthcare funding to deliver needs-based safe nurse staffing
- effective staffing systems based on both patient safety and the health and wellbeing of staff
- public awareness of the impact that safe nurse staffing has on patients, families and communities
- an end to the creation of substitute roles for Registered Nurses
- promotion on nurse staffing research that includes economic analysis

The evidence presented in this new ICN position statement goes hand-in-hand with similar issues raised in two recently released ICN publications: one on nurses' salaries and the other on retention of nurses. These show that many nurses around the world have experienced a real terms' fall in their purchasing power over the past 10 years, and that when nurses are enabled and supported to do the job they were trained to, they are less likely to leave the profession.

For further information please contact: Julie Clerget at media@icn.ch

Nurses: Leaders in a Changing World

Proceedings of a Maltese
Nurses' conference held on
the 30th - 31st May, 2018

Each of the twelve presentations of this two day conference offered the participants, a ray of hope, if not a tangible lead, that shared learning is possible and within our grasp. Moreover, the emphasis was on providing the right commitment and environment for a supportive structure to afford the backbone to the initiatives shared by our Nurse Leaders.

The conference theme was introduced with Dr Corinne Ward's doctoral research, Specialist Nurses' Role and Potential, proceeding to share the main findings from the interdisciplinary focus groups amongst nurse managers, medical consultants and nurses in specialist roles. The medical consultants' positive view of nurses in specialist roles, was qualified by a need for further education. The approach where an interview determined the assignment of a nurse to the role of a 'specialist nurse' was questioned, further advising on the need of an educational and practice linked competence path. The lack of legal standing and support was a shared concern by the individuals in the post. Fifteen years since the introduction of the specialist nurse role in Malta, a national policy perspective leading to regulation, is needed, whilst a 'revalidation to practice' system, supported by a live 'nurse specialist' public register, was suggested

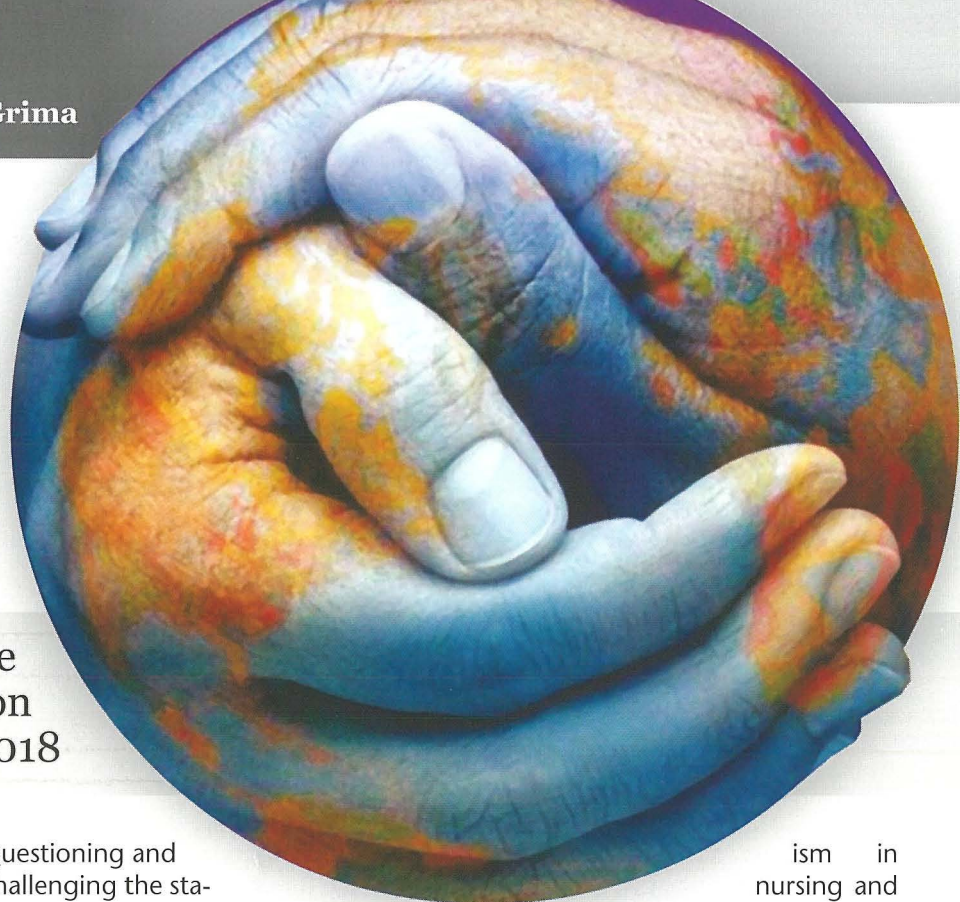
Questioning and challenging the status quo, being leaders in nursing practice, Apple's Steve Jobs clip seemed to sum up the presentation's notion. It offered a tribute to the "crazy ones, the misfits, the ones who see things differently [...] they push the human race forward [...] the crazy ones who think they can change the world are the ones who do".

**A courageous
value laden leader
embracing a need for
constant adjustment,
with an enduring
attitude and a focus
on innovation, were
essential qualities,
advocated upon.**

Prof Charlotte McArdle presentation Enabling Professionalism-Creating a Strong Narrative elaborated on Dr Ward's assertion that nurses need to have proof of their professionalism. A framework to enable professional-

ism in nursing and midwifery prepared by four UK Chief Nursing Officers, through three UK nursing organisations, was presented. Articulating what being a part of a profession means and [what] professional behaviour looks like in practice, whilst understood by the public and policy makers, Prof McArdle acknowledged that professionalism means different things to different people. Within a media world interpretative potential, emphasising specificity and choice of language in a profession's practice framework, comes natural. Hence, whilst practising with other professions, nurses and midwives should still be able to quantify what makes them distinct from others, what their contribution is, in order to improve, strengthen and develop it. Emphasising the relativity of a 'scope of practice' to a profession, the need for periodical review, was advised.

Maintaining professionalism's theme, Prof Elizabeth Rosser 'Advanced Practice: Importance of Education for Leadership' provided a historical background to the establishment of 'advanced practice' nursing roles. Same as within our shores, uncertainties in defining and allocating the role/s to these nurses in the UK, also existed. Prof Rosser presented



an action learning approach towards this enabling stance, through the sharing of a learning experience. The insight provided nurses in 'advanced practice' to visualize one's professional role, embedded within a leadership/education/research/practice paradigm, thus potentiating its value. Whilst the difficulties are universal and dependent on what part of the world the nurse comes from, the accountability of the individual nurse towards a self-leading role, was highlighted, notwithstanding. She stressed that the nurse needs to 'accept oneself internally' and 'take ownership' of arising decision-making situations, in nurturing, a much needed self-leadership trait.

In Celebrating the Science and Art of Nursing, Prof Laura Serrant explained that as a profession, nursing was always at the forefront to support people and communities to manage their lives and their health. In spite of the human and financial resources challenge faced, upholding the focus on policy, practice and research remains an aim. Perceived of having no more than a 'caring' and 'responsive' role, the nursing profession is deemed as secondary to the scientific achievements of medicine; this albeit several nurse scientists' contribution towards establishing both traits [art and science], as pillars to the nursing profession. Being culturally competent, compassionate in care and leadership, the 21st century nurse will

be championing both pillars.

Attributes of 21st Century Nurse Leaders paved the often convoluted path for a number of nurse executives to be effective 'by making things happen' within their roles, as illustrated by Ms Helen Kirk. Pushing the glass ceiling in Nursing Occupational Health (OH) England, through an array of self-conducted studies, Ms Kirk exemplified the attributes for an effective leadership.

These included knowledge of the work place, 'organisational scanning', 'listening' and 'being a powerful influential operator'. A courageous value laden leader embracing a need for constant adjustment, with an enduring attitude and a focus on innovation, were essential qualities, advocated upon.

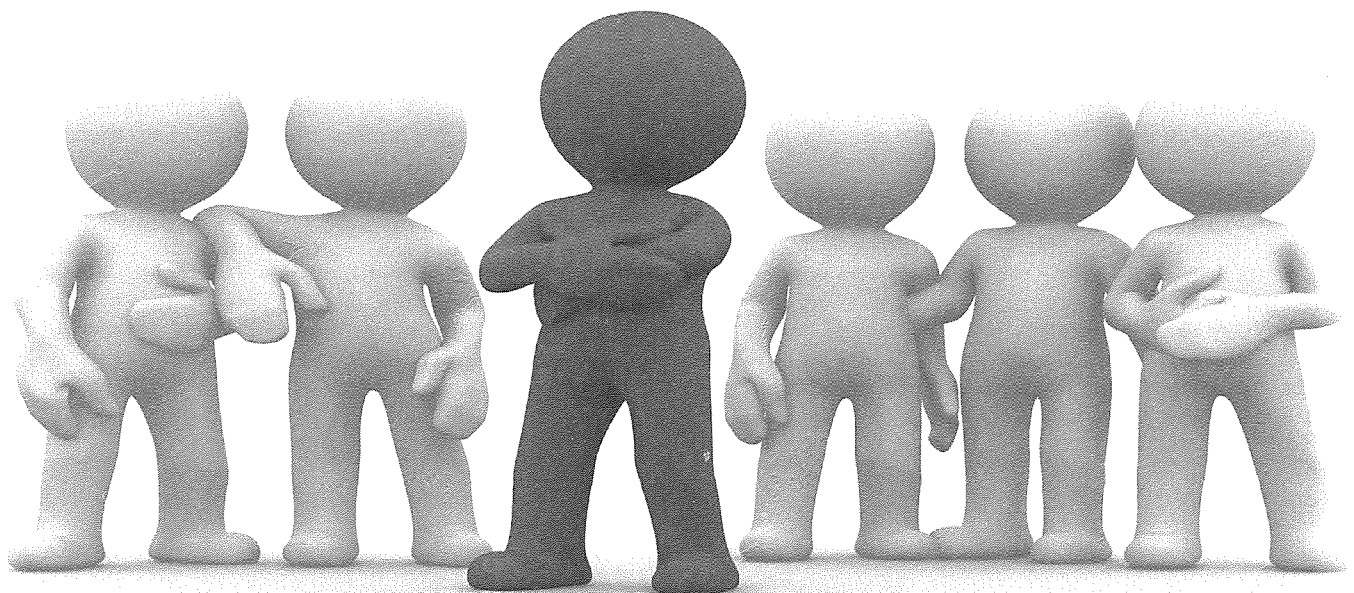
In A Seat at the Table or Standing by the Door, Mr Paul Trevatt brought the strong influence nurses have through an advocacy role towards policy preparation and enactment. It was asserted that policy should be part of the clinical area, by being integral to nurses' duty and responsible for change in patient care and national policy. Mr Trevatt demonstrated a structured example of nurse lead initiative, in namely a threat to a specialist [nurse] role in UK. An appraisal of beneficial patient outcomes provided the *raison d'être* for a sustainable ratio of nurse specialists to the patient cancer in-

cidence across the whole of UK. A government policy commitment ensued, with the oncology care path being guided by the specialist nurse. Windows of opportunity occur of their own accord, thus policy approaches have to match the arising opportunity in its flexibility.

Mr Martin Ward discussing People Centred – Care, highlighted that the patient and healthcare provider should be equal partners in the care process. To achieve this, nurses need to think differently and conquer that paternalistic, controlling way of working that dominates traditional professional behaviour. Hierarchical, controlling health systems may limit the delivery of people-centred care through abusive blame oriented managerial system/s. In an environment deemed value neutralising, a question follows- "What happened to our students?" to which Mr Ward's response being "They became like everyone else!"

Mr. Dustin Balzan's presenting The Consequence of Silence asserts that the first obligation in healthcare is to keep the patient away from harm. An awareness and action towards healthcare errors, latent and active, may be stifled by a failure to act and speak up in fear. Flagging safety alerts promptly whilst sharing the lessons learnt may reduce preventable mishaps, hence patient harm.

• continued in next issue



Choosing the Right Absorbent Continence Device

Incontinence has significant negative effects on the quality of life of patients including social isolation, loneliness and sadness, embarrassment, stigmatization, disturbed sleep and negative effects on sexual relationships. Incontinence may also be a factor for a person to be admitted to long term care and to induce low staff morale in health-care institutions. Correct advice, management and nursing care of incontinent persons greatly influences their quality of life and that of their carers.

Types of Incontinence: *Bladder Incontinence* involves the unintentional loss of urine that is sufficient enough in frequency and amount to cause physical and/or emotional distress in the person experiencing it.

Faecal Incontinence is the loss of bowel control, resulting in involuntary passage of stool. This can range from an occasional leakage of stool with the passage of gas, to a complete loss of control of bowel movements.

Choosing the right device:

Main products used in continence care include pads and pull-up pants for bladder incontinence; and pads, diapers and pull-up pants for total incontinence. Levels of incontinence in different persons may vary in range, from light to medium to heavy. The absorption capacity of product chosen should be based according to patient needs. The more absorbent the product, the less it is discreet. Hence, persons who have light incontinence do not need to use highly absorbent products, which are possibly less discreet and more expensive. Whereas, high absorbency products are better utilised for persons suffering from heavy incontinence, who are highly concerned about security from leakage, especially during sleep/night-time where changes are less frequent. However, absorption capacity does not always totally determine nor ensure security against leakage. Other factors, such as anatomically shaped products, in order to fit body contours, may critically influence the level of security and wearing comfort. Hence, it is also very important to choose the right product size according to waist/hip measurement, whichever is the greatest, in case of pull-up pants or diapers. Some products are also specifically designed according to gender, male and female versions of products to ensure a perfect fit.

Patients' perceptions and desirable features of incontinence products mainly concern security and reliability, odour control, absorption capacity, leakage protection, skin friendliness, wearing comfort, ease in handling, discretion and a good quality/price ratio.

Good quality continence devices are able to provide:

- **A Perfect fit** since they are tailored to fit closely and safely to the body
- **Discretion** having an odour neutralizer, are not bulky, and do not rustle on movement
- **Security** through the use of a system that locks wetness away quickly & safely usually achieved through the use of super absorbent gels such as poly-acrylate in the core material
- **Integrity of device** without tear during use
- **Comfort** through the use of air-permeable materials similar to normal underwear. In contrast to occlusive materials, semi-permeable materials enable the circulation of air and consequently allow heat exchange for a balanced skin climate. Reduction of heat and sweat build-up, enhance skin comfort and support prevention and reduction of skin redness and irritations.

Choosing the right product to address patient needs will lead to better use of the products' potentials thus avoiding excessive consumption and waste. Individualising product requirements of patients involves identification of the correct kind of product thus avoiding unnecessary oversizing and malpractice. In elderly homes, involving personnel in the correct management of continence devices helps achieve correct use of products and cost control in continence care. The main advantages to be achieved are:

- Better comfort for the residents
- Reduced workload for the personnel
- Substantial savings in laundry costs
- Reduced waste
- Less skin problems

Quality continence products are considered to make an integral part of professional continence therapy as a cornerstone for a professional holistic approach to patient care. Patients usually seek professional advice from nurses, carers, pharmacists and doctors. The busy and often times overloaded health professional can gain the best advantage for the patient by seeking advice from healthcare professionals specialised in continence care or suppliers of quality continence devices, in order to meet patients' needs in the best way possible.



Continence care that protects the skin

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

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International Council of Nurses supports WHO revised DR-TB treatment guidelines



International Council of Nurses
The global voice of nursing

The International Council of Nurses (ICN) is supporting the dissemination of World Health Organization's (WHO) changes to drug-resistant tuberculosis (DR-TB) treatment recommendations to more than 20 million nurses. WHO announced the need to use of newer and less toxic medications in their Rapid Communication.

"ICN supports these new recommendations and encourages nurses working with DR-TB to read and adopt the new guidelines so that patients with DR-TB will benefit from the newer, less toxic medications; experience fewer adverse effects and be successfully treated and cured. Dr Carrie Tudor, Director of ICN's TB/MDR-TB project said. "These recom-

mendations will really make a big difference to those affected by DR-TB as we move closer to an injectable free regimen."

The WHO Global TB Programme recently convened a Guideline Development Group panel to revise the current DR-TB treatment guidelines. The expert panel reviewed outcomes and side effects of medications used to treat DR-TB and made recommendations based on the evidence. The results of this review have led WHO to announce that the medications have been regrouped into three groups with later generation fluoroquinolones (levofloxacin and moxifloxacin) and other newer medications, linezolid and bedaquiline, being prioritized. Injectable medications, kanamycin and capreomycin, are no longer recommended due to an increased risk of treatment failure and high rates of adverse events such as permanent hearing loss.

ICN commends WHO for making these recommendations; recognises the need to make new medications available to all who need them; and supports the introduction and implementation of these developments in treatment and to improve the lives of those affected by DR-TB.

According to Dr Isabelle Skinner, ICN CEO, "Nurses continue to play a critical role in the care and treatment of those affected by DR-TB. The ICN TB/MDR-TB Project has trained more than 2,200 nurses around the world on TB/MDR-TB and those nurses trained have gone on to train another 173,000 other nurses, allied health workers and members of the community".

ICN has developed a "job aid" for nurses working with DR-TB patients to assist them recognise potential adverse events early and to address them to minimize and alleviate patient discomfort. This job aid (ICN Nursing Guide for Managing Side Effects to Drug-resistant TB Treatment) will be available soon in English, Russian and Chinese with additional languages to follow.

Drug-resistant TB remains a major global health problem. It is estimated that 600,000 people were diagnosed with DR-TB in 2016; an estimated 240,000 of them have died (WHO 2017 Global TB Report). Additionally, DR-TB accounts for nearly one-third of all deaths due to antimicrobial resistance. DR-TB is difficult and expensive to treat with many unpleasant and some severe adverse effects. Those diagnosed with DR-TB often endure up to 24 months of toxic treatment with old medications including six to eight months of daily painful injections.

Patients on treatment for DR-TB face many challenges, most notably difficult side effects such as nausea, permanent hearing loss, muscle and joint pain, psychosis and fatigue that may impact the patient's quality of life, capacity to work and ability to continue activities of daily living. Recent studies have identified medication side effects as a major factor for patients stopping treatment prematurely. The 2017 WHO Global TB Report noted a continued crisis related to treatment outcomes for drug-resistant TB with only 54% of patients successfully completing treatment in 2014.

For further information and references please contact: Julie Clerget at media@icn.ch



Il-lingwa Maltija uzata fid-dinja Medika

minn Joe Camilleri, Charge Nurse - It-Tieni Parti

Fil-ewwel parti ta' dan l-artiklu iddiskutejna l-użu tal-kliem bil-Malti fid-dinja medika u allura wkoll fin-Nursing u f'dak kollu li għandu x'jaqsam mal-isptarijiet. Illum ħa nkompnu nagħtu eżempji ta' dan.

Fix-xenarju tal-qwiebel, 'Obstetrija' (*Obstetrics*), 'neonati', 'trabi tat-twelid'/'trabi' u l-Ġinekologija' (*Gynaecology*) insibu kliem u frażijiet bħall-'sekonda' (*placenta*); 'taqgħalu ż-żokra' (*umbilical cord stump*); 'guf' (*womb*); 'qasma tas-sniem'; 'tagħqida tal-ħniek'; 'treddiġħ', 'tredda' jew 'rdiħ', 'tagħtih iż-żejża' jew 'is-sider' (*breast feeding*); 'mammalora' (*breast pump*); 'toftom it-tarbija' jew 'ftim' meta t-tarbija jkollha 12-il xahar (*weaning*); 'xaħxieħa' jew 'xaħxiħa' (*pacifier, titty* jew 'xi ħaga li traqqad/tikkalma'.

Xaħxiħa tirreferi wkoll għall-pepprin (*poppies*); 'teħles', 'tixtri' jew 'ħlas' (*childbirth* jew *delivery*); 'ċumnata' kienet xarba li tingħata lill-ommijiet biex ittaffi l-uġiġħ tal-ħlas fi žmien meta ma kienx hemm 'epidurali' (*epidural*). Tarbija tista' 'titwieled għaxja' (*limp*); u l-omm jista' jkollha 'emorraġija interna/esterna' jew 'żvinat' (*haemorrhage*); Kliem ieħor insibu 'fetħa' jew 'miftuħa' (*dilation*); 'iċcartet'/'tiċrita' (*tear*); 'qarnita' mal-għonq tal-utru' (*cervical polyp*) fejn

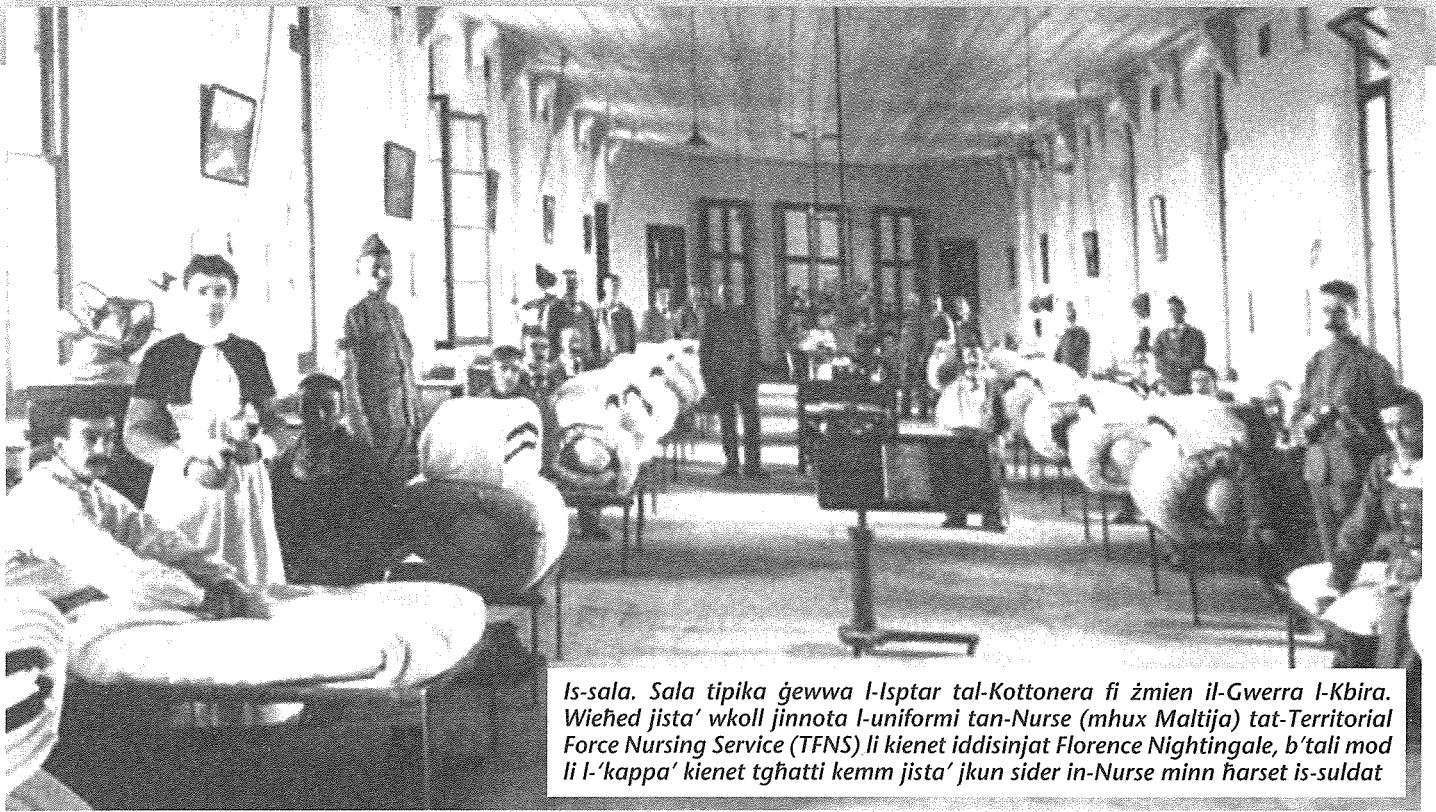
'qarnita' insibuha fl-għajnejn (*Pterygium*) ukoll. Insibu wkoll 'tqila'/'tqala' jew 'ħobbla' (*pregnant*), għalkemm ta' l-aħħar hija aktar assoċjata mat-tqala ta' l-annimal; 'gażaža' (*baby soothers*); 'dendil taż-żaqq' wara t-tqala; Fl-irġiel nitħaddtu fuq 'ċirkonċizzjoni' jew 'taħtin' li ġejja minn ħatten jew ħaten (*circumcision*); 'il-ġilda' (*prepuce*); 'impotenza'/'mielaħ' (*impotence*); Fin-nisa nsibu 'mutilazzjoni tal-ġenitali tan-nisa' (*Female genital mutilation/female genital cutting/circumcision*); 'furraxx'; 'mard tan-nisa/sifilde' (*sexually transmitted disease/syphilis*); 'pixxikalda' / 'gonorreja' / (*venereal disease/gonorrhoea/clapp*); il-'merkurju' (*mercury*) kien jintuża biex 'ifejjaq il-mard tan-nisa'; 'klitoride' jew 'qannuba' (*clitoris*); 'raxkament' (*dilatation and curettage*); 'tisfija vaġinali' (bajda jew safra)/ovulazzjoni (*ovulation*); 'għoqda/boċċa fis-sider' (*lumps*); 'menopawsa' (*menopause*); 'infaqqħa l-ilma' (*breaking the waters*); 'korriment' (*miscarriage*); 'abort' (*abortion*); 'tneħhi l-utru' (*hysterectomy*); 'episjotomija' (*episiotomy*); 'stupru' (*rape*); 'abort' li nistgħu insibuha 'rimi' (*abortion*); 'ġiha' jew 'waqgħet it-taraġ' (*menstruation*); 'sterilu'/'mielaħ' (*sterile*); 'embrijun' (*embryo*). Insibu wkoll 'fisqija' (*swaddling clothes/cradle*) u

kienet ukoll tintuża biex 'jintrabat id-dahar' fil-kbar (speċi ta' kurpett). It-terminu 'tkabbar /iċċekken is-sider' u anke 'tirraŋġa'/'tagħmel' il-wiċċ/l-immieħer' eċċetera, jirreferi għall-cosmetic surgery.

Il-kelma 'qabla' (fil-plural 'qwiebel') mhux xi popolari ħafna biex tingħad, għaliex il-kelma 'Midwife' u 'Majjistra' kienu u għadhom jintużaw aktar ta' spiss. 'Kumhari' kienet dik il-mara mħallsa apposta li terfa' t-tarbija appena titwieled.

Espressjonijiet oħra huma attribwiti mal-mewt. Per eżempju meta n-Nurses jgħidu 'waslet Ġensa l-mewt' (*grim reaper*) ikunu qed jirreferu għal meta numru ta' pazjenti jmutu f'daqqa jew f'perjodu relativament qasir.

L-użu tal-kelma 'sala' (*ward*) ovvjament ġejja mit-Taljan u it-tnejn jintużaw ta' spiss waqt li 'Is-sala l-kbira' (il-big ward) kienet tirreferi



Is-sala. Sala tipika ġewwa l-Isptar tal-Kottonera fi żmien il-Gwerra l-Kbira. Wieħed jista' wkoll jinnota l-uniformi tan-Nurse (mhux Maltija) tat-Territorial Force Nursing Service (TFNS) li kienet iddisinjat Florence Nightingale, b'tali mod li l-'kappa' kienet tgħatti kemm jista' jkun sieder in-Nurse minn ħarset is-suldat

għall-akbar sala fl-Isptar San Luqa jew 'iċ-Ċentrali' (L-Isptar Ċentrali ta' Floriana). Kmamar oħra kienu s-single room, it-2-bedded, 4-bedded u 6-bedded. Il-kelma 'Is-Sanità' nattribuha għal-Palazzo Castellania, palazz fejn fl-1895 gie kkonvertit għall-Head Office tal-Public Health Department u wara sar Ministeru tas-Saħħa, l-Anzjani u Kura fil-Komunità. 'Tas-Sanita' mill-banda l-oħra tfisser dawk li jaħdmu mad-Dipartiment tas-Saħħa Pubblika (*Public Health*) u jagħmlu spezzjonijiet fi kċejjen, ħwienet, is-suq eċċ. Dan l-aħħar kollega fuq ix-xogħol, xi tletin sena izgħar minni fl-eta', semghani ngħid il-kelma 'parlatorju' (*visiting hours*) u qalli: 'din x'hini?'

Jien skantajt imma wara rrealizajt li hemm hafna kliem li ż-żgħar fl-età ma jafuħx. Per eżempju 'żgambella' (*bedside locker*), 'impul-luzza' jew 'skutella tal-bekk/bek' (*feeding cup*), 'titqiba' jew 'injezzjoni ipodermika' (*injection*), 'intravini' (*intravenous*), 'il-labra' (*hypodermic needle*); 'fjala' (*vial/phia*); Interessanti li għall-ampoule ma ngħidux 'ampulla' imma nerġghu nużaw il-kelma 'fjala'; 'medikatura' jew 'tim-medika' (*change of dressings*), 'tap-sina' (*bedpan*), 'flickun ta' l-awrina' (*urine bottle*); 'pipetta' (*pipette*), 'il-ħġieġa tad-deni' (*clinical thermome-*

ter); 'korsija' (*beds in ward corridors*), 'veranda' (*verandah*), 'kabinetti' (*isolation rooms* fl-Isptar Monte Carmeli) fejn il-pazjent ikun 'segreat', 'L-Im-gieret' jew 'tax-xjuħ' (Has Serħ jew Saint Vincent de Paul Hospital).

Il-kelma 'xiħ' jew 'xjuħ' ukoll ma bqajniex nuzawha hafna 'b'rispett' lejn l-individwu u daħlet il-moda li ngħidu 'anzjani'. Insibu wkoll ffaxxaturi /faxex/ faxxa/ infaxxat/ spika (*bandages/ bandaging*) u lista twila ta' kliem attribwit magħhom bħall-'faxex tal-lastiku/ tal-lamtu/ tas-silikat/ tal-gibs/ tal-flanella/ u tal-għarkub', 'faxxaturi spirali/ tas-swa-ba/ tal-irkoppa/ bir-rivolti/ tal-wirk/ tar-ras/ tal-għajn/ tas-swaba tas-sieq/ mghaqqda/ tat-tronco (tas-sider)/ trijangolari (ingravati)/ tar-romblu/ ta' Mayor/ tal-magħqad/ tal-perineo/ tal-iscroto (*scrotum*) u / rqieq'. Insibu wkoll 'spica tar-rkiek' u 'tad-driegħ'. Fil-bidu tas-seklu għoxrin kienu jir-referu għat-tip ta' sodod differenti bħal-'sodod tal-frattura/ tal-ernja/ tad deliranti/ tat-trabi/ tax-xjuħ/ tal-ħlas' u 'għall-bronkite'.

Espressjonijiet oħra huma attrubwiti mal-mewt. Per eżempju meta n-Nurses jgħidu 'waslet Ċensa l-mewt' (*grim reaper*) ikunu qed jir-referu għal meta numru ta' pazjenti jmutu f'daqqa jew f'perjodu relattivament qasir. 'Telaqna' / 'telqitna'/

'ħalliena'/ 'ħallietna' / 'mar id-dinja l-oħra'/ 'mar għand Alla'/ 'għalaq għajnejh'/ 'straħ'/ 'spicċa' (*passed away*) ngħidu għall-meta jmut xi pazjent. Ngħidu wkoll 'qieghed bil-Grizma' jew 'bid-dilka' (*last offices/ anointment of the sick/extreme unc-tion*) għal-meta namministraw il-Grizma tal-Morda jew meta l-qraba tal-pazjent jistgħu izuru l-isptar kull meta jkun hemm periklu ta' mewt.

Nispjegaw li 'moribond' ikun 'qieghed fl-aħħar' jew 'agonizzanti' meta jkollu l-'ħarħara/horħara/ ħurħara tal-mewt' (*death-rattle*). 'Iħarħar' (*crepitus*) huwa terminu użat ukoll biex jispjega it-tip ta' nifs li qed jiehu pazjent.

Ngħidu wkoll 'mhux qieghed sew' (*unwell*), 'mghadur', 'mghaffeg', 'mghattan', 'maħsus', 'imkabar', 'is-far mewt', 'marid mejjet', 'malandat', 'jilgħaba', 'wasal/wasal fl-aħħar', 'ħa diskata'; 'isfar lellux' jew 'sfar', 'aħ-dar ħaxix' jew 'ħdar', 'kiesah silg' jew 'kesah' u 'aħmar nar' għal-meta l-pazjent ikun 'ħazin hafna', 'ma jif-laħx' jew biex nispjegaw kuluru.

Interessanti li l-kelma 'jiflaħ' ġejja mill-Għarbi 'falaħ' u tfisser li 'tagħzaq l-art' ('fellaħ' tfisser ukoll bidwi) u al-lura jfissru 'li tkun b'saħħtek' u biex tagħzaq l-art hekk trid tkun! Mhux

• ikompli f'paġna 36

• ikompli minn paġna 35

b'disrispett il-pazjent jista' jkun 'diżastru', 'splodut', 'spiccut', 'imnejjek', 'imnellah/tmellah' (to become ill jew anke 'miet'), 'imdamdam' jew 'mandra/immandar', 'baqa tahtha', 'kabočča' u 'għoqda', imma tajjeb li dawn il-kliem jiġu evitati għax jistgħu jinsulentaw.

Ngħidu 'qatagħlu l-kundanna' meta l-pazjent jirċievi aħbar hażina mit-tabib. Ngħidu wkoll 'tagħtu taqliba'/'qaleb għall-għar'/'qaleb għajnejh' għall-meta l-kundizzjoni tal-pazjent tinbidel għal-hażin f'daqqa; 'jirkupra'/'jigi għall-quddiem' meta pazjent jaqleb għall-aħjar; 'Gej il-Vjatku' (*Viaticum*, jew 'is-Sagrament') dari konna ngħidu, waqt li illum ngħidu 'gej il-Patri/Father/Tqarbin'. Il-pazjent ta' sikwit isaqsu għas-Sacerdot biex ikunu jistgħu 'jiskorru' jiġifieri 'jqerru' jew 'jirċievu l-assoluzzjoni'.

Illum rarament il-pazjent jindifen 'povru' (*pauper*) jiġifieri meta l-

pazjent ikun fqir hafna u m'għandu 'l hadd biex jgħamillu funeral u 'jitkeffen'/'kefna'/'kfejna' (shrouding/small shroud) meta jmut, kelma antika hafna b'għerq Semitiku u illum ssib minn jgħid 'nippakkjawh' bit-tajjar. It-tabib 'jiċċertifika' 'l-mejjet' (the dead) meta jsir 'ċertifikat tal-mewt' (*death certificate*). Ngħidu wkoll 'ibbies' u 'kesaħ' meta l-'katavru' (*cadaver*) ikun għadda perjodu ta' ħin minn fuq. Dari konna nirreferu għall-'bokkamort/bekkamort', illum nirreferu għall-'kommissjonant' (*undertaker*). Fil-qasam tal-Patologija ngħidu 'rigor mortis', 'mortwarja', 'fil-friża', 'ibbalzmar', 'karru tal-mejtin' 'katavru' u 'awtopsja'.

Fl-'Emergenza' (*Casualty*) il-pazjent jidhol 'mifquh', 'hażin', 'mifluġ', 'accumu', (b'referenza għall-Ecce Uomo fil-Ġimgħa l-Kbira kollu dbenġil, demm u feriti), b' 'accident', f' 'disgrazzja' jew 'traġedja'.

Fil-qasam soċjali konna nirreferu għall-'vagabond' li illum tisser homeless.

Kliem ieħor użat mill-pazjenti fl-isptarijiet huwa bħall-użu hażin tal-kelma X-Ray u li tingħad 'extrejt' jew 'ritratt tal-qalb'; 'Laflavin' jew 'l-isfar' meta konna nirreferu għall-Acridflavin; 'Gyner' għall-Gynae Ward; 'l-ipstar' meta nirreferu għall-isptar; 'pirmli'; bil-'cutter' jew 'katitru' għal-min għandu l-catheter u 'tal-messaġġi' għall-physiotherapists. 'Taħraq l-awrina/il-pipi' kienet tintuża meta tit-testja l-awrina, għalkemm it-terminu ma kienx skorrett għaliex wieħed kien jiddetermina 'iz-zokkar fid-demm' (*blood sugar*) /awrina billi kien jaħraq l-awrina flimkien mal-Benedict's solution. Uħud jgħidu 'pilloli' meta jirreferu għall-'pinnoli' waqt li 'pinuri' (kelma użata f'Ghawdex) tisser ukoll pinnoli jew *tablets*). Dari konna nitkellmu fuq 'trab tal-Penicellina' (Penicillin) li kien 'antibijotiku' (*antibiotic*). Illum 'it-trab' nużawh bħala thickener f'pazjenti li għandhom problema biex jibilgħu l-ikel. Fil-folklor u 'ħxejjex mediċinali' niltaqgħu ukoll ma 'duwa tal-patrijiet', fejn fost



Il-qabla (Midwife) tal-M.M.D.N.A. qed taħsel tarbija tat-twelid wara ħlas f'dar privata

ħafna taħlit li kien isir insibu 'žejt', 'minju', 'mastka', 'incens', kamfra u anke 'xemgha'. Insibu wkoll 'bajda tal-Lunzjata', 'čarruta mxarrba' (*tepid sponging*), qamħ maħruq u 'pal bajtar tax-xewk mixwi'.

Kliem ieħor li niltaqgħu miegħu huwa 'bil-maskla' jiġifieri 'bil-maskla tal-ossigħnu; 'bil-pajp' jiġifieri bil-pajp ta' l-awrina, ta' l-ikel jew tan-nifs (*urinary catheter*, Ryle's tube jew *oxygen*); 'bit-tubu' (*intubated*); 'affann' jiġifieri 'b'nifsu maqtuġħ'; 'tah il-mejt' (frazi wżata l-aktar Għawdex) jew 'għaxwa' jiġifieri 'ħassu ħazin' jew 'anemija ċerebrali', waqt li 'għaxxej' (*person subject to fainting fit*); 'ħedla' jew 'telqa'; 'xipli', 'debbulizza/debboli' (*weak*), 'marradi/ja', 'suxxettibli' (*susceptible*); 'mitluf minn sensih' jew 'sinkope'; 'għaddietu' / 'għaddietu dik', 'kongestjoni ċerebrali', 'inqatgħetlu/instadditlu vina' jiġifieri 'puplesija' (*stroke/CVA*); 'paraliżi' jew 'nofs ġismu mejjet' (*paralysis*); 'ħalqu mgħawweġ' (*paralysis of the face*); 'tal-qamar' jew 'konvulsjonijiet tal-qamar' (*epilepsy*); 'ikkuppat' (*constipated* jew *chest tightness*); 'maqsum' (*full bladder* jew muġuġħ ħafna), 'misdud', 'għandu tapp'; 'xedda' / 'sadda' meta jkun 'ikkonstipat', 'stitiku' / 'stitikezza' u 'mimli' meta l-ħarqa tkun maħmuġa jew l-imsaren b'ippurgar' / 'ħmieġ' iebes; 'morliti/murliti/emorrojdi' (*haemorrhoids* jew *piles*); 'imkisser' , 'imčafas' , 'imdamdam', 'imġandar' jew 'imħassar' (*in severe pain or uncomfortable*); 'uġieġħ ta' ras' (*headache*) u postijiet oħra bħall-irkoppa, fl-għadam, fid-dahar eċċ; 'migranja', 'emikranja' jew 'emigranja' (*migrains*); Fir-rigward tal-uġieġħ ngħidu 'jitgħawweġ bl-uġieġħ' jew 'kobba bl-uġieġħ'; 'ħlewwa ta' qalb' tirreferi għall-uġieġħ partikolari kultant inspiegabbli; 'imdaħdaħ' jew 'fgat' (*blocked nose/suffocated*); 'tisfir' (*tinnitus* jew *wheezing*); 'widnejn itamburu/isaffru/ idamdmu'; 'tharhir' (*rhonchi*) waqt li t-tabib jgħid lill-pazjent jirrepeti 'disgħa w disgħin' (*ninety nine*); 'żarżir' (*ear ringing*); 'tonsillite' / 'bit-tunsilli' (*tonsillitis*); 'bil-qamel', 'berghut', 'qurdien', 'baqq', 'skabbja' / 'skrejbil' / 'bid-dud' (*lice/ticks/scabies/*



Il-Benedict's Solution

nits); 'bid-duda' jew 'ħniex' (*tape-worm*); 'qxur /qoxra tar-ras/tal-ġilda/qxejra' (*dandruff* jew 'briija'); 'kallu/kallijiet' (*corns*); 'dermatite' (*dermatitis*); 'għandu/għanda dak' / 'għandu ta' barra minn fuqna' (*he has/she has cancer* jew 'kanċer'); 'kanċer rieqed' jew 'kanċer mifrux'; 'metastasi' (*metastasis*); 'telf t'aptit' / 'naqqas l-aptit' / 'ingħalaqlu l-istonku' (*loss of appetite*); 'tnaqqis fil-piż' / 'telf ta' piż' (*weight loss*); 'xlieqa' / 'ponta tad-deni' (*exulceration/herpes simplex*); 'postumetta/postulettu' / 'stumetta' / 'kustumetta' / 'fuqqieġħa' / 'boqqieġħa' / 'ulčera tal-ħalq' / 'qalza' (rari tintuża) (*aphthous ulcer*); 'ħrar' (*oral candidiasis/thrush*); 'ħafsa' (plural 'ħafas') (*prickly heat/heat rash*), 'infafet' (*postules*); 'nuffata' jew 'fossa', 'buzzieqa/bziezaq', 'faqqieġħa' jew 'boqqieġħa/baqqieha' (*blister* jew *vesicular fluid*); 'ekzema' (*eczema*); 'raxx' (*rash*); 'selħa' / 'sliħ' (*abrasion*); 'ħażzieħ' (infjammazzjoni bil-fungus); 'xquq is-safra/xafra' / 'qsim fl-għarqub' / 'qieġħ is-siq imfellel' (*cracked heel*); 'farrett' (*gash* jew *laceration-contused wound/LCW*); 'ferita' / 'ferut' / 'gerħa' / 'pjaga' (*wound* jew *wounded*); barxa/brix' (*scratch*); 'fsada' jew 'fagra' (*epistaxis*); 'flebotomija' (*phlebotomy*); 'ħmura tal-ġilda' (*redness*); 'materja' (*pus*); 'gangrena'

/ 'kankrena' (*gangrene*); 'tnixxija' (*oozing*); 'ħorriqqa' (*hives*); 'suffejra' (*jaundice*); 'dieħes' / 'subgħa jġma' (*whitlow/suppurate*); 'seqi' (*chill-blains*); 'xolliefa' / 'xulliefa' (*agnail*); 'mard tas-sider' (*tuberkolosi/T.B.*); 'qtuġħ il-laħam' (*muscle soreness*); 'ħobza' (*swelling*); 'laħam ħazin' fl-immieħer (*adenoids*); 'rukkell' (*tube used in grommets*); 'bir-ross' (*lipoma*); 'laħam żejjed' (*lymphatic tissue* jew *nasal obstructions*); 'ħzieza' / 'dbabar' (*ringworm* jew *herpes*); 'musmar', 'musmar maqlub' jew 'fistla/fissla' fil-'warrani' (*boil/fistula*); 'ponta' (*pimple*); 'felul/a' (*wart/s* u li kultant tirreferi għall-kanċer biex nispegaw lill-pazjent u ma nkunux daqshekk esplicitu fir-rigward tad-'dijanjożi' / diagnosis); Il-felul 'jinħarqu' ('jiġu ffrizati') permezz ta' kimika jew liquid nitrogen (*cryotherapy*); 'għazza' (*mole*); 'česta' (*cyst*); 'ħakk' / 'ikel' jew 'urtikarja' (*itching, pruritus, urticaria*); 'mard tal-ġilda' (*skin disease*); 'tbajja'; 'tbenġila' / 'kuħħala' / 'tagħtina' (*bruise/haematoma/contusion*); 'cellolite/cellulite' (*cellulitis*); 'purpora' (*purpura*); u 'gundalla' / 'tumakka' (*bump*). Meta jkun hemm 'gdim tan-nemus' ngħidu li l-pazjent 'tqatta' jew 'imqatta'.

• Ikompli f'ħarga oħra

Għar-riferenzi kkuntattjaw lil: Joe Camilleri

Measles cases in the EU treble in 2017

Outbreaks still ongoing in France, UK and Sweden

The number of measles cases in the EU has trebled in just one year, according to the European Centre for Disease Control.

In 2017, 14,451 measles cases were reported, three times the number of cases reported in 2016 (4,643).

The highest number of measles cases to date in the EU since January 1, 2017 were in Romania (10,623), Italy (4,991), Greece (1,463) and Germany (926).

This increase was due to a number of outbreaks in EU countries – some of which are still taking place, such as those in France, the UK and Sweden.

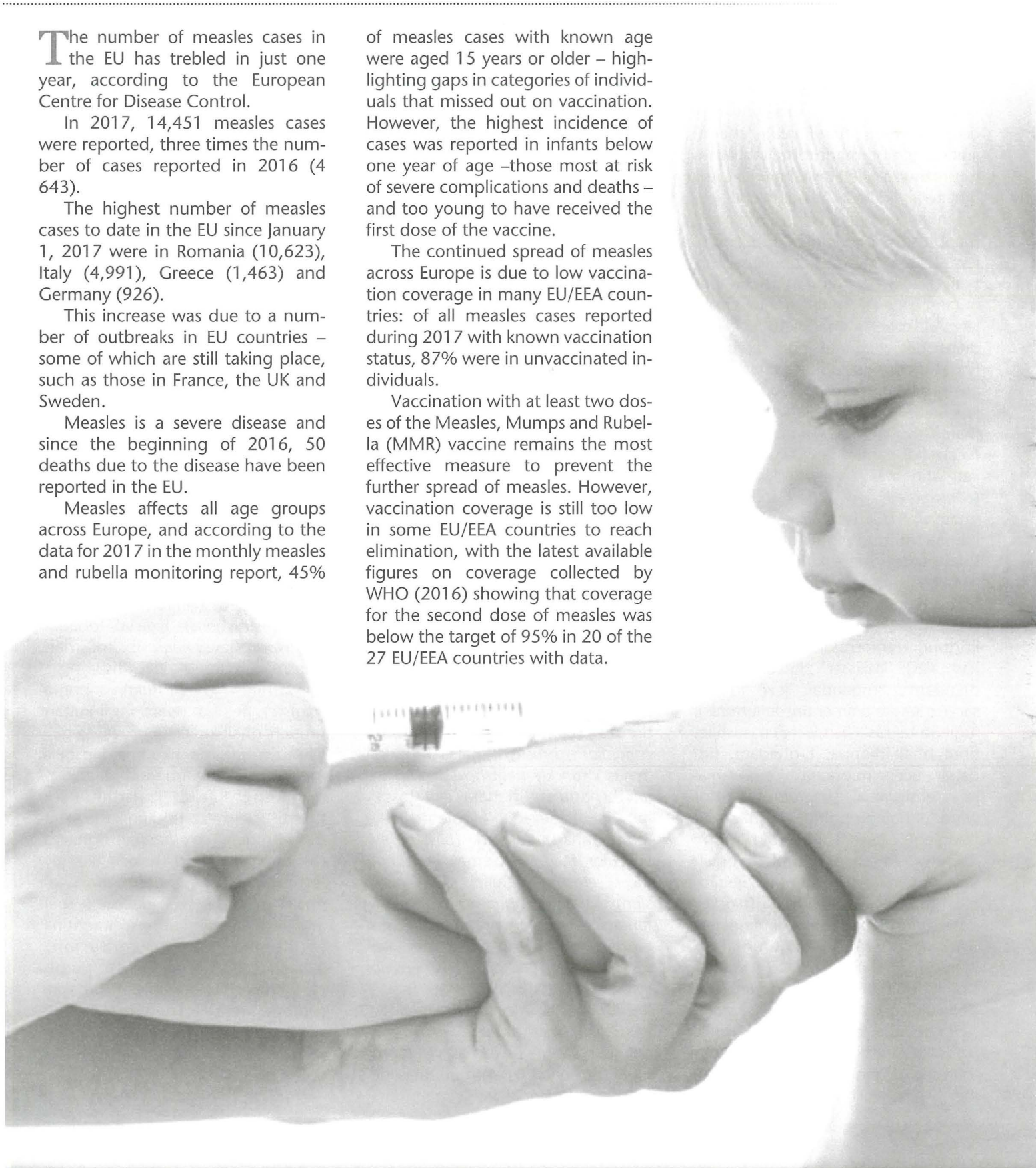
Measles is a severe disease and since the beginning of 2016, 50 deaths due to the disease have been reported in the EU.

Measles affects all age groups across Europe, and according to the data for 2017 in the monthly measles and rubella monitoring report, 45%

of measles cases with known age were aged 15 years or older – highlighting gaps in categories of individuals that missed out on vaccination. However, the highest incidence of cases was reported in infants below one year of age – those most at risk of severe complications and deaths – and too young to have received the first dose of the vaccine.

The continued spread of measles across Europe is due to low vaccination coverage in many EU/EEA countries: of all measles cases reported during 2017 with known vaccination status, 87% were in unvaccinated individuals.

Vaccination with at least two doses of the Measles, Mumps and Rubella (MMR) vaccine remains the most effective measure to prevent the further spread of measles. However, vaccination coverage is still too low in some EU/EEA countries to reach elimination, with the latest available figures on coverage collected by WHO (2016) showing that coverage for the second dose of measles was below the target of 95% in 20 of the 27 EU/EEA countries with data.





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