Il-Musbieħ

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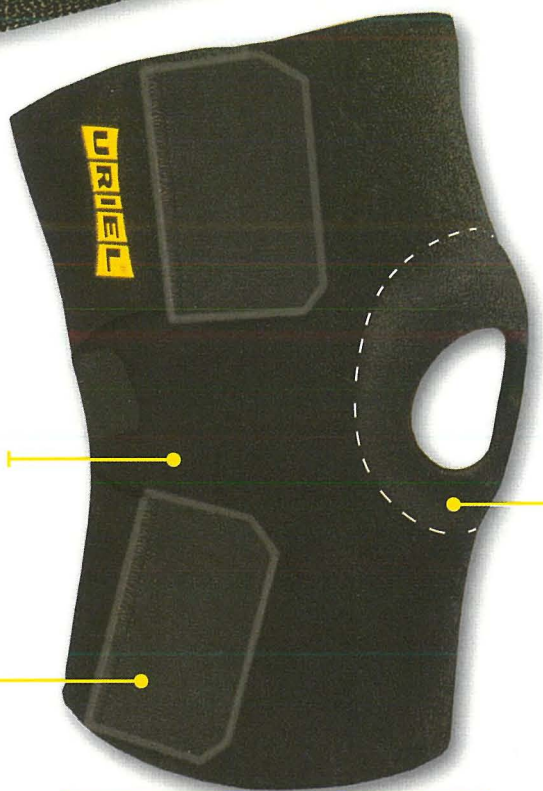

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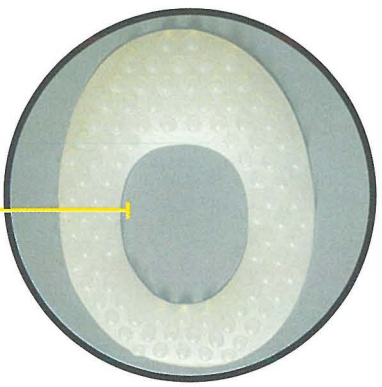

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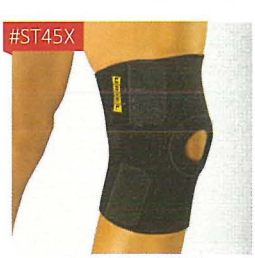

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KNEE SUPPORT

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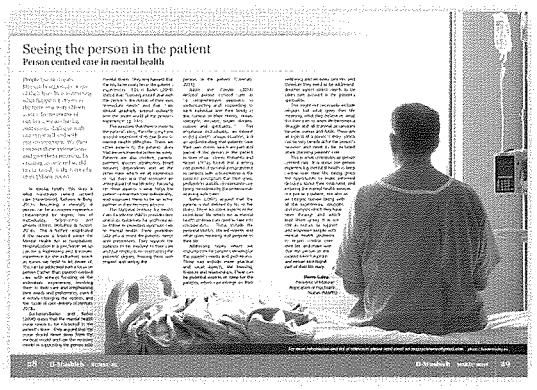

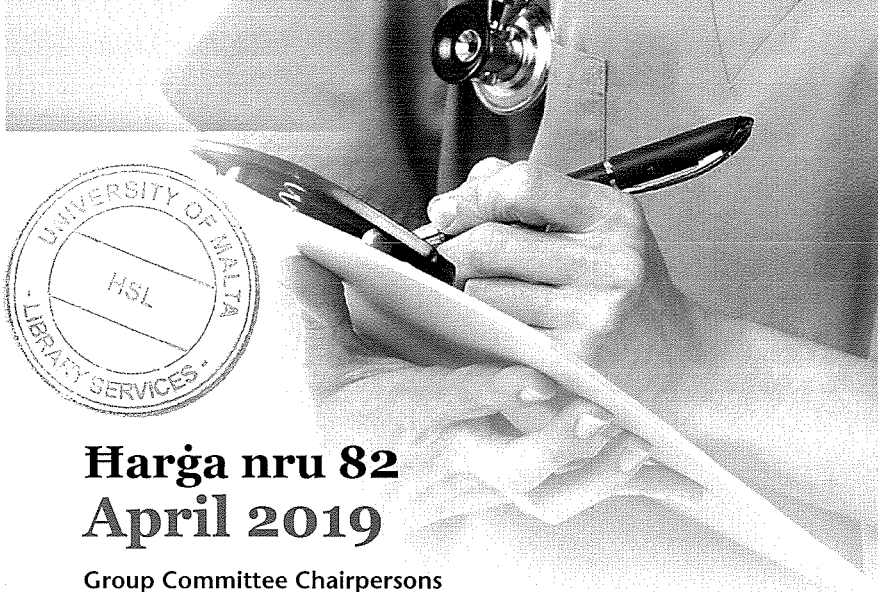

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Cold weather and influenza

Mater Dei Hospital has been admitting an average of 200 patients per day, leading to increased waiting times at emergency for patients to be allocated a bed. MDH was simply inundated with patients and every year during winter time the hospital operates very close to full capacity. High patient numbers at Mater Dei Hospital persist during the cold spells with the hospital operating at above normal activity levels. The sudden drop of temperatures has created difficulties for people who suffer from chronic heart and respiratory problems but obviously the influenza (type A) has not helped.

Patients with Swine flu, treated at Mater Dei Hospital contracted the virus from the community and were admitted to hospital for the management of respiratory complications. H1N1 strain was included in this year's seasonal influenza vaccine which is given for free in all health centres.

At one point in time there were as much as 30 patients and more who were being treated for the virus at Mater Dei Hospital, half of which were elderly patients from St Vincent de Paul Hospital. A cohort ward was actually set up to control, as much as possible, the spread of the virus.

Mater Dei experiences winter peaks like all other hospitals across Europe. There is obviously an increase in waiting time for patients who visit A&E every year. Other problems which affect our duties are low stock items, overcrowding, problematic discharges, staff on sick leave and stress.

Each year, Malta's Public Health publishes instructions to the community to protect the population from harm to health due to cold weather. The key public health messages are directed toward the general population and are to "get the flu jab" if they are in one of the risk groups, and to keep their home warm. Despite these preparations, there is still considerable excess mortality and morbidity every winter. All people at high risk should be vaccinated against Influenza including doctors, nurses and other employees in hospitals and doctors' offices, including emergency response workers, employees of nursing homes and long-term care facilities who have contact with patients or residents, employees of assisted living and other residences for people in high-risk groups, people who provide home care to those in high-risk groups and household members (including children) of people in high-risk groups.

With regards the general population, most people who want to lower their chances of getting the Flu can get vaccinated. People who provide essential community services (e.g. police, firemen etc.) should consider getting vaccinated to minimise the disruption of essential activities during Flu outbreaks. Vaccination is also encouraged for students or others in institutional settings (e.g. those who reside in dormitories). It is worth noting that vaccination of healthy adults reduces the morbidity rate by 65% on average. This is also cost-saving to the Maltese society. One should also take note that an ageing population coupled with an increase in the number of foreigners moving to the island could prove to be problematic for the entire health system. This means that very soon our hospitals might not have enough beds to treat all patients.

Hospital staff work very hard during these times and many go the extra mile even with such an influx of patients at the jam-packed hospitals. Thankyou everyone.

President's message

If I am writing this article in this issue of the 'Il-Musbieh', it is thanks to you for the overwhelming support which you gave me. I must be the first union president in the country, to return back to the same union, once again as President. As President I would like to thank also the past Council members and all candidates who contested to become Council members but unfortunately did not make it. All such members are already providing a sterling service and I am sure that their service is just as valid.

Needless to say, the health sector is continuously evolving, thus when one issue has been resolved, five new issues crop up. What is clear is that the nursing profession, midwifery and other health care professions within MUMN have become more stressful, more demanding and more frustrating. To add the cherry to the cake, nurses are now being taken to court, prosecuted for criminal offenses on issues well beyond their capabilities. The legal implications are the last straw which nurses, midwives and other health professionals are now facing with dire consequences to their well being and their families.

I can guarantee to all members that the MUMN Council will be holding all the necessary meetings with various establishments, being Steward, MDH, MCH etc. as to guarantee that Nurses, Midwives and other Health Care Professionals will have some form of legal protection when supervision, constant watch or level one is ordered. Nurses are no punch backs and no one deserves to be prosecuted on issues which are beyond their means.

Shortage of staff is another issue which is leaving a toll on the health of nurses, midwives etc. This issue has been long standing and it is clear that although figures issued by the Health Department are showing an increase in man power, the bone of contention has never been solved. Shortage of staff on the wards is also having its toll on the nurses, midwives, etc. mental and physical well being.

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On the other hand, the worst hospital as regards infrastructure is without any doubt Mt. Carmel Hospital. With all the hype that Mt. Carmel will be seeing huge investments and upgrading, MCH has become the most dangerous hospital to work with supporting columns to hold condemned ceiling structures being added every month.

It is a pity, since the true stigma in the Mental Health service is not the condition of the patient but the poor infrastructure of MCH. With all the various direct orders issued by every ministry on various works, MCH was allowed to deteriorate since not even a tender was issued to start addressing any of these huge infrastructural issues. It is a great pity, since hospital workers and patients deserve better.

I have just mentioned some issues and I am sure that there are other issues in other clinical areas which still need to be addressed and I have not mentioned.

On a personal note...well I have to confess, I missed you, the union and all the challenges which lay ahead of us. I will be making it a point that in the coming months to try to visit you in your working places being in Malta and Gozo.

All the members of the Council will be having different roles in the union and all will be contributing according to their given role. MUMN is not a one man union but a strong union with one voice which is built on good foundations. I am sure that all Group Committees, being that of the industrial, social or educational will continue to be at the service to all MUMN members.

What can I say.....a thank you to all for not just supporting me but all members elected, thank you for all the candidates who contested and yes, a thank you for my family and friends who were there for me in my most difficult times.

Paul Pace
President

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Kelmtejn mis-Segretarju Ġenerali

Iż-żmien ma jistenna lil ħadd. Beda terminu ta' Kunsill ieħor, terminu li jwassalna sa 2023. Nieħu l-opportunità sabiex nirringrazzja lill-membri kollha li pparteċipaw f'din l-elezzjoni. Dan ir-riżultat jerġa' jitfa' fuqi responsabbilità kbira peress li għal darb'oħra kont l-aktar kandidat li ġibt voti. Dan jimlini b'kuraġġ u determinazzjoni sabiex b'umiltà inkompli nservik għal erba' snin oħra.

Dan il-Kunsill għandu oġġettiv primarju li jħares il-kundizzjonijiet tax-xogħol tal-membri. In-nuqqas ta' Nurses, Social Workers u ECG Technicians qed iwasslu biex dawn il-professjonisti jiġu ttrattati b'mod differenti mill-*management* minħabba l-istess nuqqas.

Dan ifisser li dawn il-membri mhux qed isofru biss in-nuqqas ta' *compliment* u *supporting staff* iżda qed jiġu wkoll ttrattati b'mod inferjuri. Eżempju ta' dan huwa l-*vacation leave*. Problema oħra hija n-nuqqas ta' *carers* sabiex jiġu koperti l-*constant watches* li jkun hemm fis-swali.

Sfida oħra akuta hija s-sitwazzjoni miskina li jinsab fiha l-isptar Monte Karmeli fejn l-infrastruttura hija waħda tal-biża u ta' periklu. Dawn il-problemi ta' nuqqas ta' saħħa u sigurtà qed jirriżultaw ukoll f'nuqqas ta' sodod, liema nuqqas qed jikkawża konġestjoni f'ħafna swali.

Sfida oħra se tkun il-ħtieġa li jiġu ffirmati l-Ftehim Settorali tal-Physiotherapists u s-Social Workers f'dawn ix-xhur li ġejjin. Stennejna biżżejjed u għalhekk issa wasal il-waqt li tittieħed azzjoni.

Dan il-Kunsill irid jara wkoll is-sistemi tal-ikel li qed jiġu addottati mill-*management* ta' numru ta' sptarijiet. Irridu naraw meta ħa jinbena l-*campus* il-ġdid tan-*nurses* kif ukoll strutturi oħra li l-membri tagħna mhux qegħdin sew fihom bħal ma huwa d-Dipartiment tal-Physiotherapists fl-isptar San Luqa. Irridu naraw kif l-iskema ta' *insurance* mill-Gvern ma ġietx addotata wkoll fil-Ministeru tas-Saħħa.

Dawn huma ftit mill-punti li dan il-Kunsill il-ġdid se jkin qiegħed jitratta. Naturalment il- Kunsill waħdu mingħajr l-Attivisti u l-Membri ma jagħmel xejn. Irridu naħdmu kif dejjem ħdimna bħala ponn wieħed, qaqoċċa waħda. B'hekk biss nistgħu nkunu effettivi.

Ma nistax nispiċċa dawn il-kelmtejn mingħajr ma nirringrazzja l-membri kollha tal-Kunsill li għadu kemm spiċċa, speċjalment lill-President tiegħu Maria Cutajar fejn mexxiet dawn l-erba' snin b'għaqal u b'viżjoni. Xhieda kemm dan il-Kunsill baqa' attiv sal-aħħar hija l-Konferenza tal-Commonwealth fejn l-organizzazzjoni tagħha kienet perfetta u kull min attenda ħareġ sodisfatt. Prosit lil kull min ikkontribwixxa għas-suċċess ta' din il-Konferenza.

Huwa importanti li nagħmlu kuraġġ u nkomplu naħdmu fl-interess tal-membri kollha u dan huwa proprju dak li se jagħmel dan il-Kunsill ġdid bl-għajnuna ta' kull min għandu għal qalbu dawn il-ħames professjonijiet li nirrappreżentaw.

Saħħa,

Colin Galea
Segretarju Ġenerali

Florence Nightingale Benevolent Fund

In-nurses u l-midwives membri fil-Florence Nightingale Benevolent Fund u li waslu fis-sena tal-irtirar tagħhom wara numru sostanzjali ta' snin li taw servizz lill-pazjenti. Dan il-Fund bħala sinjal ta' apprezzament lejn il-ħidma fejjieda li wettqu dawn il-membri, ippreżentalhom Momento permezz tal-E.T. President ta' Malta li hija wkoll il-Patrun tal-istess Fund.

Three important attitudes in *pastoral care*

Pope Francis is surely the Pope we need for our turbulent times. This has been attested by his diverse yet insightful thoughts on myriad of subjects, some of them regarding controversial and delicate discussions. Some time ago I have come across an interesting address he gave to the Assembly of Congregation for Clergy. The Holy Father delivered this compelling speech on June 1 2017.

The more I delved deeper into this speech the more I realised how actual it is to my pastoral care as a chaplain at Mater Dei Hospital. What the Pope had in mind when speaking to the members of the Congregation were us, young priests. In his address the Pope said that "young priests ... live the joy of the beginning of the ministry and, at the same time, perceive its weightiness. The heart of a young priests lives between enthusiasm for the first projects and the anxiety of apostolic efforts, in which he immerses himself with a certain fear, which is a sign of wisdom. He feels profoundly the jubilation and the strength of the anointing received, but his shoulders begin to feel gradually the weight of the responsibility, of the numerous pastoral commitments and the expectations of the People of God".

Knowing well the challenges we face in our ministry the Holy Father gave us three pivotal pastoral attitudes that keep us improving our personal and pastoral identity as priests. As Francis righty observed young priests make him rejoice because in them he sees "the youth of the Church". So what are these attitudes that should mark young priests and orient them as missionary disciples in permanent formation? These attitudes are: pray without tiring, walk always and share with the heart.

The Pope right away explains the first attitude, pray without tiring. He says that "pray without tiring, because we can only be 'fishers of men' if we first realize that we have been 'caught' by the Lord's tenderness. Our vocation began when, having abandoned the land of our individualism and our personal projects, we are journeying for the 'holy journey,' giving ourselves over to that Love that sought us in the night and to that Voice that made our heart vibrate. Thus, as the fishermen of Galilee, we have left our nets to grip those that the Master has given us. If we do not remain closely bound to Him, our fishing will not be successful. I recommend: pray always!

During the years of formation, the schedules of our days were scanned so as to leave the necessary time

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for prayer; afterwards, one cannot have everything so systematized – life is something else – everything organized, from the moment that one is immersed in the rhythms, sometimes pressing of the pastoral commitments. However, precisely what we acquired in the time of the Seminary – living the harmony between prayer, work and rest – is a precious resource to address the apostolic labours. Every day we have need of pausing, of listening to the Word of God and of staying before the Tabernacle. 'But I try, but . . . I fall asleep before the Tabernacle.' Fall asleep also, which the Lord likes, but stay there, before Him. And to take care also to listen to our body, which is a good doctor, and which lets us know when exhaustion has surpassed its limits. Prayer, the relationship with God, the care of the spiritual life give soul to the ministry, and the ministry, so to speak, gives body to the spiritual life: because the priest sanctifies himself and others in the concrete exercise of the ministry, especially preaching and celebrating the Sacraments".

After reading such an inspiring reflection I would simply ask as a chaplain the following pertinent questions. First, do I realize that I have been caught by the Lord to work as a chaplain within the hospital setting? Second, do I acknowledge the fact that I am journeying a holy journey with the patients left under my care? Third, does my life enjoy a balanced harmony between prayer, work and rest? In what way my pastoral ministry with patients is being nourished by prayer? And how my prayer life is, in turn, being nourished by my pastoral ministry?

The second crucial attitude the Pope mentions that should characterize the life of a young priest is "walk aways, because a priest has never 'arrived.' He always remains a disciple, pilgrim on the roads of the Gospel and of life, overlooking the threshold of the mystery of God and of the sacred land of the people entrusted to him. He will never be able to feel satisfied or extinguish the healthy restlessness that makes him extend his hands to the Lord to let himself be formed and filled. Therefore, update oneself always and remain open to God's surprises! In this openness to the new, young priests can be creative in evangelization, frequenting with discernment the new places of communication, where to find faces, stories and questions of persons, developing the capacity of sociality, of relation and of proclamation of the faith. In the same way, they can 'be in the network' with other presbyters and impede the woodworm of self-reference from braking the regenerating experience of priestly communion. In fact, in every realm of priestly life it is important to progress in faith, in love and in pastoral charity, without becoming rigid in one's acquisitions or being fixed in one's schemes".

Here are some of my reflective questions before this life-giving

• continued on page 10

• continued from page 9

pericope. First, do I humbly admit the fact that I have not yet 'arrived'? In other words that in the art of hospital chaplaincy I do not know it all? Do I accept the fact that I will always remain a disciple, a pilgrim of the Gospel of life when caring for the sick? Do I comprehend the need of updating myself so as to be creative in my provision of spiritual care? Do I attend chaplains conferences abroad to broaden my horizon? Am I reading and getting a sound supervision to help me better respond to the challenges the pastoral ministry continually presents to me? How flexible am I when giving spiritual care? Do I regularly share about how am I doing pastorally with my fellow chaplains?

The last attitude Pope Francis refers to is to "share with the heart, because presbyterial life is not a bureaucratic office or an ensemble of religious or liturgical practices to attend. We have spoken so much of the 'bureaucrat priest,' who is 'cleric of the State' and not Pastor of the people. To be priests is to stake one's life for the Lord and for brothers, bearing in one's own flesh the joys and anguishes of the People, spending time and listening to cure the wounds of others and offering all the tenderness of the Father. From the memory of their personal experience – when they were in the Oratory, cultivating dreams and friendships animated by youthful love for the Lord –, new priests have the great opportunity to live this sharing with young men and boys. It is about being in their midst, — also closeness here! — not only as a friend among others, but as one who is able to share their life with his heart, to listen to their questions and to participate concretely in the different vicissitudes of their life. Young people do not need a professional of the sacred or a hero that, from above and from the outside, responds to their questions; they are attracted, rather, by one who is able to be sincerely involved in their life, helping them with respect and listening to them with love. It is about having a heart full of passion and compassion, especially towards young people".

As a hospital chaplain do I see myself as a bureaucrat employer or as a cleric paid by the State? Or do I see myself as a pastor of people in need? While doing pastoral ministry am I spending time with the patients I am called to serve? Am I bearing in my flesh their joys and anguish? Am I letting the Lord curing their wounds by listening attentively to them? Do I understand that, in listening empathically, I am displaying to the people involved the Father's tenderness? Do I cherish the fact that such closeness to patients means listening to their queries, respecting and listening to them with love?

All in all being a hospital chaplain is a risky, but, at the same time, a fascinating ministry. These three important pastoral attitudes presented by Pope Francis are surely a great help to me and to all those who feel privileged that they were being called by the Lord to serve him in the least of his brothers and sisters, the sick.

Fr Mario Attard OFM Cap

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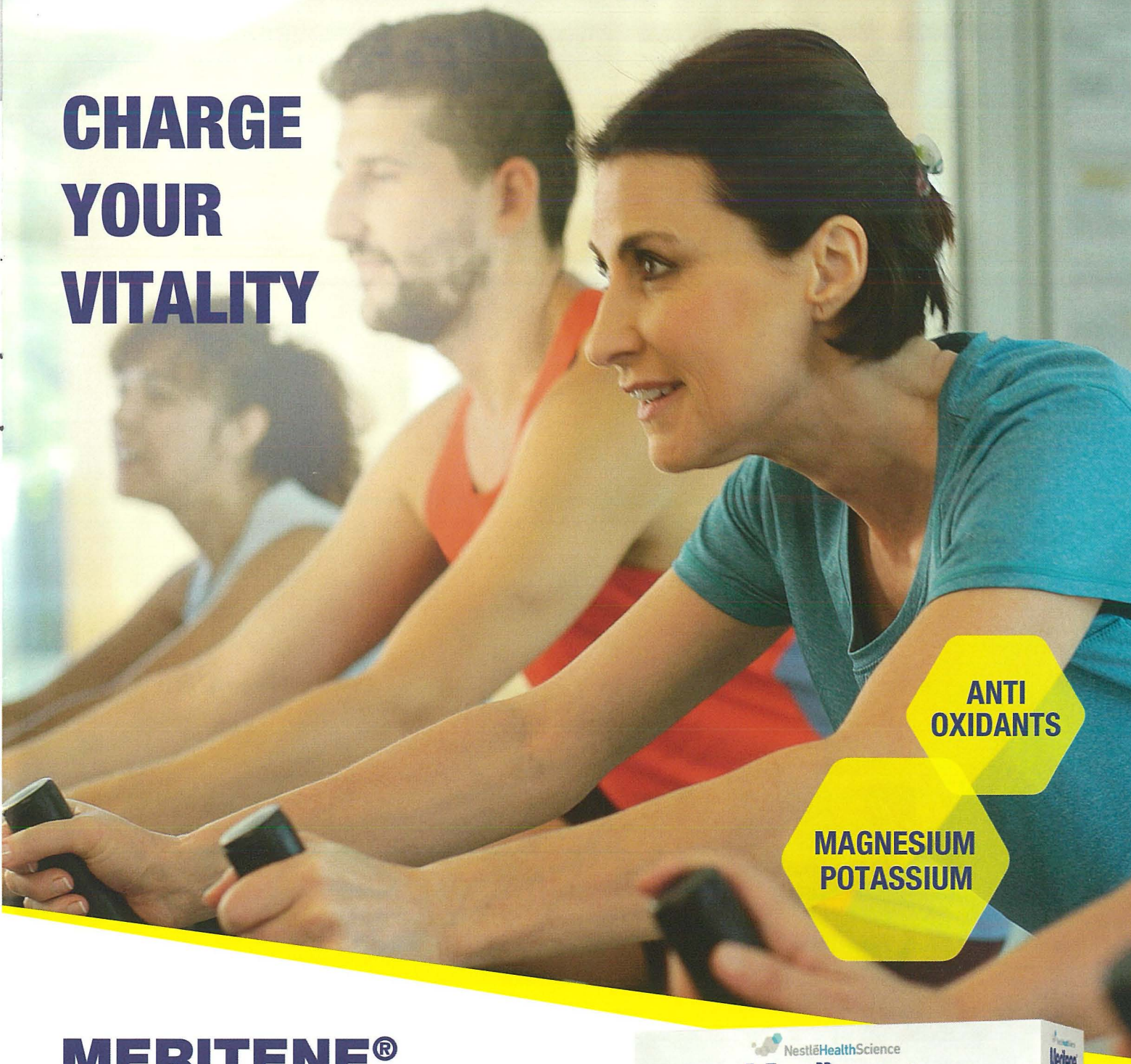

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Hoping that the situation will not be so busy in your homes and that you find time to do at least a walk between meals, remember, if you wish to get back into shape, you need to start from doing some physical activity and follow these simple tips given by our dietician Mirko Cirolli:-

Drink water only! Drinking alcohol is harmful not only due to the high calorie content (7 Kcal/ml), but also it could damage your liver, thus to get back into shape drink plenty of water. Your liver, muscles, skin, kidneys, and your body in general will reap the benefits. In addition, drinking water increases the sense of satiety and you will eat less!

Introduce healthy foods! After the festive excesses, your body may naturally crave light and healthy foods, therefore, cucumbers, cauliflower, cabbage, brussels sprouts, spinach and even broccoli seem more appealing. When doing your shopping, choose fruits and vegetables and healthy snacks, such as yogurt and natural unsalted nuts.

Eat moderately! Try to eat 5 to 7 little meals a day, at least 3 portions of vegetables and 2 fruits a day. During the main meals try to reduce processed carbohydrates like white bread and pasta, by replacing them with whole grain products like, barely, oat and whole rice. **Never skip protein source, otherwise you will lose your lean mass!** If you feel hungry, have a salad and include a protein source, like tuna, wild salmon, eggs or cold legumes. It is also recommended to consume legumes at least 5 to 6 times in a week in order to rebalance your microbiome by eliminating harmful substances accumulated. You should not consume cheese more than 3 times in a week, and do not consume eggs and red meat more than 1 time weekly. Malta is rich in fresh fish; feel free to have even 5 portions of wild fish weekly!

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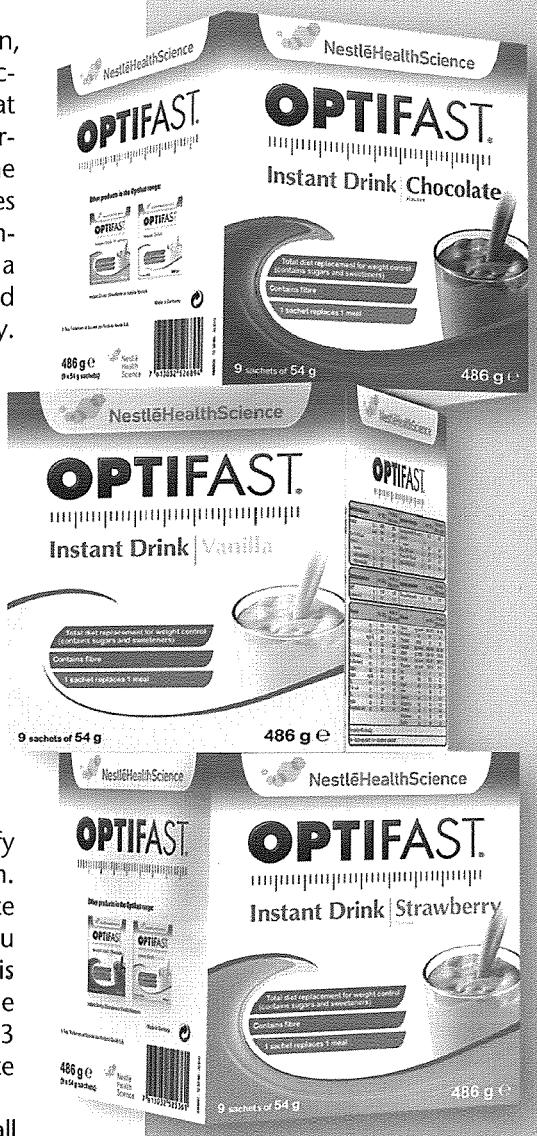
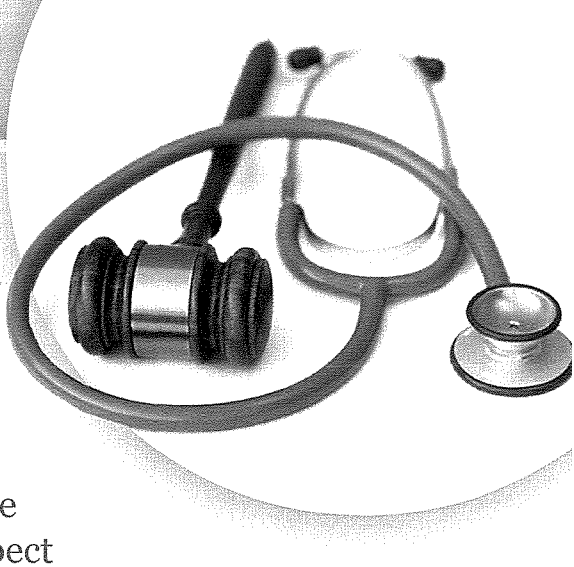


This article has been brought to you by:
Mirko Cirolli
BSc (Hons.) Dietetics(Italy) MSc Human Nutrition (Rome, Italy)
Business Developer Nestlé Infant Nutrition & Nestlé Heath Science

Conscientious Objection



Respect for persons is an important ethical principle. It is an approach that nurses and health care professionals in general should uphold and promote in their practice. However, respect for persons is not just concerned with how we treat others, it should also be considered in extension to oneself, meaning that we respect ourselves in the same manner that we respect others.

The conscience is said to have three characteristics, namely; an inner sense that distinguishes right act from wrong actions, the internalisation of parental and social norms, and a reflection of the integrity and wholeness of the person (Benjamin, 2004). Lachman (2014) explains that violating any of these characteristics can unsettle an individual's moral integrity. She explains that moral integrity is about being faithful to religious or moral convictions. Acting against these convictions can lead to a sense of self-betrayal and loss of self-respect.

The choices we make affect our moral integrity. Acting against our conscience can lead to moral distress and this can result in burnout, fatigue and emotional exhaustion (Lachman, 2009). Focusing on nursing, the choices we make as nurses can have a lasting impact on ourselves as well as our patients. Nurses can express conscientious objection when they find themselves in situations that violate professional moral standards or go beyond their moral integrity (Lachman, 2014). Torro-Flores et al (2017) explain that conscientious objection should be seen as a collision of rights and a conflict regarding values. Guillen & Sendin (2009) define conscientious objection as "the refusal to comply with professional obligations as stated by law or institutional rule, doing so by claiming moral or conscientious reasons."

The current local code of ethics for nurses and midwives does not refer to conscientious objection, or on what basis conscientious objection can be accepted. It must be acknowledged that conscientious objection can be challenging to verify. When one considers that there are problems with conscientious objection, such as false motivations and acknowledging that some acts of conscience are morally wrong – distinguishing this is difficult (Lachman, 2014) and creates challenges. It must be remembered that nurses have a professional obligation to respect patient dignity, promote patient autonomy as well as protect patient from harm. These principles are clearly referred to in the Maltese Code of Ethics for Nurses and Midwives (NMB, 1997).

That said, Magelssen (2012) proposes a set of criteria for the acceptance of conscientious objection (Lachman, 2014; Magelssen, 2012). These are presented in the table below: -

When the following criteria are met, it is recommended that conscientious objection should be accepted: -

1. Providing health care would seriously damage the health professional's moral integrity by constituting a serious violation of deeply held conviction.
2. The objection has a plausible moral or religious rationale.
3. The treatment is not considered an essential part of health professional's work.
4. The burdens to the patient are acceptably small: - a. The patient's condition is not life threatening. b. Refusal does not lead to the patient not getting the treatment, or to unacceptable delay or expenses. c. Measures have been taken to reduce the burdens to the patient.
5. The burdens to colleagues and health care institutions are acceptably small.

In addition, the claim to conscientious objection is strengthened if: -

6. The objection is founded in nursing's own values.
7. The medical procedure is new or of uncertain moral status.

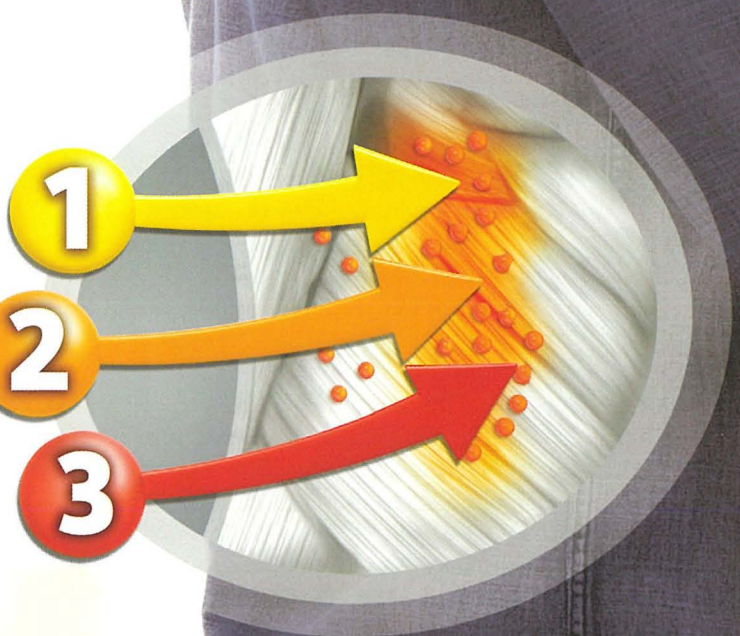
(Magelssen, 2012)

Conscientious objection is often considered in relation to controversial ethical practices such as abortion, sterilisation, reproductive technologies, as well as euthanasia, palliative sedation and with-drawing life support measures amongst others. More recently, topics related to genetic testing and stem cell research are also areas where nurses and other health care professionals are choosing to make conscience-based refusals. These topics will be discussed in future writeups in this section, whereas the upcoming article will continue to explore the subject of conscientious objection, with the aim of elaborating further on some of the points put forward here.

Marisa Vella

You may contact Marisa on marisalvella@gmail.com for references and information related to this article. Join the group Ethically Speaking on Facebook.

Penetrates deep to relieve pain



Relieves pain 1

Fights inflammation 2

Speeds natural healing 3

3

With **Triple Effect pain relief**

L-istorja tas-Siringa

Is-siringa Pascal

Interessanti li s-siringa ġiet ivvintata ferm qabel il-labra ipodermika. L-oriġini tagħha jmur lura għal żmien il-letteratura Griega u Rumana fejn hemm deskrizzjonijiet ta' qasab vojt minn ġewwa għar-ritwali tad-dlik tal-ġisem, u bħala strumenti tal-mużika bil-*plunger* jintuża biex titbiddel it-tonalità.

Il-kelma *syringe* fil-fatt ġejja mill-Grieg *syrinx*, u tfisser tubu *tube*. Galen (129-200 CE), Eġizzjan, jiddeskrivi l-użu ta' siringi sempliċi bil-*piston* biex jintużaw għall-kremi u ingwanti għall-użu mediku waqt li Ammar bin Ali al-Mawsili, irraporta fid-900 CE l-użu ta' tubi tal-ħġieg biex jikkawżaw *suction* għall-katarretti.

Fl-1650, Pascal għamel esperiment fil-*hydraulics* (Pascal's Law) u vvinta l-ewwel siringa moderna li permezz tagħha seta' jamministra l-mediċina.

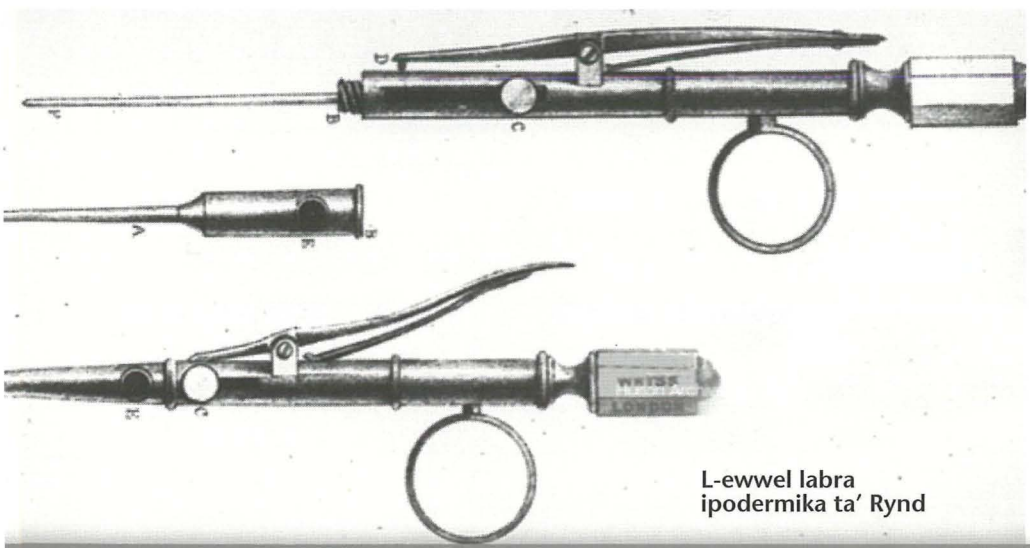
Christopher Wren (arkitett), uża teknika ta' *cut-down* biex jinjetta fil-vini tal-klieb bl-estratt tax-xaħxieħa (poppy) permezz ta' rixa tal-wiżż. Sal-1660 it-Tobba Major u Esholttz użaw dan l-istess metodu fuq l-umani b'riżultati fatali minħabba żball fid-doża u l-bżonn li jisterilizzaw l-apparat u l-infużjoni. Minħabba l-konsegwenza disastruża ta' dan l-esperiment l-użu tal-injezzjoni mar lura b'200 sena.

L-ewwel labra ipodermika ġiet ivvintata minn Francis Rynd f'Dublin fl-1844, billi ntużat it-teknoloġija biex minn strippi tal-ħadid isiru tubi, billi jiġġebbdu sakemm tinħoloq labra b'tubu rqieq u dejjaq minn ġewwa. Il-ponta tal-labra tinqata b'angolatura, tiġi msinna, tiġi miżjuda l-*hub* u anke l-aġġeġġ ikollha.

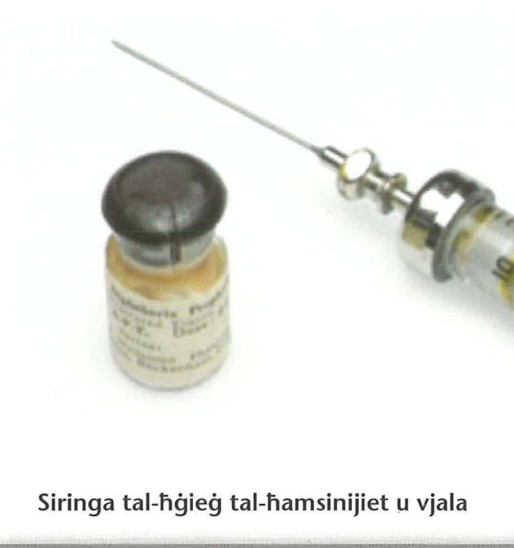
Charles Pravaz, fi Franza, amministra koagulant linnagħaġ fl-1853, waqt li Alexander Wood, minn Edinburgh, fl-istess sena kkombina siringa funzjonali ma' labra ipodermika, biex jinjetta l-morfina lill-umani u propabbilment għandu jieħu l-kredtu li kien hu li vvinta din it-teknika.

Ta' min wieħed jinnota li hu u martu kienu ġew *addicts* għall-morfina tant li martu tibqa' tissemma' bħala l-ewwel mara fid-dinja li mietet b'*overdose* ta' morfina injettata. Fl-1899 Letitia Mumford Geer minn New York iddisinjat siringa li tista' tħaddimha b'id waħda. Daqs ħamsin sena wara, fl-1946 ic-Chance Brothers tal-Ingilterra pproduċew l-ewwel siringa magħmula kollha mill-ħġieġ.

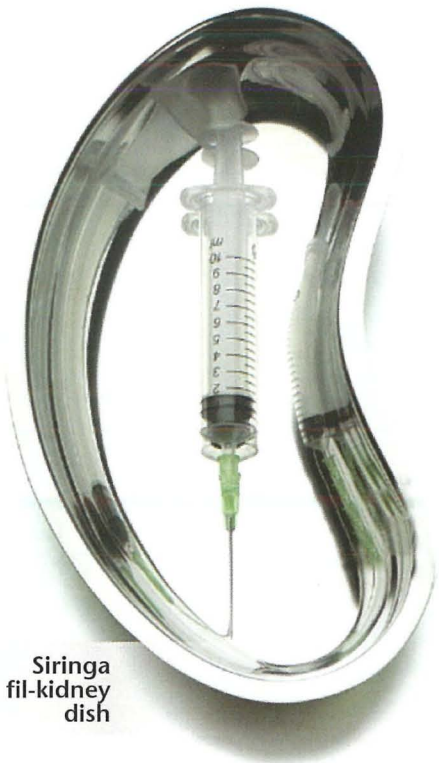
L-inventur Awstraljan Charles Rothauser kien l-ewwel li ntroduċa l-plastik fl-1949. Għan-nofs tal-ħamsinijiet id-disinn bażiku ma nbidilx



L-ewwel labra ipodermika ta' Rynd



Siringa tal-ħġieġ tal-ħamsinijiet u vjala



Siringa fil-kidney dish

Iċ-Cheatle u ċ-Cheatle Jar

wisq u l-użu komplet tal-plastik fisser l-użu universali tas-siringa, waqt li daħal il-kunċett tal-użu tal-labbra li tintuża darba u tintrema' (disposable). Dan kien kollu mertu tal-inventur Colin Murdoch minn New Zealand. Becton Dickinson u l-Plastipak, fl-1961, kienu bdew il-*mass production* tas-siringa.

Sal-bidu tat-tmeninijiet, meta kont student, għadni niftakarni niġi mqabbad niċċekkja l-labra għadiex tajba jew le, minħabba l-użu kontinwu tagħha, billi konna ngħadduha minn fuq tajjara: jekk jeħel xi ftit tajjar konna narmuha u jekk ma jeħilx jintefgħu fl-isteriliser biex jissajru. Ma kellniex *sharp boxes* u għalhekk konna narmuhom fi fliexken tal-ħġieġ jew tal-plastik. Kien hemm żmien, li jien ma lħaqtux, li l-labar kienu jissinnu fuq 'ġebla' biex għall-anqas ma jikkawżawx infezzjonijiet bil-materja jew *cellulite*.

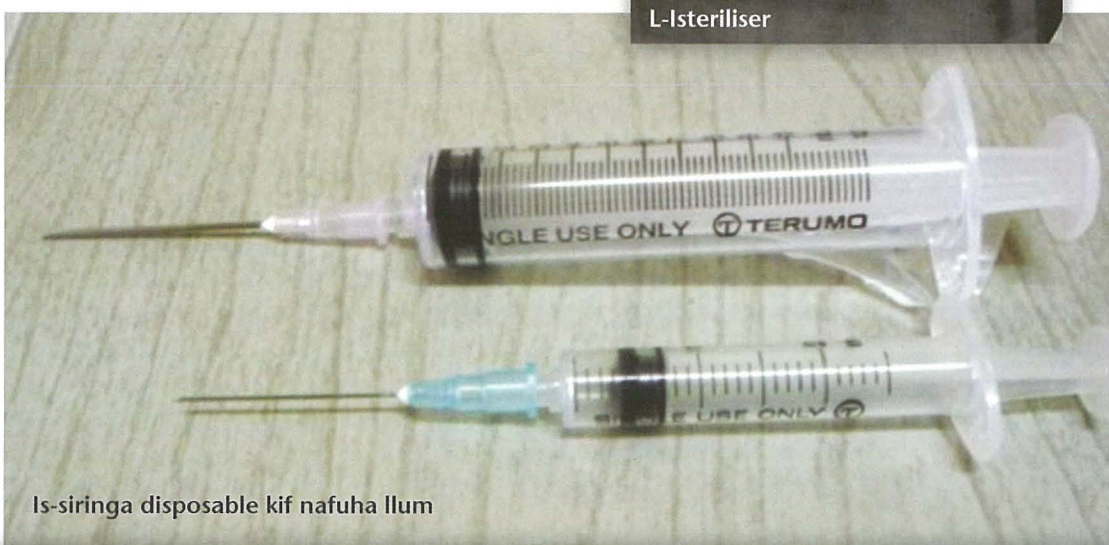
Ma ninsewx li l-injezzjonijiet intra muskolari kienu ferm aktar popolari u aċċessibli mill-intravinus. Mhux l-ewwel darba li kont tmur tagħti IM injection fil-warrani ta' xi ħadd, tagħmel il-famuż 'salib' bħala marka u x'ħin tfaqqa' b'xi labra spuntata bilkemm ma tismax il-laħam jiċċarrat u l-pazjenti waħwaħ waħda fl-art u l-oħra fis-sema! Is-siringi tal-ħġieġ ukoll kienu jiġu ċċekjati, però aħna lħaqna żmien interessanti fejn kienu għadhom kif iddaħħlu s-siringi *disposable* u l-kultura ta' uża w armi ma kienitx għada daħlet, għalhekk kienu jerġgħu jitgħallew is-siringi tal-plastik għal ma nafx kemm il-darba u jintremew biss meta s-siringi jittebbaw b'kulur isfar ikrah li jqażżek. Minn ma jiftakarx dak il-fwar ħiereġ mill-isteriliser meta jitgħalla u jimla' t-*treatment room* b'dik ir-riħa partikolari?

U x'inhu l-futur tas-siringa? Il-pazjenti se jibqgħu jgħidu 'ajma' meta jittaqbu fil-muskolu? Fl-2013, Mark Prausnitz ppropona prototip bl-isem ta' Microneedle.

Din taħdem bħall-*patch* tan-nikotina fejn ikun hemm mal-400 labra mikroskopika tas-silikon li huma tant żgħar li ma tħosshomx. Għalkemm l-użu tal-intra muskolari naqas sew fid-dinja medika tal-Punent, dawn l-avvanzi jawguraw tajjeb għal-kull marid.

Joe Camilleri
Charge Nurse

L-Isteriliser



Is-siringa disposable kif nafuha llum

from our diary

MUMN 1996
Malta Union of Midwives and Nurses

Part of the opening ceremony where the entertainment was at its best

The closing ceremony was also superb... a Gospel Choir entertained all those present and wished everyone a safe journey

MUMN Administration Committee met with two MEP Candidates representing the two main political parties on our island – Dr. Frank Psaila and Dr. Josianne Cutajar.

The conference delegates took the opportunity of a sunny day and had their coffee break outside

MUMN organised the Commonwealth Conference for this year's edition – Delegates are registering and having a morning chat!

We have celebrated also the Women's Day in style where each female delegate was handed a commemorable flower

Delegates settled down for the conference to kick off

INTERNATIONAL COUNCIL OF NURSES

Position Statement

International career mobility and ethical nurse recruitment

Providing quality healthcare and achieving universal health coverage depends on a healthcare workforce with an adequate number of qualified, motivated, and well-supported nurses. It is important for nurses to be able to access career mobility in order to further their professional development, fulfil their personal career goals and make maximum use of their skills and qualifications in contributing to safe and effective care. Career mobility can include the movement of nurses (or in some cases student nurses) between different specialties and within and between organisations, sectors, regions and countries.

Flows of nurses between countries, often termed international migration, has been an ever-present feature of nursing labour markets, but in recent years has risen markedly in magnitude and in its policy challenges for health, education, immigration and regulation.1 Factors underlying or enabling this growth include skills shortages, renumeration differentials, education and career opportunities, job and personal security, international trade agreements, mutual recognition agreements and improvements in transport and communications.ICN respects and supports the rights of nurses to pursue professional achievement and to better the circumstances in which they live and work. Migration of professionals offers potential beneficial outcomes including multicultural practice and enhanced learning opportunities.

The trend towards increased mobility has contributed to a global health labour market which is characterised by uneven levels of healthcare professionals between countries and regions leading to severe shortages of nurses and other health workers in many countries. Alarming mismatches between need, supply, and demand have been reported.2 Upper-middle-income countries and the Western Pacific region are projected to have strong economic demand for healthcare workers which will create a heightened competition for available nursing human resources from low- and lower-income countries, who often cannot compete financially in order to retain these staff, and contribute to a continued increase in international mobility.2 There are a range of 'push' and 'pull' factors that lead nurses to seek employment outside of their country of origin.3 Examples of push factors include low pay, pay discrimination, poorly funded health systems, and unfavourable working conditions including those that pose safety concerns. Destination countries often have pull factors such as better salaries and conditions of employment and career development opportunities. Some high-income countries have come to regard inward international migration as a permanent solution to their nursing shortages.4,5

Recruitment abuses during the processes of international recruitment have been reported. Recruitment agencies and employers may use unethical recruitment strategies that focus on large numbers of recruits or maycontract a large number of

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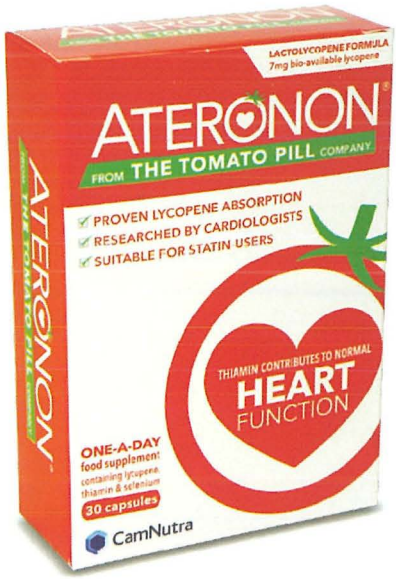
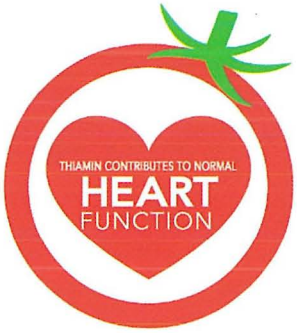
newly graduated nurses from a given educational institute, significantly depleting the institution or health facility. Nurses may be recruited using false or misleading information about their terms and conditions of employment, remuneration and benefits. They may also be discriminated against in employment and in access to education and career opportunities. Internationally recruited nurses can also be at risk of exploitation or abuse because of challenges related todistance, language barriers and cost in verifying licensing and regulatory information and in the terms of employment.

Losing highly skilled nurses to actively recruiting high-income countries is compromising the capacity of some countries to achieve and sustain health systems improvements and provide universal access to quality healthcare.6In addition, for countriesthat sustain long-term high levels of active international recruitment, there is a risk that this will delay local measures that would improve recruitment, retention and long-term human resources planning and would support workforce stability. The WHO Global Code of Practice on the International Recruitment of Health Personnel establishes and promotes voluntary principles and practices for the ethical international recruitment of health personnel and the strengthening of health systems, including effective health workforce planning, education and retention strategies.6As highlighted in the Code, the goal for all countries should be to have a sustainable national nursing workforcewhich focuses on a stable core of domestically trained nurses whilst acknowledging and enabling the contribution of international nurses and other health professionals.

Help hearts run smoothly





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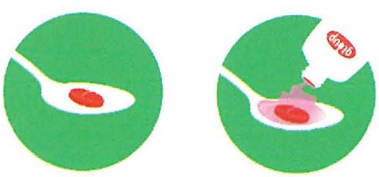

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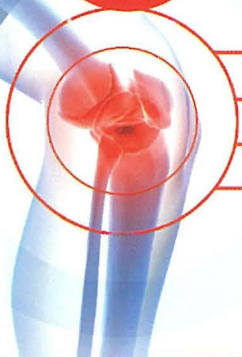

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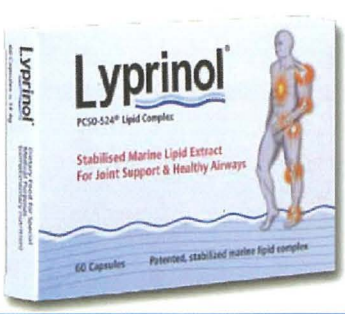

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Nursing now

International Council of Nurses and Nursing Now bring nursing voice to Global Conference on Primary Health Care and call for nurses to work to full capacity to achieve vision of Astana Declaration

Astana, Kazakhstan; Geneva, Switzerland; 26 October 2018 – The International Council of Nurses (ICN) and Nursing Now today called on governments to remove barriers that impede nurses to work to their full scope to achieve the vision set out in the Astana Declaration. The joint statement was made during the Global Conference on Primary Health Care in Astana, Kazakhstan, 25-26 October, celebrating the 40th Anniversary of the Declaration of Alma-Ata.

ICN and Nursing Now played a key role in bringing the nursing voice to this landmark event. Dr Isabelle Skinner, ICN's Chief Executive Officer was on the panel of the joint WONCA/ICN/FIP[1] side event onWho Needs to be in the Modern Primary Care Team to Achieve Universal Health Care. Lord Nigel Crisp, Co-Chair of the Nursing Now campaign, moderated a session on Primary Health Care Workforce, and Howard Catton, ICN's Director of Nursing and Health Policy and Barbara Stilwell, Executive Director, Nursing Now Global Campaign, took part in a parallel session at the Astana Conference on Empowering People at the Centre of Primary Health Care, speaking on The Voice of Women, Nurses and Midwives.

"People must be at the centre of healthcare delivery and able to lead decisions about how their own health is managed and delivered" said Howard Catton. "Putting people first is at the centre of nursing philosophy and practice and nurses have a critical role to play in making a reality of people centred and integrated health care."

Lord Nigel Crisp, Co-Chair of the Nursing Now Campaign emphasized that "a new model of primary health care is emerging with nurses at its heart. They are the health professionals who are closest to the community and can coordinate care, deliver services and work with local people on health promotion, disease prevention and health literacy"."

Both ICN and Nursing Now have endorsed the Civil Society Statement which calls on governments to strengthen political leadership and governance; improve financing; enhance accountability; and advance country-led solutions.

"ICN strongly believes that political will is vital to delivering the ambitions of the Astana Declaration" said Dr Isabelle Skinner, ICN CEO, during her presentation at the PHC Conference in Astana. "We call on Ministries of Health to integrate PHC as the foundation of their health systems and ensure adequate financial investments in PHC".

ICN, as the global voice of the over 20 million nurses worldwide, strongly believes that the effective and safe delivery of comprehensive PHC services depends on the strength, capacity and capability of the health workforce. Since nurses make up more than 50 % of the global health workforce, ICN calls on governments to make it possible for nurses to work to their full capacity to achieve the vision set out in the Astana Declaration.

According to health workforce experts there will be a global shortage of 7.6 million nurses and midwives by 2030. Reflecting on the Astana Declaration's commitment to ensuring an adequate public health and primary care workforce to address modern health needs, the joint ICN/ Nursing Now statement emphasized that appropriate remuneration and financial resources should be in place to support this workforce.

Annette Kennedy, President of ICN, highlighted that "Ensuring health is a human right is a priority for ICN and a strategic focus of our 2017 and 2018 International Nurses Day resources which highlight how nurses are improving access to health care. Throughout my work as a Commissioner of the WHO Global Commission on Noncommunicable Diseases, I have stressed the important role of nurses in disease prevention and I join my colleagues at Nursing Now to support the commitment of the Astana Declaration to ensuring investment in the healthcare workforce to deliver quality primary healthcare to all."

The Global Conference on Primary Health Care, co-hosted by the Government of Kazakhstan, WHO and UNICEF, aims to renew a commitment to primary health care to achieve universal health coverage and the Sustainable Development Goals. More information on the outcomes of the meeting can be found here.

[1] World Organization of Family Doctors / International Council of Nurses / International Pharmaceutical Federation

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Seeing the person in the patient

Person centred care in mental health

People live in stories. Human beings make sense of their lives by constructing what happens to them in the form of a story (Moen 2006). In the course of our lives, we are having continuous dialogue with our inner self and with our environment. We then connect these interactions and give them meaning, by creating an ordered world in our mind, in the form of a story (Moen 2006).

In mental health, this story is what constitutes patient centred care (Hummelvoll, Karlsson & Borg, 2015). Becoming a mentally ill person can be a complex experience characterized by stigma, loss of individuality, helplessness and anxiety (Dixon, Holoshitz & Nossel, 2016). This is further complicated if the person is treated under the Mental Health Act or hospitalized. Hospitalization in a psychiatric set up can be a frightening and traumatic experience for the individual, which as nurses we need to be aware of. This can be addressed with a focus on person (rather than patient) centred care, with services focusing on the individuals' experiences, involving them in their care and emphasising their needs and preferences, even if it entails changing the system, and the mode of care delivery (Coleman, 2018).

Buchanan-Barker and Barker (2008) states that the mental health nurse needs to be interested in the patient's story. They argued that the nurse should move away from the medical model and use the recovery model in supporting the person with mental illness. They emphasised that the key to recovery lies in the patient's experiences. Ellis in Barker (2009) stated that "nursing should deal with the person's description of their own immediate needs" and that "care should gradually extend outwards into the wider world of the person's experience" (p. 145).

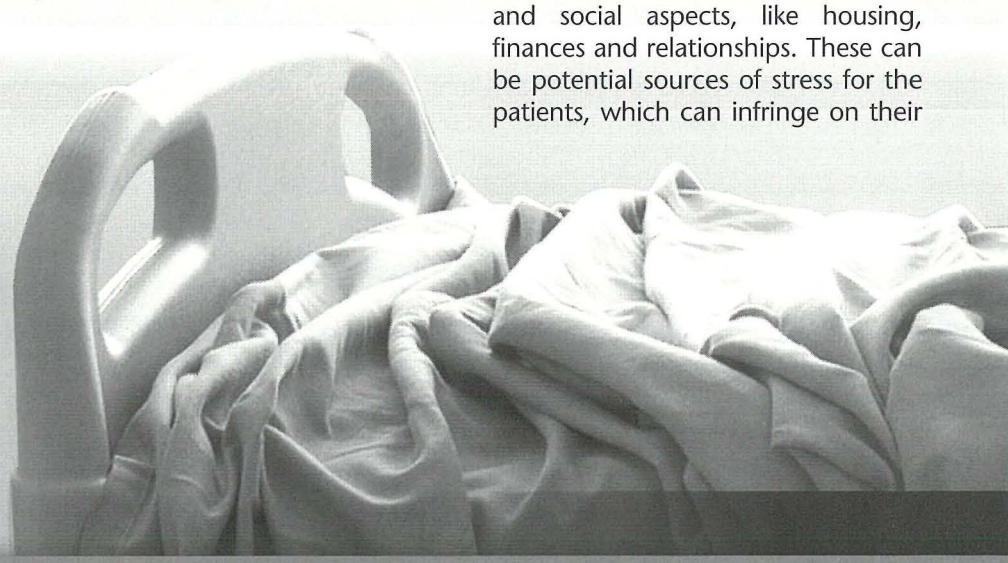
This assumes that there is more to the patient's story, then the symptoms and the treatment of mental illness or mental health difficulties. There are other aspects to the patients' story that are very essential to their recovery. Patients are also children, parents, partners, spouses, adolescents, bread winners, dependents and all the other roles which we all experience in our lives and that represent an integral part of our life story. Focusing on these aspects is what helps the patient to maintain their individuality, and empower them to be an active partner in their recovery process.

The National Institute for Health Care Excellence (NICE) provides best practices guidelines for professionals to follow in providing optimum care in mental health. These guidelines take into account the patients' needs and preferences. They support the patients to be involved in their care and put emphasis on maintaining the patients' dignity, treating them with respect and seeing the person, in the patient (Coleman, 2018).

Adam and Grieder (2014) defined person centred care as "a comprehensive approach to understanding and responding to each individual and their family in the context of their history, needs, strengths, recovery, hopes, dreams, culture and spirituality...". This emphasise individuality, an interest in the patient's unique situation, and an understanding that patients have their own stories, which are part and parcel of the person in the patient in front of us. Dixon, Holoshitz and Nossel (2016) found that a strong component of successful engagement in patients with schizophrenia is the patients' perception that their goals, preferences and life circumstances are being considered by the professionals working with them.

Barker (2001) argued that the patient is not defined by his or her illness. There are other aspects of the individuals' life which we as mental health professionals need to take into consideration. These include the personal identity, the self esteem, and what gives meaning and purpose to their life.

Addressing issues which are important for the patient is allowing for the patient's needs and preferences. These can include more practical and social aspects, like housing, finances and relationships. These can be potential sources of stress for the patients, which can infringe on their

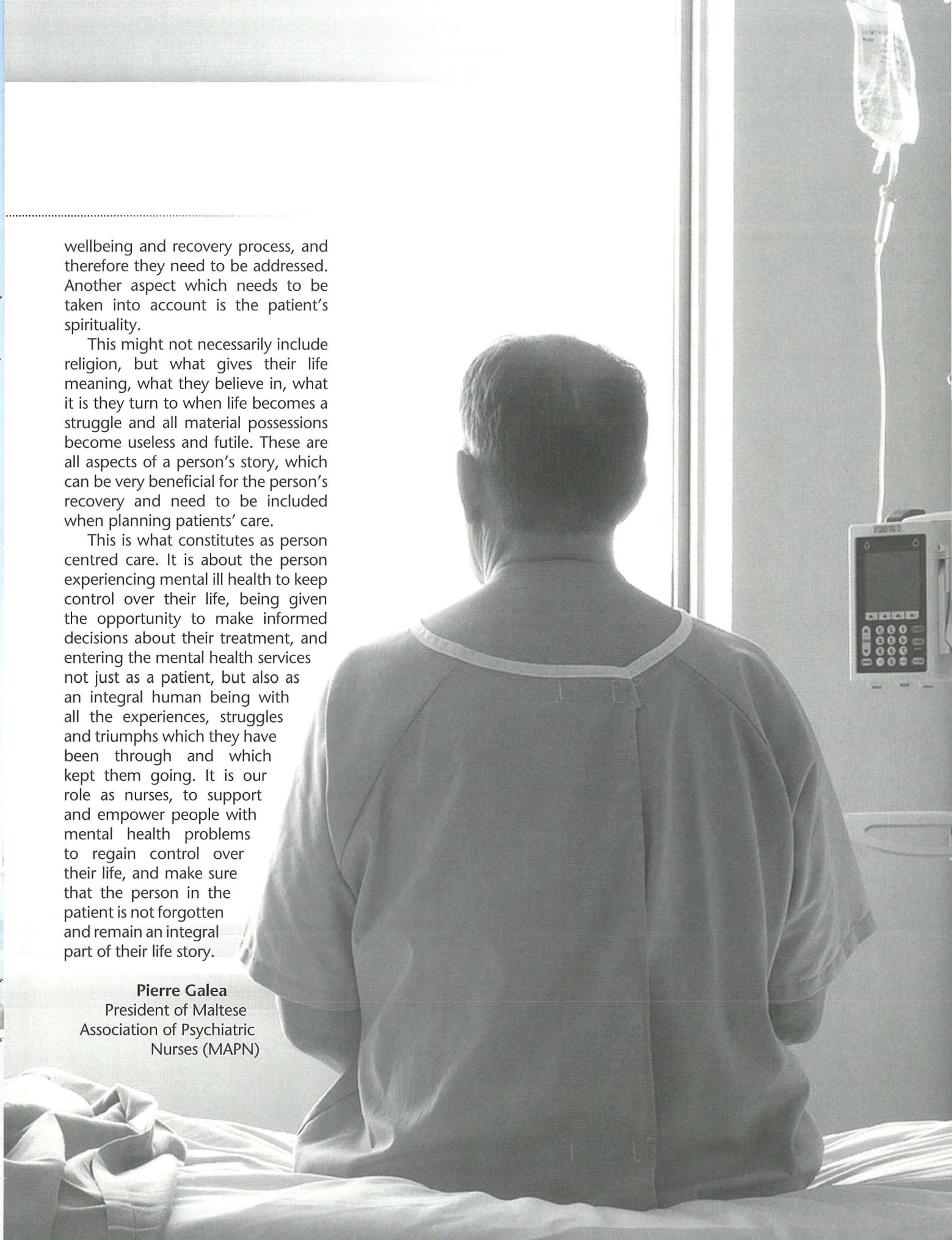


wellbeing and recovery process, and therefore they need to be addressed. Another aspect which needs to be taken into account is the patient's spirituality.

This might not necessarily include religion, but what gives their life meaning, what they believe in, what it is they turn to when life becomes a struggle and all material possessions become useless and futile. These are all aspects of a person's story, which can be very beneficial for the person's recovery and need to be included when planning patients' care.

This is what constitutes as person centred care. It is about the person experiencing mental ill health to keep control over their life, being given the opportunity to make informed decisions about their treatment, and entering the mental health services not just as a patient, but also as an integral human being with all the experiences, struggles and triumphs which they have been through and which kept them going. It is our role as nurses, to support and empower people with mental health problems to regain control over their life, and make sure that the person in the patient is not forgotten and remain an integral part of their life story.

Pierre Galea
President of Maltese Association of Psychiatric Nurses (MAPN)



For more information and list of references please send email on mapsychnurses@gmail.com photo | flanderstoday.eu

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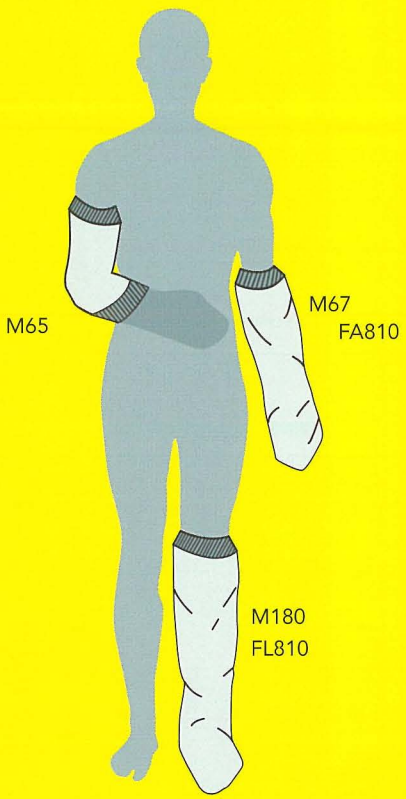

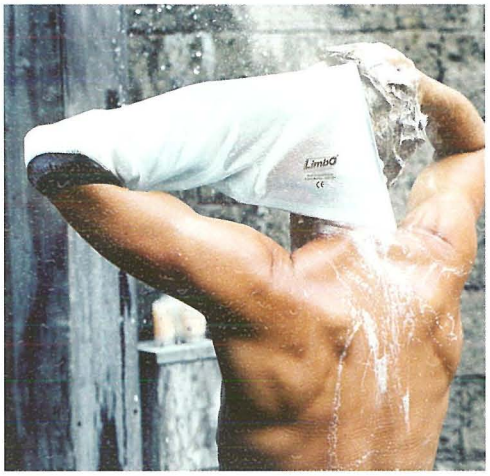

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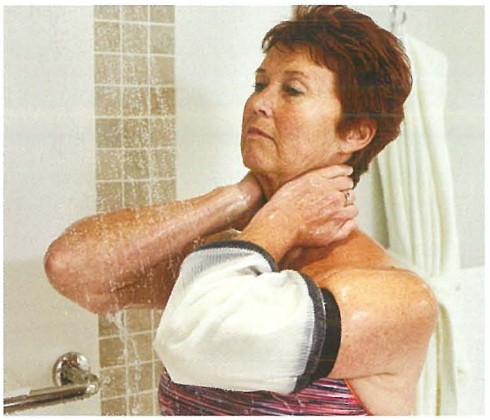

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Mijiet ta' professjonisti mediċi taħt saqaf wieħed

Aktar minn tliet mitt professjonist mediku minn kull rokna tad-dinja jinsabu f'pajjiżna għal konferenza tal-Commonwealth; li mifruxa fuq jumejn qed tittella' f'lukanda ewlenija fil-Qawra. Il-maġġoranza tal-professjonisti huma qwiebel u infermiera, u ħafna minnhom ġejjin mill-Ingilterra u Ċipru.

Il-President tal-Unjin Maltija tal-Qwiebel u l-Infermiera Maria Cutajar, spjegat li taħt saqaf wieħed, il-professjonisti qed jiddiskutu l-aktar riċerka riċenti li saret fis-settur biex flimkien jaqsmu l-ideat ħalli jaraw xi żviluppi jistgħu jsiru biex tissaħħaħ il-kura li tingħata lill-pazjent.

"Hemm best practices li huma komuni kemm lokali u internazzjonali u jkun hemm oħrajn li juru li aħna qegħdin anki 'l quddiem minn pajjiżi oħra jew inkella viċi-versa u bis-saħħa t'hekk waqt id-diskussjoni naraw x'qed nagħmlu aħna lokalment, fejn nistgħu mmorru għax jista' jkun naraw li qegħdin tajjeb ukoll, u through dawn ix-sharing of experiences intejbu dak li nkunu qed nagħmlu mal-pazjent," qalet is-Sinjura Cutajar.

Din il-konferenza reġjonali Ewropea qed tittella' għat-tlettax-il sena konsekuttiva mill-Federazzjoni tal-Infermiera u Qwiebel tal-Commonwealth.

Il-Ministru tat-Turiżmu Konrad Mizzi nnota li permezz ta' laqgħat bħal dawn, Malta tkompli ssaħħaħ il-pożizzjoni tagħha bħala ċentru informattiv, biex pajjiżna jkompli jsir ċentru għall-konferenzi u laqgħat ta' livell għoli.

Innota li huwa fatt pożittiv ħafna li wara ċ-CHOGM tal-2015, f'pajjiżna baqgħu jittellgħu laqgħat mill-Commonwealth, u dan jikkonferma kemm ir-reputazzjoni ta' pajjiżna qed tikber u tissaħħaħ fuq livell reġjonali.

"Flimkien mal-Gvern, l-MUMN qed taħdem ħafna u dawn l-aħħar snin ħdimna biex inwessgħu kemm jista' jkun l-edukazzjoni għan-nurses. Filwaqt li għandna l-Universita ta' Malta li għandha fakulta b'saħħitha ħafna fin-nursing, ħdimna biex ġibna Malta lin-Northumbria University.

Il-programmi tan-Northumbria bħalissa huma fully operational u qed jagħtu u jsaħħu l-best practice ta' Malta f'dan is-suq," qal il-Ministru Mizzi.

Learning to live with arthritis

We do not know what causes some diseases. These are known as idiopathic diseases, from the Greek idios – 'one's own' – and pathos – 'suffering'.

Very often the words 'primary', 'agnogenic' or 'cryptogenic' are used in clinical notes to describe a disease the cause of which, or its progression, is not known. There are many diseases that have unknown causes. Unfortunately, one of the main diseases of older age, arthritis, remains idiopathic.

In 2013, approximately one in five US adults reported some form of disability, and the most frequently reported disability related to mobility – not being able to move around or to do things for yourself. A third of all mobility issues are caused by arthritis and back and spine problems. Although being the main cause of disability among older adults, very little is known about this disease.

Even though most older people suffer from arthritis – which results in swelling, pain, stiffness and reduced motion – the majority live with it without much interest from outside.

Being a disease that causes inflammation and attacks the joints, arthritis is more than just one disease. There are some 63 different types of conditions all lumped together under arthritis. Some of these diseases are known independently, such as bursitis, fibromyalgia, gout, inflammatory bowel disease, lupus, osteoarthritis, osteoporosis, Paget's, rheumatoid arthritis and spondyloarthritis.

We know more about some of these specific diseases than others, but we do not know what causes them. We see great variance of these diseases by geography, education, income, marital status and gender. More women than men have arthritis and generally the disease becomes increasingly more common in older age.

Although diet can be a primary contender, especially for some diseases such as gout, there are some people who cannot control their arthritis through diet.

Arthritis is a long-term disease that will not be cured. Learning to live with it will save a lot of anxiety

With other types of arthritis, we see a genetic relationship, as with spondyloarthritis, having identified 50 genetic mutations related to this disease although there are other causes that are unclear. Some suggest infections. Especially for infectious arthritis, where a bacterium, virus or fungus enters the joints and triggers inflammation.

There can be many causes of arthritis, maybe even all of these causes combined. This makes the cause of the disease particularly

difficult to determine and more difficult to manage. Symptoms of the disease are also variable.

Symptoms may come and go and they can be of different intensity and for different periods of time. However, severe arthritis can be debilitating. The constant pain might result in the inability to do daily chores, climb stairs or even walk.

Arthritis can also cause permanent joint damage. We can see some of these changes, while others remain hidden. These hidden changes can damage the joints but also the eyes, kidneys, heart and lungs.

Osteoarthritis, being the most common of the arthritis group, causes great pain. Where the joints meet, the bones have a polished soft surface called a cartilage. In osteoarthritis this cartilage wears down. This results in the two bones rubbing against each other.

The pain causes the body to protect itself by reducing the friction the only way it knows, by causing swelling and stiffness. This protective function, however, has negative consequences. Over time, joints can lose strength and pain may become chronic. The disease can be controlled in most cases by staying active, maintaining a healthy weight and by avoiding injury and repetitive movements.

Kate Lorig, a retired professor from Stanford University, developed a programme to help with controlling arthritis. The programme focuses on managing and not curing the disease. Most of the exercises are designed to reduce pain and improve mobility, using methods to reduce negative emotions such as anger, fear and depression through relaxation, visualisation, distraction and self-talk.

Exercises to ease the pain and increase movement include gentle circular movements. Some of the medications, both (cortico) steroid, as well as non-steroid drugs, can be useful, but all have some complications. Steroids work by reducing the inflammation, but they also have some negative side effects, including difficulty sleeping, blurred vison, weight gain and muscle weakness.

At the end of the day, we need to learn to live with the disease, taking pain medication when necessary, staying as active as possible without causing stress to the body, keeping our weight at an optimum to reduce the stress on the body and perhaps, most importantly, keeping a positive disposition.

A tall order. But arthritis is a long-term disease that will not be cured. Learning to live with it will save a lot of anxiety. Arthritis may have unknown origins but at least if we continue learning how to manage it, perhaps one day it will stop being idiopathic.

Mario Garrett was born in Malta and is currently a professor of gerontology at San Diego State University in California, US.

Letter from Pauline Fenech

Chairperson, Physiotherapists Group Committee

Dear Colleagues ,

The Physiotherapy Group Committee within MUMN has been working on several issues concerning physiotherapists in the past year .

Although we had finalised a draft regards the sectoral agreement on the feedback collated from amongst members , the inital meetings were slow and sluggish . Since last June all discussions were halted. Now that the sectoral agreement for nurses and midwives has been finalised, we hope that the sectoral for the allied health professionals is kicked in , knowing that what was gained by our colleagues the nurses and midwives can pave the way for our negotations.

As you can see that the Physiotherapy Group Comittee has done several work, sometimes visible and other times not, we shall continue to work on the imminent needs but also will be collaborating with other stakeholders on other apects which concern physiotherapists.

We also are following up closely with the specialisation act, earlier this year we had a meeting with Ms. Joanne Chetcuti who is heading the project regards the specialist training structure. Lately she had summoned all allied health professionals for a seminar and workshops regards the matter. On going communication with the physiotherapist representative on CPCM is also going on. We shall follow up matters accordinly. On a good note we would like to inform you that MUMN has now the officiall authority to speak up on behalf of Physios on matters arising from the Health Care Professions Act.

We worked on simplifying the part two of the CAF as requested by the health directorate. We worked with a representative from the goverment entity as the employer and another representative from the MAP .

We carried out a pilot study at Mater Dei regards working analysis , from which we established reccomendations for better outcome. We hope that both management and physiotherapists are on board in order to improve such practices which can also enhance motivation at the place of work.

We also intervened in order to address issues related to lack of adequate legends for physiotherapists on reduced hours at Mater Dei. We worked hand in hand with the physiotherapy management so that more timely legends are available adequate for physiotherapists. Till now the situation seems under control.

We met up with physiotherapists who are thinking of returning to practice or are on reduced hours. We collated all feedback on how physiotherapists returning to practice can be assisted in making such a switch fruitful and uneventful. We compiled a reccomandation letter to the the health directorate , to which we are still awaiting a response.

We also kept our now annual meeting with new graduates on two occassions: the MAP seminar entitled students to professionals and another one in November. We have noticed that such a meeting was essential as most information given in the first seminar was not all taken on board. In such meetings we are targeting issues related to HR, right and obligations of employed and self employed physiotherapists and also medicolegal issues.

We are following closely the situation within the Steward Health Care , were we had to intervene a couple of times within KGH by issuing directives to our members. One issue was related to urgent need of waterproofing within the physiotherapy department and one related to an exercise related to internal transfers of permanent senior physiotherapy staff within the wards of KGH which goes against the policies established within the Physiotherapy Service and against the agreement signed between MUMN and the goverment regards VGH/ Steward Health Care.

We visited members at their work of place to liase with different physiotherapists and target their issues better . This was done frequently at Mater Dei, Karen Grech which are the larger hospitals however we also paid visits to our members within Mt Carmel Hospital, Commcare and Paola Health Centres when invited.

We also kept our intervention on personal issues for each of our members.

However MUMN is not only about union & work related matters, through the Institute for Health Professionals physiotherapists can attend CPD lectures organised frequently at the office. This year 4 physiotherapists members of MUMN finalised a course in management organised by MUMN in collaboration with the Centre of Liberal Arts and Sciences within University of Malta.

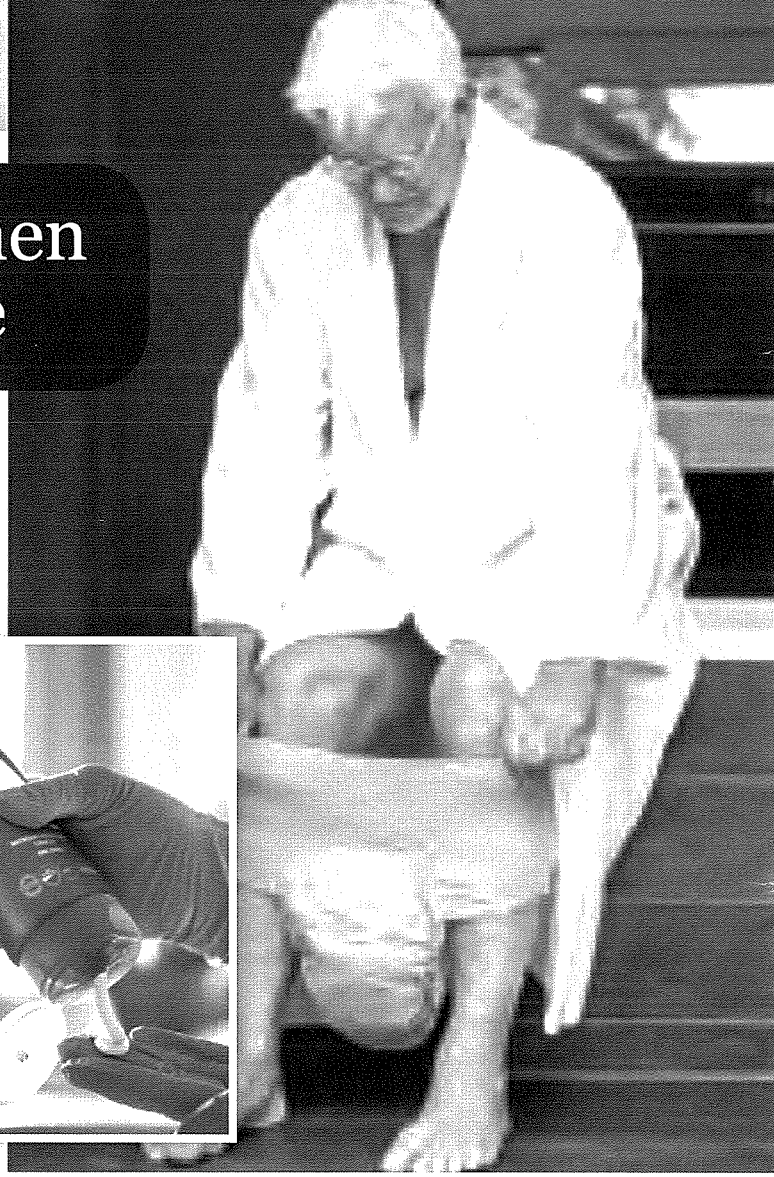
As you can see that the Physiotherapy Group Comittee has done several work, sometimes visible and other times not, we shall continue to work on the imminent needs but also will be collaborating with other stakeholders on other apects which concern physiotherapists.

We encourage our members to assist us and support us to continue working and pushing foward. We invite you all to participate in our meetings, come foward with ideas, plans and by giving a helping hand when need be.

Pauline Fenech
Chairperson, Physiotherapists
Group Committee

photo | prorehab.co.uk

Protecting the skin when you have incontinence



Good skin care is essential for people with incontinence and their carers, unfortunately this is sometimes neglected.

Nowadays experts consider skin problems to be a major long-term complication for incontinent persons. Problems include skin irritations, reddening, allergic reactions, "nappy rash", and dermatitis caused by urine and faeces which can damage the skin.

This can be distressing, uncomfortable and socially isolating and persons suffering from incontinence regard related skin problems as a significant limitation of their quality of life.

Cleanliness every day is necessary to maintain healthy skin, avoid damage, prevent odour and make a person feel comfortable.

What are the main complications related to incontinence and how are they caused?

Inflammation of the skin surface

Usually occurs due to moisture build-up as a result of using conventional airtight materials for the outer layer of continence products. Since the skin constantly loses water to the surrounding via perspiration, it needs air circulation for moisture to evaporate.

If the necessary breathability is not allowed, a moist environment develops, causing the skin surface to become inflamed.

This results in redness (erythema), pain and itching (pruritis) and sometimes swelling and/or blisters, dryness, flaking, or itching. This damaged skin is now vulnerable to infection.

Ageing skin

Ageing skin needs careful daily attention. Generally, it's much more open to skin problems and is even more fragile than a baby's skin and therefore requires special attention and the use of products specifically intended for elderly skin.

Creation of ammonia:

Bacteria producing ureases start off the decomposition of urea to ammonia. The alkaline characteristics of ammonia attack the skin's acid protection mantle, damaging the skin and allowing bacteria to overcome the protection barrier. The decomposition of urea to ammonia is also responsible for the intense odour.

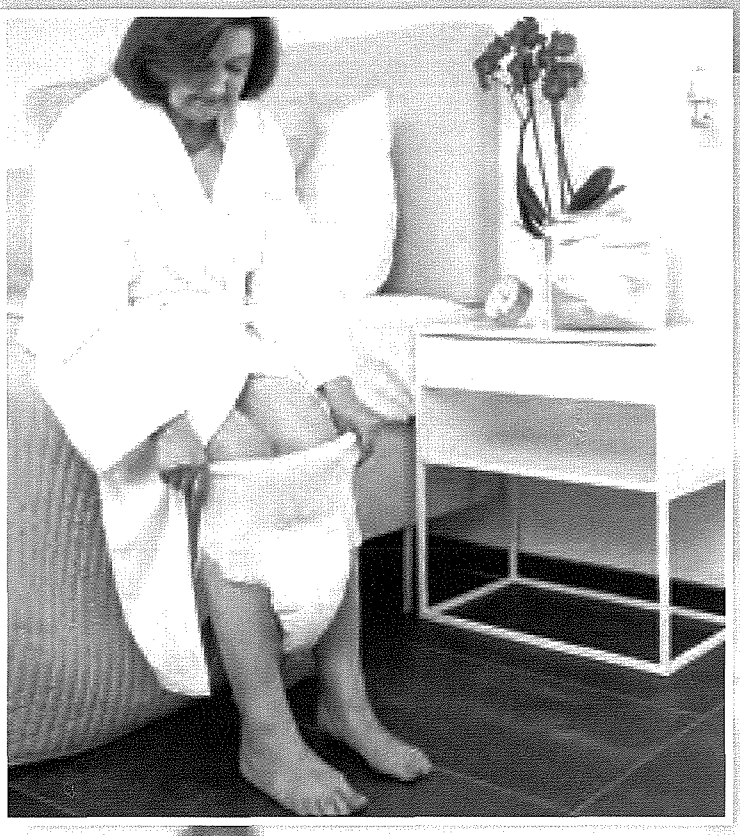
Skin irritations/allergies: are often triggered by allergenic materials in close contact with the skin. Due to age-related changes, elderly skin is particularly at risk of developing allergies. Since the thickness of the outer layer of skin decreases steadily with age, the skin becomes less able to produce moisture-storing epidermal fats, becoming drier, more flaky and porous. Hence, not only bacteria but also allergens can penetrate more easily into the deeper skin layers. People with a predisposition to allergies may end-up with reactions like nappy rash leading to Eczema.

How can such problems be avoided?

The use of specially designed materials to keep the skin dry is paramount when caring for incontinence sufferers is vital.

Breathable side panels on adult diapers and the breathable textile back sheet on pull-up diapers allow high permeability to air and moisture but not to liquids. Such innovative air active materials stop the skin surface from swelling and stabilize the acid protection mantle, creating a healthy skin climate.

The Molicare® Range of products available in adult diapers and pull-ups, provide secure leakage protection, protect skin from irritation, ensure a high wearing comfort and are easy to use.



When using the right absorbent incontinence products, a lot of quality of life can be given back to people affected.

The use of Dermatologically Tested, Hypoallergenic Materials is very important when considering that these products are in constant contact with the skin.

If materials used in continence aids have an allergenic potential, contact allergies are inevitable.

Hypoallergenic and dermatologically tested products offer the best possible option of reliably preventing allergic reactions. High quality continence products are put through rigorous testing procedures prior to being declared as "Hypoallergenic".

MoliCare® Skin is a complete cleanse, protect and care range of products for compromised and ageing skin. The range works in combination with continence products to reduce skin irritations and infections without impacting absorbency of continence aids.

In conclusion, the negative impact can be avoided by using suitable high-quality continence care products and optimized nursing routines. Dealing well with incontinence today means assuring healthy skin as well! Correct advice, management and nursing care of incontinent persons greatly influences their quality of life.

Molicare® Adult Diapers & Pull-ups and Molicare® Skin products are available from pharmacies.

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For more information and to receive the references please contact: tcarabott@alfredgera.com

Court orders PSC to stop Gozo promotion exercise

Employee should be given information about job interviews

The Public Service Commission has been dealt a blow by the Courts which ordered it to suspend a promotion and give a government employee access to information on job interviews after he claimed the exercise was vitiated.

The commission is a constitutional organ responsible for staffing and discipline within the public service.

Following a law suit against the PSC and the Gozo Ministry by Joseph Bajada, an engineer who felt aggrieved by a recent promotion exercise, Mr Justice Wenzu Mintoff ordered the PSC to freeze the exercise and to give Mr Bajada access to all the information required in order to defend his position.

The issue goes back to last summer when the Gozo Ministry issued a call for the post of assistant director for public cleansing in Gozo.

Despite the fact that he had been deputising for the post issued for promotion since 2006, Mr Bajada, an engineer by profession, placed second in the interview and was awarded two marks less than the applicant who placed first.

Feeling aggrieved, Mr Bajada filed a complaint petition to the PSC, as required by law, challenging the promotion exercise.

His petition was accepted and Mr Bajada was asked to produce his comments and defence in writing, but the PSC refused to give him a copy of the file relating to the way the promotion exercise had been conducted and how the interviewing board arrived at its conclusions.

Despite insisting on his right to access all the information, even through his lawyer Ian Spiteri Bailey, the PSC kept insisting that it would only grant Mr Bajada information about his interview and not those of the other candidates.

The issue was referred to the Civil Court, asking for a prohibitory injunction to stop the PSC from awarding the promotion until he was given access to the documents so he could submit his defence.

The Court upheld his plea and, in a strongly worded judgment, noted that while it would not enter into the merits of who should be promoted, as this was the competence of the PSC, the constitutional body "was bound to observe the principles of natural justice in every process it handles".

The court made it clear that Mr Bajada should be given access to all the information, including the results of the other candidates, in order to be in a position to make his representations in the best possible way.

The Court threw out an argument brought by the PSC that the promotion exercise should still continue as the government would not be able to meet public cleansing targets if it was not concluded.

The court observed that Mr Bajada has been effectively heading the department since 2006 and nothing was going to happen if the situation was to be prolonged by a few more weeks until his petition was heard and the exercise fully concluded.

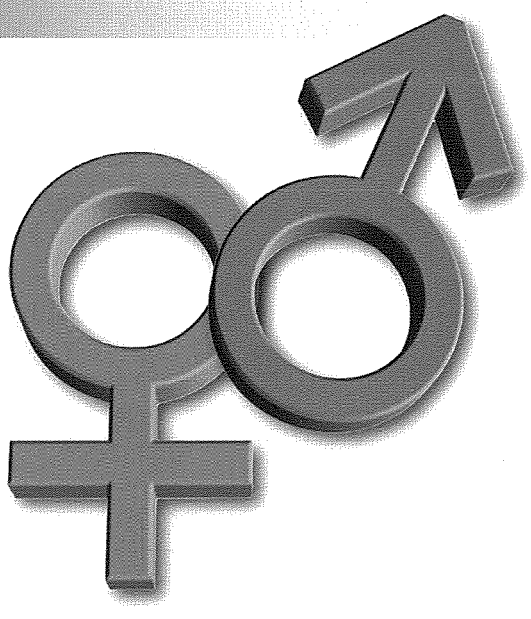
The Gender Wellbeing Clinic

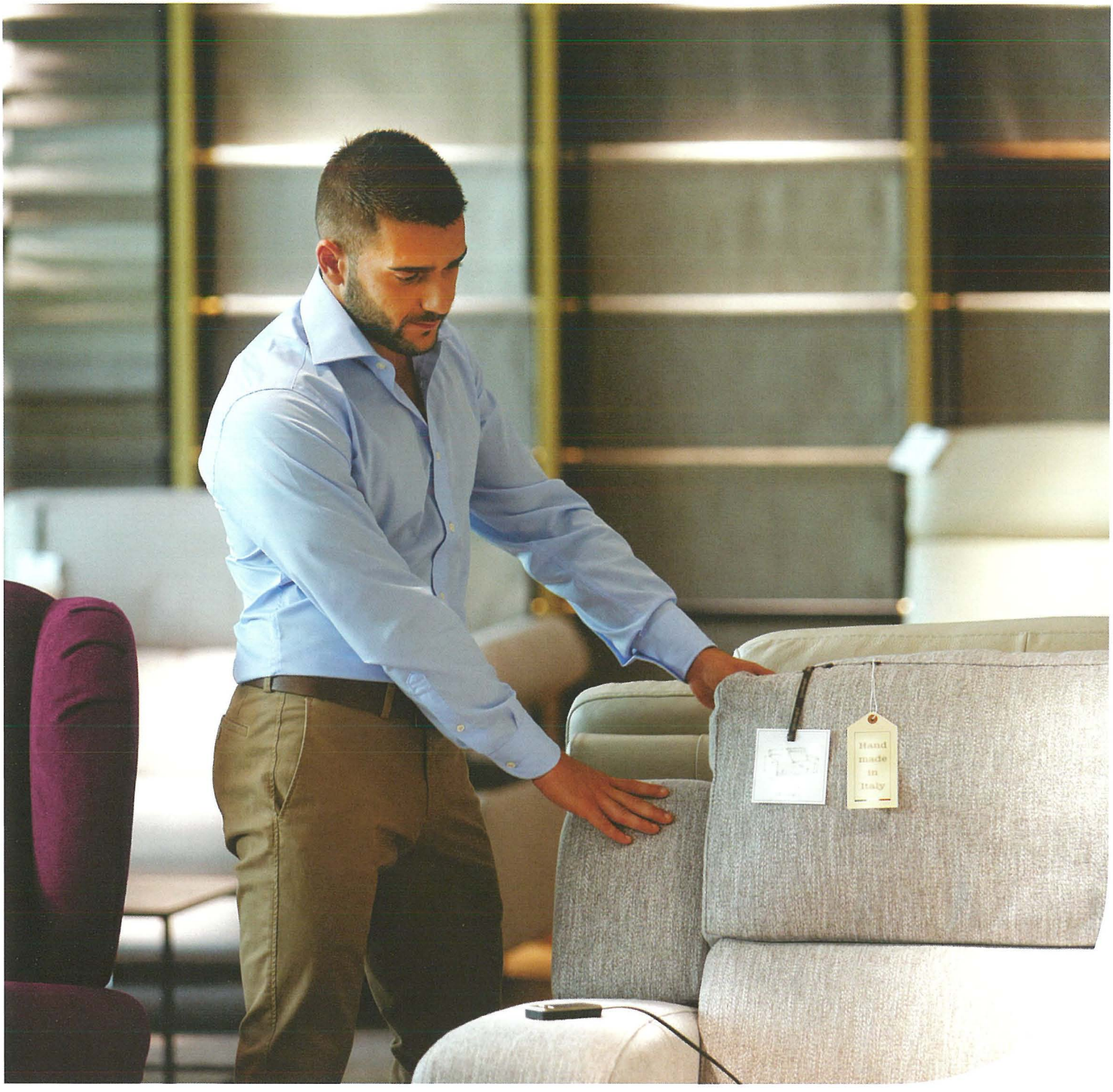
In November 2018, the Gender Wellbeing Clinic started to operate from Mtarfa Health Clinic, aiming to offer transgender inclusive healthcare and access to safe therapy, through a multi-disciplinary, person-centered and holistic approach to care.

Following amendment in the Schedule V (Social Security Act), transgender persons are now eligible for free treatment and medicines available on the Government Formulary List.

Any person with Gender Identity & Sex Characteristics Related Conditions, including transgender persons seeking gender affirmative health care, may be referred to this clinic by medical doctors, psychologists and social workers. Clients can be referred by a specific referral ticket (as attached to DH Circular 94/2018), which is either scanned and emailed to transhealthcare.health@gov.mt or else delivered by hand to Mater Dei Hospital Reception.

Those referrers who have a CORP account can request access to an electronic referral system by sending an email to transhealthcare.health@gov.mt





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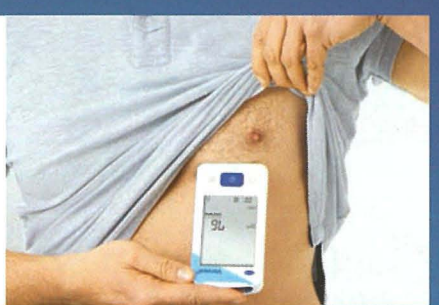

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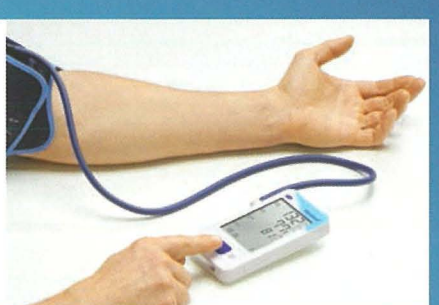

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