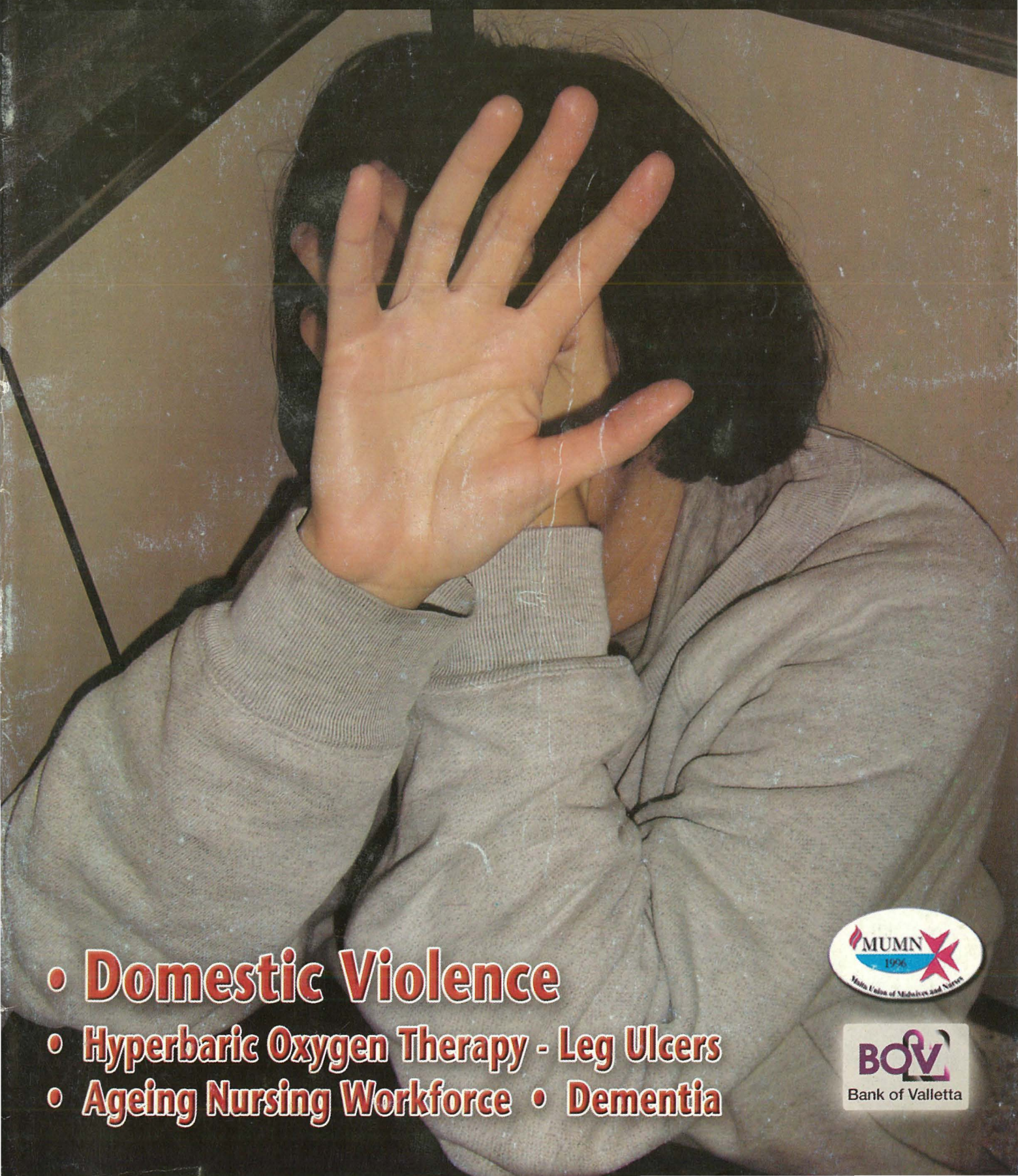
IL-MUSBIEĦ

MALTA NURSING AND MIDWIFERY JOURNAL

MALTA UNION OF MIDWIVES AND NURSES

Ħarġa Nru. 38 - Marzu 2008



- Domestic Violence
- Hyperbaric Oxygen Therapy - Leg Ulcers
- Ageing Nursing Workforce • Dementia

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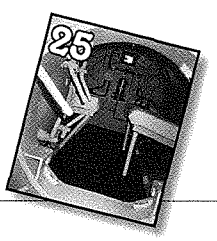
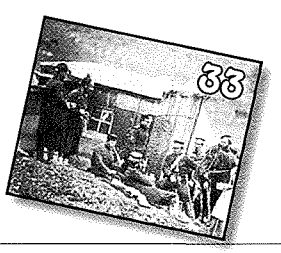
F'Din il-Ħarġa





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

Il-bord editorjali jiggarantixxi d-dritt tar-riservatezza fuq l-indirizzi ta' kull min jirċievi dan il-ġurnal.

Kull bdil fl-indirizzi għandu jiġi kkomunikat mas-Segreterija mill-aktar fis possibli.

Il-**Musbieħ** jiġi ppublikat 4 darbiet f'sena.

Minħabba kuxjenza ambjentali li tħaddan l-MUMN, il-ġurnal jitwassal għand il-membri tiegħu f'boroż tal-karta u mhux tal-plastik.

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editorjal

Ir-rwol tan-Nurse fil-kontroll tat-tabakk u t-twaqqif tat-tipjip

In-Nurses għandhom ħafna opportunitajiet biex ikunu f'rwol ta' *leaders* biex jiġġieldu l-epidemija tat-tabakk. Nurses fid-dinja kollha għandhom aċċess għall-popolazzjoni f'kull livell u jgawdu fiduċja għolja mill-pubbliku. Nafu diga' b'eżepji ta' Nurses li bdew u implimentaw b'suċċess programmi ta' prevenzjoni u trattament għax jagħmlu parti minn *team* sħiħ.

L-ICN tisħaq li n-Nurses għandhom ikunu nvoluti f'kull livell tal-kontroll tat-tabakk, prevenzjoni, twaqqif u *policy*. Tinkoraġġixxi wkoll li jkunu fuq quddiem fil-kontroll tat-tabakk f'livell lokali u internazzjonali, billi tibni *partnerships* ma gruppi oħra professjonali, u ma organizzazzjonijiet tal-gvern u mhux. L-ICN għalhekk, biex tiżgura kompetenza fin-Nursing f'dan is-suġġett żviluppat: *Position Statements* fuq L-Użu tat-tabakk u s-Saħħa/*Elimination of Substance Abuse in Young People*; *fact-sheet* fuq *Smoke-free Living*; *Survey* fuq *policy* tat-tabakk ta' assoċċjazzjonijiet nazzjonali tan-Nurses; kollaborazzjoni mal-WHO, Assoċċjazzjoni Medika Dinjija u oħrajn f'*survey* dwar it-tipjip f'professjonijiet tas-saħħa.

Kemm jekk Nurse taħdem fi sptar jew fil komunità, skola jew fabbrika, din tippromwovi s-saħħa, tevita mard u tikkura l-bniedem ħajjitha kollha. Ir-rwol divers tan-Nurse u l-viċinanza li għandha man-nies tpoġġiha f'pożizzjoni prinċipali bħala parteċipanta ewlenija fil-kontroll tat-tabakk u t-twaqqif tat-tipjip.

Iridu jindunaw li anke suċċessi żgħar huma ta' benefiċċju kbir għal individwu u se jikkontribwixxu f'li jnaqqsu it-tipjip fuq skala nazzjonali.

Biex jirnexxielna nnaqqsu r-rata ta' mwiet hekk imħabbra minħabba l-konsekwenzi ta' morbidità u mortalità relatati mat-tabakk, kull professjonist tas-saħħa irid u hemm bżonn jaħdem wieħed ma l-ieħor. In-Nurses u t-tobba huma *advocates* b'saħħithom għall-*policies* tas-saħħa pubblika u miżuri iebsa għall-kontroll tat-tabakk.

Ikun għaqli li qabel jew waqt kull *admission* fl-isptar, jiġi mistoqsi rigward it-tipjip, u offrut parir qasir u assistenza għal min hu interessat li jieqaf. Min ipejjep irid jiġi avżat li fl-isptar ma tista' tpejjep imkien. Anke l-Midwives għanhom biċċa xogħol x'jagħmlu speċjalment meta jiltaqgħu ma' nisa tqal li jpejpu, billi jagħtu informazzjoni ċara u preċiża rigward r-riskju tat-tipjip fuq il-fetu u struzzjonijiet biex jieqaf it-tipjip billi joffru għajnuna speċjalizzata.

Studenti tan-Nursing ġewwa l-IHC iridu jiġu edukati dwar it-tabakk li hu l-kawża numru wieħed ta mwiet prevedibbli u disabilità u li għandhom jintervenu ma dawk f'riskju ta' dipendenza tan-nikotina, jew dawk esposti għall-*passive smoking*. Il-kurrikulu tal-edukazzjoni tan-Nursing rigward kontroll tat-tabakk irid jespandi u jiżviluppa filwaqt li jridu jiżdiedu l-opportunitajiet ta' tagħlim biex ikunu jistgħu jedukaw huma stess, jassessjaw u jissapportjaw programmi ta' twaqqif tat-tipjip u prevenzjoni ta' *relapse*. Ideja tajba tkun: li jiġu pprovduti *postgraduate courses* fuq kontroll tat-tabakk għan-Nurses tal-post.

Problema rejali hija li n-Nurse jew il-Midwife tista' tpejjep hi jew hu stess. Hemm min jiddibatti li xi Nurses iħossuhom ipokriti meta jqajmu l-*issue* tat-twaqqif tat-tipjip iżda mill-banda l-oħra Nurses li ma jpejpux, jibżgħu li ma jafux verament u ma jistgħux jempatizzaw f'problemi ta' min ipejjep. Irreleventi ta' jekk Nurses ipejpux jew le, il-parir professjonali tagħhom hu wieħed essenzjali. Jekk das-suġġett tat-twaqqif jiġi injorat minn Nurses, allura min ipejjep jista' b'mod żbaljat jemmen li mhux importanti li tieqaf u li mhux ta' benefiċċju għalihom. L-*approach* għandu jkun mingħajr wieħed ma jiġġudika, li jiddiskuti fuq li wieħed għandu jieqaf, waqt li jingħata parir fuq servizzi u trattamenti li jeżistu. Dan għandu jiġi interpretat bħala *standard nursing practice*.

In-Nurses iridu jagħmlu dak l-isforz biex jitkellmu man-nies rigward it-twaqqif tat-tipjip. Iridu jindunaw li anke suċċessi żagħar huma ta' benefiċċju kbir lill-individwu u se jikkontribwixxu f'li jnaqqsu it-tipjip fuq skala nazzjonali. Anke parir ċkejken huwa kultant biżżejjed biex jagħmel impatt. Kull darba li dan is-suġġett jiġi diskuss, n-Nurse qegħda tiftaħ għajnejn min ipejjep rigward d-dannu fuq l-istil ta' ħajja li jgħix jew tgħix. Din is-sistema taħdem u ssalva l-ħajjiet.

Message from the President

Another edition of our nursing journal has arrived. On writing this article, the whole country was in election mode with speculations on which party will be forming the next Maltese government. For me it was the rightful time to analyse what improvements should take place in the next five years with the new government. What should be the innovations in the discussions between the government and MUMN? How we as a union would be working with the new government to resolve chronic issues such as nurses shortage.

MUMN would be expecting in the next five years from the new government a more consultative approach before decisions affecting nurses and midwives are implemented. Any decisions such as expending services within the health service which will eventually effect our nurses to patient ratio should be not only discussed with this union but an impact assessment be done on the effects on our nurses and midwives due to our present depleted numbers.

Nurses and Midwives can be easily compared to an elastic band which is being continuously stretched to the limit. There is always a breaking point and any future vision should not be calculated (as it was the norm of the past) on the financial impact but on the human resources available.

Mater Dei hospital is a typical example where all focus was more on the cost of the hospital and the equipment but then today's main issue is the lack of nurses and midwives to sustain the health care service.

The second major issue MUMN is expecting from the new government is to address the inefficiency resulting from the Institute of Health Care. MUMN is expecting that to address the nation's health care needs, all numerous clauses be removed, a proper evaluation of the nursing curriculum be done and that any modifications and changes within the curriculum has to be forwarded to the Nursing and Midwifery Council for approval.

With a positive note is that both major parties have taken aboard the MUMN proposals on developing the primary health setting during their election campaign. Such an issue has been lobbied by MUMN during the last five years. Documents such as the Family Health Nurse doc which has been modified to the local settings by MUMN had been forwarded to both parties for their approval. We are late on this issue since I sincerely believe that the primary health setting should have evolved at least four ago prior the Mater Dei hospital migration. But now I expect like all Maltese citizens expect, is that the electoral promise of developing the primary healthy setting with discussion with this union materialise, once the new government is in place.

MUMN has addressed various nursing issues in the last five with the last administration and was behind all the major nursing and midwifery agreements which brought financial and dignity to our profession. Consultation is the key aspect which any political party the nation decides to elect needs to adopt . Whilst MUMN wishes the new government all the best for the next five years, informs the new health minister that MUMN is ready to collaborate and give its input in the improvement of our health care service and the nursing/midwifery profession.

Paul Pace
President

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Praying with patients in crisis

Spirituality is vital for a patient's holistic recovery. In moments where all the previous securities have somehow been shattered due to an invading illness patients start looking around to reconstruct their lives again. Prayer is a great asset to help them recover what can be recovered.

In encountering a patient with a life threatening illness, the chaplain has to first and foremost ask to herself/himself: "What is this person's need? How can I help this person attaining hope? In order to enter the patient's world, the chaplain has to skillfully and caringly invite the person to narrate her/his story. "Sitting with", "listening to", and "journeying with" are key attitudes which the chaplain needs to endorse and preserve in order that the person's story receives the hospitality, respect and attention it deserves. Through storytelling many issues are surfaced such as feelings of fear, discouragement, anxiety, anger, longing to connect with a lost loved one, self-destructive lifestyle, terminal condition and ethical dilemmas.

Before a chaplain invites a patient for prayer it is essential that a caring, supporting and nonjudgmental atmosphere is created around the patient. Negative feelings can be shared if the patient feels that the spiritual care giver can accept her/his story unconditionally. In moments of great distress a patient can find it extremely hard to voice her/his concerns. S/he might be feeling hijacked by her/his situation. It is pastorally wise to gently invite the patients to share their feelings with God rather than pushing them to recite formal prayers which might lead to nowhere. If the person finds it difficult to formulate a prayer in her/his own words the chaplain might take the feelings and concerns mentioned throughout the pastoral visit and encourage the person to tell them to God the way s/he told them to the chaplain.

In times of crisis there are four types of prayers that can be prayed to God. These are the prayer of protest, the prayer of silence, the prayer of memories and the prayer of trust.

Crisis can be a privileged time whereby God is met through protest. In the patient's view God appears to be silent, indifferent, non-responsive to her/his plea. The more the silence persists the more the person realizes that God has moved out from her/his life. Feelings of abandonment, loneliness and forsakenness can be stirred in a patient. The spiritual care giver's skill is to gently guiding the patient to voice these feelings to God through a prayer of protest.

Hospitalization is a time of reviewing one's life. Patients are in an optimal situation where they can try to figure out if there is any meaning left in their actual life experiences. The more they indulge in evaluating their lives, relationships and decisions, the more powerful memories come out. In itself this exercise is a prayer of silence whereby one's experiences are placed before the Lord.

In recalling her/his past the patient comes to terms with both positive and negative memories. It is an occasion in which the patient is called to be thankful for the past memories, let go of painful experience and undertake with courage the present moment. Thus, a prayer of memories is to incorporate all these different elements.

Prayer of memories paves the way for a prayer of trust. Hope has nothing to do with expecting a miraculous cure or comprehending the significance of suffering. On the contrary a prayer of trust reminds the patient that Jesus, our Brother, also underwent a hard time before totally trusting his Father. It is the same Jesus who is journeying, embracing and encouraging the patient in her/his struggles to trust God.

Although it is awful and possibly avoided suffering is the gateway for an honest, life giving and mature relationship with God. Protest, silence, recalling memories and trust are foundational attitudes which make this dialogue with God in times of crisis flowing and all the time maturing.

Fr Mario Attard OFM Cap
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Kelmtejn mis-Segretarju Ġenerali

Issa għaddew 5 xhur minn meta ffirmajna l-Ftehim mal-Gvern, fejn in-Nurses u l-Midwives setgħu jibdew igawdu minn benefiċċji varji, però l-ħidma tagħna ma waqqfitx ma l-iffirmar, għaliex sa din il-gimgħa stess konna nvoluti f'laqgħat sabiex il-Ftehim ikompli jidħol fis-seħħ. Lestejna l-applikazzjonijiet marbuta ma l-Ftehim dwar xogħol ta' ġimgħa mnaqqsa (25 siegħa), job mobility, account individwali tal-vacation leave u oħrajn.

Nista' ngħid li l-maġġoranza tal-membri tagħna issa feħmu sew x'jinkludi dan il-Ftehim u nixtieq nieħu din l-opportunità biex nirringrazzjakom għall-kummenti pożittivi u l-appoġġ kontinwu li tkomplu tagħtu lil din il-Union.

Akkwist ieħor importanti li sar f'dawn l-aħħar ġranet kien dwar il-partimers fejn issa għandna konferma kemm mill-MPO kif ukoll mid-Diviżjoni tas-Saħħa li l-career progression ser tidħol fis-seħħ għal pertimers ukoll. Dan ifisser li issa mux ser ikun hemm aktar ċifra fissa iżda ser jibdew igawdu wkoll mill-assimilazzjoni ta' l-iskali bħal l-kollegi tagħhom il-fulltimers, naturalment kollox pro-rata.

Ftehim ieħor sar dwar l-ikel għan-Nurses u l-Midwives fl-Isptar Mater Dei. Dawk kollha li fl-Isptar San Luqa kienu intitolati biex jieklu u f'dawn l-aħħar xhur ġew imċaħħda minn dan għaliex jaħdmu bejn 8 sa 10 siegħat f'ġurnata jew għaliex ma jaħdmux direttament ma l-pazjent, issa b'sodisfazzjon ninfurmawhom li ser ikunu intitolati li jieklu b'xejn huma wkoll.

Ix-xogħol fil-premises il-ġodda fil-Mosta miexi ġmielu u fil-ġimgħat li ġejjien ser ikunu nistgħu nittrasferixxu l-Uffiċċju Ċentrali tal-Union f'dan il-post il-ġdid. Kien wasal iż-żmien li jsir dan il-pass peress li l-Uffiċċju preżenti sar żgħir wisq kemm għal dawk li huma laqgħat ta' Group Committees kif ukoll għall-courses li l-MUMN qed torganizza. Aktar informazzjoni fuq dan tingħata aktar il-quddiem.

Fil-ħarġa ta' dan il-Musbieħ ser issibu applikazzjoni sabiex tinnominaw lil dak/dik in-Nurses jew Midwife li fl-opinjoni tagħkom i/tkun j/timmeritah li jirċievi l-MUMN Award. Huwa mportanti li ma toqgħodux lura u jekk tħossu li hemm persuna li ħaqqa li tiġi nnominata inħeġġiġkom li tagħmlu dan sa d-data stipulata.

Dan ix-xahar saret il-premazzjoni tal-Momentos lil dawk in-Nurses/Midwives li rtiraw mix-xogħol, attivita organizzata mill-Florence Nigħtingale Benevolent Fund. Tajjeb li ninfurmakom li l-Union ser tkun qed tanalizza kif dan il-fund jista' jkun ta' aktar għajnuna biex b'hekk jiżdiedu l-benefiċċji. Jekk inti għandek xi suġġeriment dwar dan nitolbok tibgħat email fuq mumn@maltanet.net.

Fi ftit ġranet oħra ser tiġi organizzata l-konferenza fuq jumejn tal-Commonwealth Nurses Federation ġewwa l-Golden Sands Hotel. Kif żgur stajtu tapprezaw irnexxielna ninnegozzjaw prezz għall-membri tagħna. Din ser tkun it-tieni darba li konferenza ta' dan it-tip ser issir f'pajjiżna. Mill-programm wieħed jista jara kemm ser tkun ta' benefiċċju għall-iżvilupp tal-professjonijiet tagħna.

Żomm dejjem f'moħħok li l-MUMN hija inti u sħabna n-Nurses u l-Midiwives flimkien. F'dawn il-ħdax il-sena kemm ilha mwaqqfa l-Union saru passi ta' ġgant sabiex il-professjonijiet li nirrapreżentaw jitligħu livelli fil-kwalità u jiġu rrispetatti minn kulħadd, kemm lokalment kif ukoll fl-isfera internazzjonali. Ħdimna bil-għaqal u hekk ser inkomplu nagħmlu però dan setgħa jsir biss bl-appoġġ kontinwu tiegħek. Ta' dan nirringrazzjak mill-qalb.

Colin Galea
Segretarju Ġenerali

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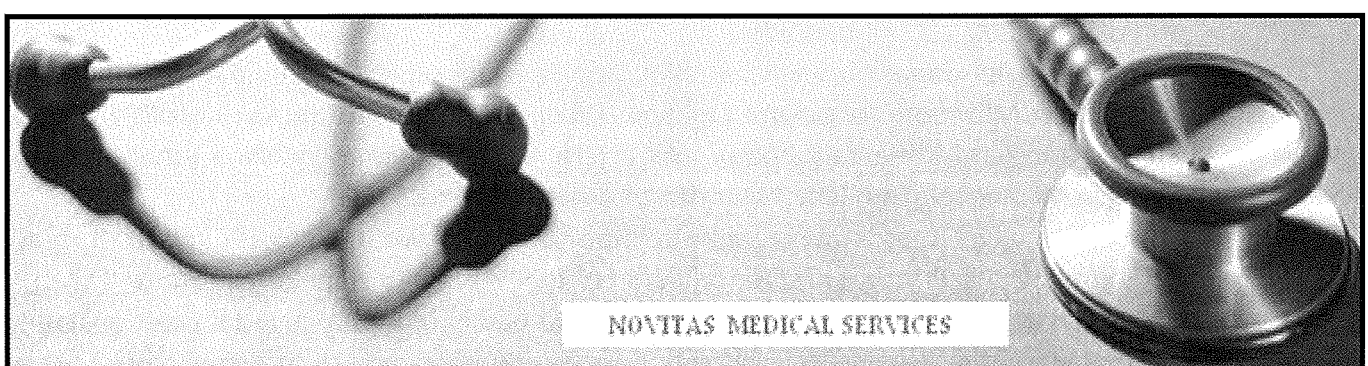
Il-Musbieħ Grupp Pensjonanti

Bħal ma tafu minn żmien għall-ieħor norganizzaw xi ħarġa għal sħabna l-pensjonanti, iżda din id-darba għamilna waħda BOMBA. Din kienet tikkonsisti fi *cruise* madwar Malta fuq il-vapur Captain Morgan u bħala attendenza kienet ta' 80 persuna. Kullħadd ħa pjaċir.

Barra attivitajiet bħal dawn nattendu għall-laqgħat fl-Alleanza tal-Pensjonanti, fejn anke ngħatu s-suġġerimenti tagħna f'dak li għandhom x'jaqsmu l-pensjonijiet u dwar affarijiet ta' saħħa, kif ukoll bħalma ħadna sehem dan l-aħħar dwar il-budget fejn kellna diskussjonijiet mal-Ministru tas-Servizzi Soċjali.

Inselli għalikom,
Paul Bezzina, *Chairman*



An Ageing Nursing Workforce

By 2020 there will be more than one billion people aged 60 years and older in the world.[1] This demographic trend has many implications, both for the demand for care and the demand and availability of carers. It will affect all segments of society.

In relation to effective workforce policies, attention and reference to ageing of the workforce have increased markedly in the last decade. For example, in the European Union, concerns about the sustainability of pensions, economic growth and the future labour supply have stimulated a range of policy processes and recommendations to promote the health and working capacity of workers as they age; to develop the skills and employability of older workers; to examine raising the pension age; and to provide suitable working conditions as well as employment opportunities for an ageing workforce.[2]

Within nursing, the situation in many industrialised countries is that the nursing workforce is ageing. Over the next 10 to15 years these countries will experience a large exodus of nurses from their workforce as nurses retire just at a time when demand for nursing and health care is on the rise; one of the reasons being the growth in the older population.

This trend, if left unaddressed, is set to deepen the current shortage of employed nurses, particularly in countries where there is a shortfall of new nurses entering the labour market. It will also have a knock on effect on developing countries where the age profile may be very different but where aggressive international recruitment efforts may drain the supply of nurses in active practice.

Facts, figures and trends

The average age of the nurse in many countries exceeds 40. See the table below.

- The legal age of retirement is not necessarily the average age at which a nurse will leave the workforce. For instance, in Canada, Ireland and Singapore the average age of retirement "in practice" is 60 while, in Iceland, the average age is 64 – several years below the legal retirement age.[3] [4]
- In the United Kingdom (UK), an estimated 180,000 nurses will reach retirement age over the next decade.[5]

Average age of an employed nurse [i, ii]	Average age of retirement by law [iii,iv]
Canada - 44.6	Canada - 65
Denmark - 43.8	Denmark - 65
Iceland - 44	Iceland - 67
Ireland - 41.4	Ireland - 65
Germany - 39.4	Germany - 65
Japan - 37.9	Japan - 60
New Zealand - 44	New Zealand - 60**
Singapore - 35	Singapore - 62
Thailand - 41	Thailand - 60
United Kingdom - 42	United Kingdom - 65
United States - 46.8*	United States - N/A

* Average age of *all* RNs in the USA not just employed.
** Average retirement age of RNs in practice only.
N/A= Not applicable.

- By 2010 predictions indicate that 40 percent of nurses in the United States (USA) will be over 50 years of age.[6] A survey of 1000 nurses (mostly managers) indicates over 55 percent of respondents plan to retire between 2011 and 2020.[7]
- Recent figures from Canada reveal that registered nurses between age 50 and 54 years make up 17 percent of the workforce, compared to 11 percent in 1994.[8]
- In some countries (e.g. USA and Ghana) ageing is affecting the nursing faculty providing education and training to the next generation of nurses.[9] For instance, a wave of faculty retirements is predicted across the USA over the next 10 years[10] and, if left unaddressed, will increasingly put restrictions on enrolments into nursing programmes.
- There is a trend in some countries, such as the UK and USA, of increasing numbers of people entering the profession at an older age (e.g. late twenties and early thirties). As a result, projections indicate that by 2010 the USA will have more nurses in their fifties than in any other age group.[11]
- There have been cases where nurses have taken industrial action because their right to early retirement has been challenged. For instance, prior to 1999, nurses in Panama had the right to early retirement at the age of 50, with benefits amounting to the last yearly income – the same percentage that is given to all public employees (e.g. fireman, clerks, sanitation, etc.). However, in 1999 the law was changed and nurses must now work until age 57 and then only receive a percentage of their last yearly income. In other words their acquired rights have been taken away and their pension benefits cut.
- A representative of the Zambian Ministry of Health recently reported that strategies to address the country's nursing shortage will include extending the retirement age by 10 years, while new graduate nurses are unable to find employment due to frozen positions and no-growth financial policies.[12]
- Results from a study of 290 health care facilities in the USA found that, while most administrators were aware of the ageing workforce and desired to retain their older nurses, only 6 percent had policies in place to address the needs of older nurses. Eighty-seven (87) percent had no immediate plans to address the ageing nursing workforce issue.[13]
- In the USA, nursing ranks third among the top 10 most injury-prone jobs.[14] Research indicates that nurses (14.7%) experience a higher incidence of back pain per year than non-nurses (11.5%), and that occurrence increases with age.[15]
- In a survey of 308 nurses over the age of 50, close to one-quarter reported having experienced a job-related injury within the past five years, and over one third suffered from health problems related to the job (e.g. back pain, anxiety, depression, etc).[16]
- Job re-design and modifications in the work environment are being introduced in a number of countries (e.g. Canada, USA). For instance, limiting heavy workloads, redesigning patient handling methods to reduce back injuries, and allowing greater flexibility in scheduling enable experienced nurses to reduce the physical demands of nursing care while increasing their role as mentors and clinical instructors.
- A survey of nurses and doctors in Australia reported that the three most important factors in determining retirement behaviour were anticipated income on retirement, availability of flexible hours, and health status.[17]

Strategies to attract and retain older, experienced nurses

Older nurses are a rich human resource pool. In many countries, they represent the fastest growing segment of the nursing workforce. Their premature or forced exit from the workforce and/or reduction in working hours means a loss of much needed and experienced nurses to care for patients. When they retire, their knowledge, wisdom and clinical expertise are lost, as is their contribution to training and mentoring the next generation of nurses. Tailoring employment strategies to this group is important to their retention. The literature suggests that older, more experienced nurses are more likely to extend their work life when the following conditions exist:

- Supportive and flexible work arrangements and practices (e.g. modified workloads, flexible scheduling options, reduction in hours of work, etc.).
- An organisational culture that promotes participation in decision-making and autonomy over practice.
- Work recognition, encouragement and positive feedback from supervisors.
- Ergonomically friendly, safe and effective work environments.
- Access to professional development activities that target the needs of experienced nurses.[18, 19, 20]

The International Council of Nurses and its International Centre for Human Resources in Nursing:

- Advocate/campaign for positive practice environments for all health professionals across all age groups, to end age related discrimination and improve working conditions.
- Publish scholarly material on managing the multi-generational nursing workforce and supervising and mentoring this workforce in order to inform and improve policy and practice in this area.
- Collect, collate, analyze and disseminate data on the nursing workforce (e.g. ICN nursing workforce profiles) in order to better assess the profile of nurses in different countries, regions and sectors.
- Raise awareness through position statements and at meetings and other forums on the specific issues facing the older nurse, including the promotion of a "living" pension.
- Develop and promote nursing human resource management competencies in order to improve the abilities of managers to develop and implement HR policies that effectively address the needs of an ageing nursing workforce.
- Evaluate and disseminate good HR management practice in this area, to lead to improvements in policy. This is accomplished through presentations at meetings and other forums and through the ICN-ICHRN website and published case studies.
- Present and discuss research and analysis of age related issues at international conferences, congresses and regional forums.
- By publishing scholarly material and making information available via the ICN-ICHRN website to support national nurses associations in their efforts to promote effective policies for an ageing nursing workforce.
- Discuss job redesign, pension benefits, and retention strategies particularly relevant for an ageing nursing workforce during Workforce Forum meetings

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Ejjew Nieqfu ftit

Nursing Fun

Because laughter really is the best medicine

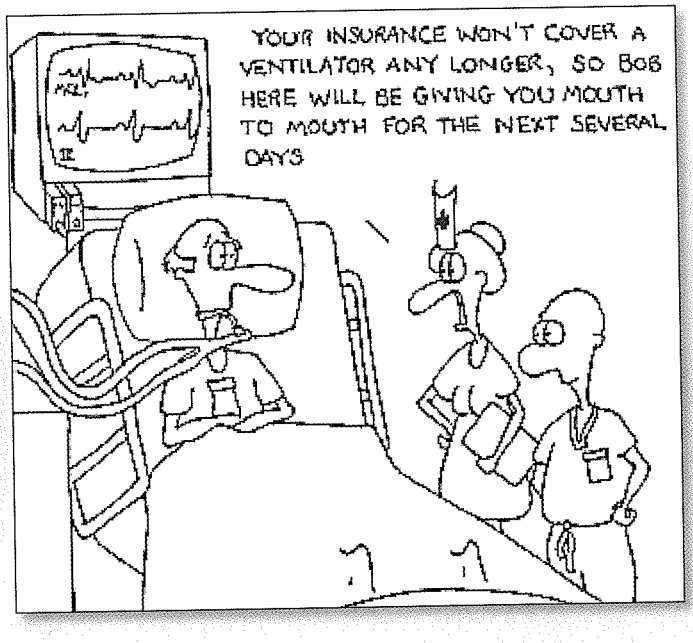
Blonde at the doctors

A brunette goes to the doctor, and says to him "Doctor I'm hurting all over my body."
"That's odd" replied the doctor "Show me what you mean"
So the girl takes her finger and pokes her elbow, and screams in pain. She touches her knee and cries in agony and so on.
The doctor says to her "Your not a natural brunette are you?"
"No I'm a blonde" she replies.
"I thought so... your finger is broken." replies the doctor

Something for Hiccups

A man goes into a drugstore and asks the pharmacist if he can give him something for the hiccups. The pharmacist promptly reaches out and slaps the man's face.

"What did you do that for?" the man asks.
"Well, you don't have the hiccups anymore, do you?"
The man says, "No, but my wife out in the car still does!"



Spare set of teeth

A dinner speaker was in such a hurry to get to the hotel that when he arrived and sat down at the head table, he suddenly realized that he had forgotten to get his false teeth. Turning to the man next to him he said, "I forgot my teeth." The man said, "No problem." With that he reached into his pocket and pulled out a pair of false teeth.

"Try these," he said. The speaker tried them. "Too loose," he said. The man then said, "I have another pair...try these." The speaker tried them and responded, "Too tight." The man was not taken back at all. He then said, "I have one more pair...try them." The speaker said, "They fit perfectly." With that he ate his meal and gave his address.

After the dinner meeting was over, the speaker went over to thank the man who had helped him. "I want to thank you for coming to my aid. Where is your office? I've been looking for a good dentist." The man replied, "I'm not a dentist. I'm the local undertaker."

Old couple goes to the doctor

An old couple went to the doctor. The old man goes first to have his physical. When the doctor is done with him, he sends the old man back into the waiting room and calls the old woman in.

The doctor tells her, "Before we proceed with the examination, I would like to talk to you about your husband first."

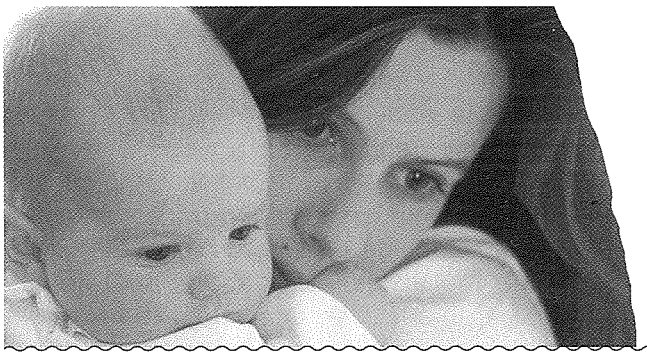
The old woman says, "Oh, no, it's his heart. I told him to lay off the eggs."

The doctor says, "Well, I asked your husband how he is feeling and he told me he felt great. He said that when he got up to go to the bathroom, he opened the door and God turned the light on for him. When he was done, he would shut the door and God would turn the light out for him."

The old woman responded, "Damn it, he's peeing in the fridge again!"

Scream for me

Dentist begging the patient: Could you help me? Could you give out a few of your loudest, most painful screams?
Patient: Why? Doc, it isn't all that bad this time.
Dentist: There are so many people in the waiting room right now and I don't want to miss the 4 o'clock ball game.



Domestic Violence

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Introduction

This discussion explores how domestic violence affects childbearing; focusing mainly on the effects on the mother's health and wellbeing. It also includes an analysis of what should and what is being done regarding this dilemma, which can in turn prevent future violent incidents and empower women to adjust their situation. Moreover, the midwife's role is discussed in detail.

Every human being has a right to live in a safe environment where dignity and respect are not encroached (Mifsud Bonnici, 2004). Domestic violence also known by the term intimate partner abuse; describes the physical, emotional and mental abuse to women by male partners or ex partners (Johnson et al 2003, Mifsud Bonnici, 2004, Rosso 2005). Victims and perpetrators of domestic violence may be male or female (Shadigian & Bauer, 2004), however the majority of victims are women and the perpetrators are men (Johnson, Haider, Ellis, Hay & Lindow, 2003). This unacceptable behaviour is an international public health issue that creates exceptional challenges for care (Nasir & Hyder 2003, Saunders 2000, Mezey & Bewley 1997). This abuse has no boundaries; it has been reported in all cultures, races, ages, sexes, educational levels and socioeconomic groups (Shadigian & Bauer 2004; Savona Ventura, Savona Ventura, Drengsted-Nielsen, Staehr Johansen 2001; Paluzzi et al 2000).

Domestic violence and its effect on childbearing

Domestic abuse is especially tragic, much more than ever, when the victim is a pregnant woman. During pregnancy the risks of domestic violence doubles because the health and safety of two victims (the mother and the fetus) is placed in jeopardy (Silverman, Decker, Reed, Raj 2006; Mezey & Bewley 1997). Domestic violence is associated with increased risks of premature birth, low birth weight (Silverman et al, 2006), miscarriages, fetal injury and also fetal death (Mezey, Bacchus, Haworth & Bewley 2003), hence the pregnancy is deemed as high risk (Saunders, 2000). The woman may indirectly harm the fetus by not being permitted to seek or receive proper antenatal or postnatal care by her violent partner – the perpetrator (Mezey & Bewley 1997). Violence in the home ruins lives, break up families and shatter whole communities. The worse part is that this abuse is usually carried out by someone (the partner) who is supposed to be the most close to that person (Mifsud Bonnici, 2004).

Saunders (2000) and Mezey, Bacchus, Haworth & Bewley (2003) state that pregnancy usually marks the beginning or escalation of violence for women; thus even during this period, the woman is not protected from domestic violence. The perpetrator use the physical, emotional and financial changes associated with pregnancy as an opportunity to establish power and control over the woman. (Shadigian & Bauer, 2004; Saunders, 2000). The enlarged gravid abdomen is a frequent target during an assault because the perpetrator intends to harm the fetus (Saunders, 2000). Behaviours in domestic violence includes pushing, shoving, punching, slapping, kicking, choking, leaving the victim in a dangerous place and refusing to help the sick or injured victim (Shadigian & Bauer 2004).

This partner abuse is a significant cause of morbidity and mortality for women in every country. It can lead to acute medical conditions such as multiple injuries to the face, neck, head, breast or abdomen, and in chronic conditions such as headaches, abdominal pain, pelvic pain and sexual dysfunction (Campbell 2002). Moreover it also results in serious reproductive health implications, which include increased levels of sexually transmitted infections and inability to use a consistent contraceptive method hence resulting in unwanted pregnancies. There are also the psychological consequences which include suicide and mental health problems (National Council of Woman of Malta, 2003).

The consequences of domestic violence do not affect the victims only. Children of abused mothers tend to develop social, emotional, psychological and/or behavioural problems, are several times more likely to abuse drugs and/or alcohol and are at a higher risk of running away. They may also grow up thinking violence is an acceptable part of family life.

cont...→

Boys who have witnessed abuse of their mothers are 10 times more likely to abuse female partners as adults. If the child is a girl she is more likely to be passive and withdrawn. Moreover, the child lives in daily fear, which causes increased stress, confusion and tension. This constant strain can result in a lifelong fear and inability to trust others. This fragile child will feel responsible for the abuse and helpless to stop it (Stop Child Abuse Now, 2005).

Women are limited in the extent to which they control or should be expected to control the perpetrator's behaviour. The abused woman is constantly living in stress; she is anguished, ashamed and isolated. Often women are reluctant to seek help and to speak about their situation, even when they suffer from physical and psychological illnesses (European Commission, n.d). Bacchus, Mezey & Bewley (2004) state that although domestic violence occurs frequently and can adversely have an effect on pregnancy, health professionals seldom enquire about abuse. Moreover, The European Union states that generally, health professionals within the European Union are ill-equipped to deal with this problem (European Commission, n.d).

It is simple to state, that the woman should leave her home and thus prevent herself from further abuse! However, it's easier said than done. Firstly, domestic violence is treated as a taboo subject (Mifsud Bonnici, 2004); hence the woman may feel ashamed of herself. Moreover, for many women leaving a violent home will bring about a substantial fall in income and even the risk of homelessness. Thus it explains why some women return to their homes again and again with the consequences of getting repeated violence. Effective help must be directed towards enabling the woman to build a new life and be offered realistic choices. (Rosso, 2005).

The midwife's role

Most of the time the perpetrator of domestic violence remain invisible and unacknowledged, but their criminal behaviours (such as bruises etc.,) are obvious on their victims by the medical community. The midwife and other health care providers have the responsibility to provide excellent medical services, acknowledge the existence of abuse and identify cases, and be able to offer interventions. All health care professionals need to understand that partner violence is an unaccepted behaviour.

As the midwife is usually the first point of contact for the abused pregnant women, proper guidance is essential in order to develop a 'pragmatic' and 'sensitive' approach in recognizing the signs of domestic violence whilst caring for these victims (European Commission, n.d.). Development of routine protocols and procedures for assessment and identification of domestic violence should be initiated (Sheehy & Pisarick, 1999) so as to enhance the safety of the woman and her unborn child (Mezey & Bewley, 1997). To be able to effectively implement routine enquiry for domestic abuse, the midwives and other health professionals need in-depth training, resources, staff support and policies in order to ensure that screening can be conducted safely and confidentially (Mezey et al 2003).

Early detection and appropriate intervention by the midwife can aid in preventing future violent incidents and their consequences, which can help to save lives. The victim should be provided with proper medical care for the present injury, emotional support, establishment of a safety plan, legal protection and information on available support services and community resources.

According to Sheehy & Lenehan (1999) the midwife and other health professionals should be on the lookout for any indications of domestic violence which may include:-

- The woman admits to past or present physical or emotional abuse
- The woman denies physical abuse, however she has unexplained bruises, grab marks, lacerations etc.
- Bruises and marks are found in sites that are usually hidden by clothing or hair
- Type of injury and extent vary from what the woman is stating
- Multiple injuries at various stages of healing
- The suspected abuser (usually the partner) accompanies the woman, and insists on staying close to the patient and may also try to answer any questions that are directed to the woman
- Repeated visits to the emergency department or other medical services

The abused woman is twice as likely to begin prenatal care during the third trimester of pregnancy, resulting in a potential increase in maternal and fetal

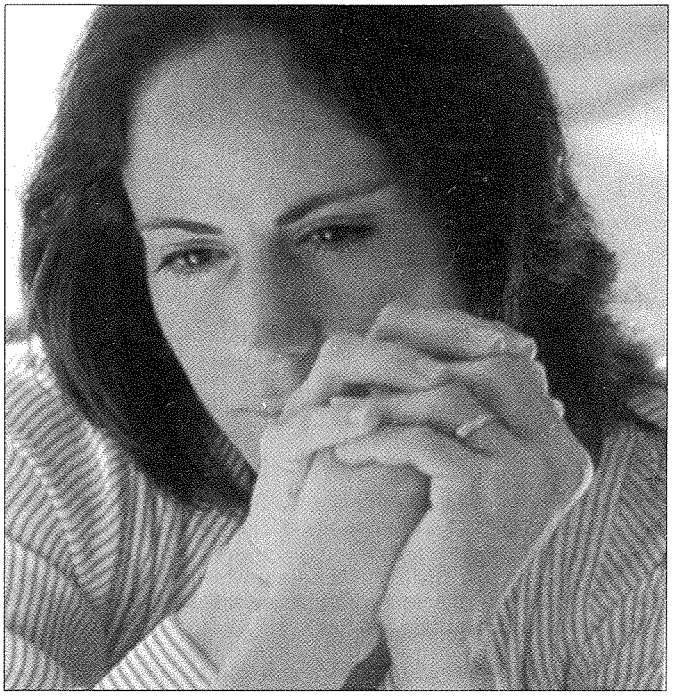
cont...→

complications (Shadigian & Bauer, 2004). Moreover, most of the time, the perpetrator accompanies the woman to these visits (Mezey & Bewley, 1997). The midwife needs to understand that for good reasons the woman may be embarrassed and reluctant to talk about her abuse. This can be due to stigma, shame and fear. The woman is afraid that her partner might find out that she have told someone and/or fear that her children will be taken away (National Council of Women of Malta, 2003). Less antenatal visits will lead to less contact with the health professionals, hence decreasing the woman's opportunity to be screened for partner violence. Partner violence during a previous pregnancy strongly indicates a risk for future abuse (Shadigian & Bauer, 2004).

Whilst the woman is receiving maternity care, the midwife has an opportunity to establish a relationship of trust with the women, thus the woman might find it easier to reveal her situation to the midwife. The midwife should have two things, a greater understanding of the issue of domestic violence and the competence and the confidence to take appropriate action (National council of Women of Malta, 2003). Screening is essential and should be carried out by a midwife that has been educated about the dynamics of domestic violence, the safety and autonomy of the abused patient and the importance of culturally competent care (Shadigian & Bauer, 2004). Studies that examined a variety of screening strategies revealed that higher prevalence rates are found when screening occurs more than once during pregnancy, later in pregnancy and when women are offered detailed interviews with trained professionals (Gazmararian, Lazorick, Spitz, Ballard, Saltzman & Marks 1996).

The midwife should assess the woman in a quite and private environment to provide privacy and to protect the patient. Questions should be asked in a non-humiliating manner so that the woman feels more at ease (Johnson et al, 2003 and Sheehy & Pisarick 1999). The key factor when taking a comprehensive history includes that the midwife ask direct questions in an emphatic way which can be accomplished whilst the midwife is taking the social history. The midwife should first ask questions such as cigarette, alcohol and drug use and then in the same tone of voice, ask questions which relate to domestic violence (Shadigan & Bauer, 2004).

It is important that the midwife keep in mind that the victim is usually made to feel worthless and ignorant by the perpetrator. Moreover, the perpetrator may have told the woman that if she reveals her abuse, more violence will follow. Hence it is extremely difficult for the woman to take the first step. (Sheehy & Pisarick, 1999). Sandall (1996) states that were there was continuation of midwifery care, the mother might be more ready to talk to the midwife about her feelings. If the midwife shows that she is uninterested, unsympathetic, and



hostile or in a hurry, more damage than good takes place. Insensitive or judgemental responses by the midwife can easily make the woman feel inferior and helpless. Hence the midwife must be sensitive to the woman's needs (Mezey & Bewley 1997).

In view of this, during the antenatal visits, standard questions about violence should be included in the same way as questions eliciting risks such as hypertension and diabetes mellitus. Monthly and weekly antenatal visits may provide the greatest opportunity for the midwife to screen the woman for domestic violence (Shadigian & Bauer, 2004).

Conclusion

Domestic violence should have a priority on the health and human rights agenda (Mifsud Bonnici, 2004). The midwife should acknowledge that domestic violence is unacceptable and that she is in a position to identify the victims and be a pivotal part of the effort to stop this partner violence (European Commission, n.d.). If we as health professionals do not identify domestic violence we will be failing those that are vulnerable in our society (National Council of Women of Malta, 2003). The midwife needs to be aware of signs and symptoms that indicate possible abuse. Moreover the midwife should screen, assess, identify, detect, offer appropriate intervention, educate and refer the mother if need be. The midwife should be on the lookout for physical and emotional signs of abuse, social signs of a pathologic relationship and the associated maternal behaviour that can complicate recognition and care (Saunders, 2000). Nonetheless, the manner in which the midwife and other health carers respond to a woman's attempt to seek help can make an immense difference to that women's life (Rosso, 2005).

cont...→

Health Promotion has an important role in raising awareness of the significance of this major problem. Awareness may improve care, support and even the outcome for the abused women and their newborns (Bacchus et al, 2004).

We should have zero tolerance to domestic violence

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From our diary

Mid-djarju tagħna...

4

5

1 L-MUMN tilħaq ukoll Ftehim mal-*Management* ta' l-Isptar Zammit Clapp dwar ir-*Retainment Package* li jitratta diversi inċentivi u *allowances*. Dan il-Ftehim kien diġa' ġie milħuq mad-Diviżjoni tas-Saħħa u l-Ministeru għall-Għawdex.

2 Għal darba oħra il-'Florence Nightingale MUMN Benevolent Fund' jagħti ġieħ lil dawk in-Nurses u Midwives li rtiraw mix-xogħol matul is-sena 2007.

3 Bħala parti mill-kampanja elettorali, il-Prim Ministru Dr. Lawrence Gonzi żar l-Uffiċċju ta' l-MUMN fejn ġew diskussi diversi punti mportanti li din il-Union temmen li jridu jidħlu fis-seħħ matul din il-leġislatura.

4/5 Ix-xogħol fuq il-*premises* ġodda ta' l-MUMN miexi b'ritmu magħġġel sabiex b'hekk din l-Union tkun tista taqdi aħjar il-funzjoni tagħha lejn il-membri. Dawn il-*premises* ser ikunu f'Independence Avenue il-Mosta, eżatt ħdejn il-kappella ta' San Silvestru.

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MUMN
1996
Malta Union of Midwives and Nurses

NURSE/MIDWIFE OF THE YEAR AWARD MAY 2008

NOMINATION FORM

A Nurse/Midwife can be nominated on one or more of these three aspects down listed by two of her/his nursing/midwifery colleagues: -

1. *Demonstrates professional dedication that exceeds regular duty requirements, which resulted in significant contributions to the health and well being of patients/clients while delivering Nursing/Midwifery care.*
2. *Exemplary leadership and skill resulting in noteworthy accomplishments, productivity, creative resource utilisation and enhancement of patient/client relationships.*
3. *Noteworthy accomplishments in professional education/research which stimulates development of new knowledge and practice in Nursing/ Midwifery.*

We are nominating Ms. / Mr. .....,

ID N° ....., Grade ..... , on aspect/s number (1 ❑ 2 ❑ 3 ❑) and are attaching all relevant documents to prove and explain in detail our nomination with this form. We understand that this form has to be sent to the MUMN's Offices in Tower Apartments, No. 1, Triq tas-Sisla, Birkirkara, BKR 13 by not later than Sunday 20th April 2008.

Nominee's Signature (1)	Nominee's Signature (2)
.....	.....
ID N°	ID N° .....

The Benefits of Hyperbaric Oxygen Therapy in the Treatment of Leg Ulcers in the Elderly

George Saliba D.N.O, Mother Teresa Ward 2, S.V.P.R. and on call staff at Hyperbaric Unit M.D.H. ❑ **gorant23@gmail.com**

Hyperbaric oxygen therapy is a system of treatment during which a patient breathes 100% oxygen intermittently inside a chamber in which the ambient pressure is raised to a point higher than sea level pressure. This is a relatively recent application of an old technology, which helps to resolve a number of recalcitrant medical problems, thereby minimizing the costs of prolonged hospitalization and medication.

Area Setting:

HBOT can be carried out either in a monoplace or multiplace chamber. The 100% oxygen can be delivered by mask, hood, or endotracheal tube. In Malta HBOT was introduced on a trial basis in 1985, in a two-person chamber situated in Kalafrana *(Fig: 1)*. In 1988 the new Hyperbaric unit was inaugurated at St.Luke's hospital and treatments started to be carried out in a large comfortable multiplace chamber which can accommodate up to 8 patients at a time *(fig: 2)*.

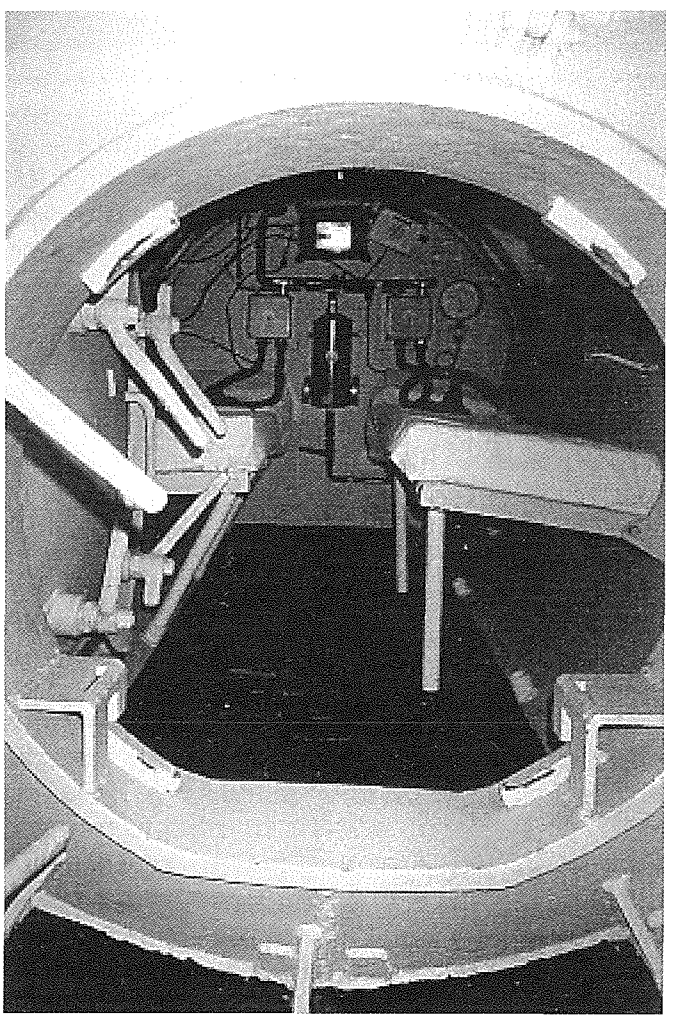


FIG: 1 Two-Person Chamber previously used at Hyperbaric Unit.

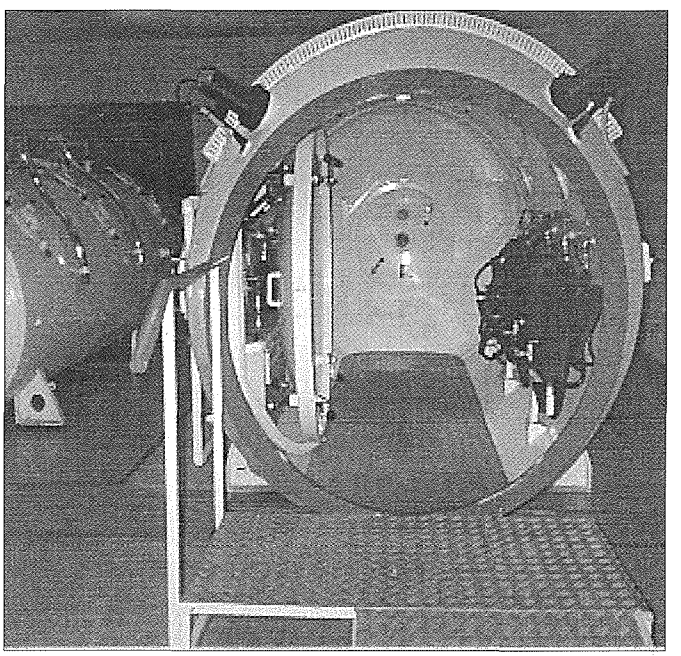


Fig: 2 The Multiplace chamber used at the Hyperbaric Unit S.L.H.

The Ageing Skin:

Like any other organ or tissue the skin undergoes numerous changes with increased age. These changes are more pronounced after the fourth decade of life. They are attributed to both intrinsic and extrinsic factors, the changes that occur with age are irreversible. The skin becomes thinner and less elastic and supple with ageing. Subcutaneous fat that normally helps absorb injury to the skin decreases. The skin becomes dry, often scaled and rough in appearance because less oil is secreted from sebaceous glands. The epidermis flattens because of the loss of papillae; therefore there is a reduction in the strength of attachment between the dermis and epidermis.

Very importantly one must note that different areas of the skin age differently. Differences are found between chronologically aged and photo-aged skin. Other changes with age include diminished perception to pain, increased vulnerability to injury, changes in the inflammatory response, and some physiological changes.

Definition of an ulcer or Wound:

One can define an ulcer or wound as a tissue breakdown due to any cause. They can occur in association with a range of diseases processes, most commonly with venous and / or arterial disease. An ulcer is an erosion or loss of continuity of the skin or of a mucous membrane.

Acute & Chronic wounds:

The healing process is a controlled, coordinated, complex series of events, which ensures healing in a healthy individual over an acceptable time scale.

Age is a significant factor in the healing process, chronic ulcers are more likely to present in the elderly or people with multiple pathologies. Ulcers are more common in those aged 65 and over, as tissues become less able to cope with insults and trauma. Skin also thins and becomes less elastic, muscle tone and blood flows are reduced and the vital inflammatory response is diminished.

Age influences each stage of the healing process; increasing age can lead to an increased incidence of complications such as wound dehiscence. Adequate oxygen carrying capacity and delivery to the cells are vital for healing. Tissue hypoxia can result in impaired collagen synthesis, decreased epithelialisation and reduced tissue resistance to infection. Patients with severe peripheral vascular disease, in particular are often unlikely to achieve healing of the lower limb wounds.

Some examples of non-healing chronic ulcers are, venous leg ulcers, arterial leg ulcers, diabetic foot ulcers and fungating wounds.

OXYGEN IN WOUND HEALING:

Cellular Effects of Oxygen.

Clinical surgical experience has indicated that ischemia impairs repair. While hypoxia is not exactly the equivalent of ischemia, for nearly 100 years it had been assumed that the administration of extra oxygen would assist repair in certain situations.

During the last 25 years advocates of HBOT through experimental and clinical evidence have shown that hypoxia is one of the fundamental properties of wounds, and that oxygen availability is a controlling factor in repair and an important factor in resistance to infection.

Regardless of the aetiology, the basic mechanism of non-healing wounds is an interplay between various degrees of tissue hyperfusion and infection. All problem wounds have the problem of tissue hypoxia and its sequila as common denominators. In a hypoxic environment, wound healing is halted by decreased fibroblast proliferation, collagen production, and capillary angiogenesis. Hypoxia also impairs oxygen dependant intracellular leukocyte bacterial filling of the most common aerobic organisms found in wound infections and creates the ideal environment in which anaerobic and microaerophilic organisms flourish. The bacterial overgrowth further compromises the wound.

Hyperbaric Oxygen Therapy:

The use of HBOT can restore a favorable cellular milieu in which the wound healing process and the host antibacterial mechanisms are enhanced. In some instances, elevation of wound oxygen tension may be as effective as antibiotics.

HBOT provides a significant increase in tissue oxygenation in hypoperfused, infected wounds. This elevation in oxygen tension induces significant positive changes in wound repair process. HBOT increase oxygen tension in ischemic and infected wound tissue. The greatest benefits are achieved in tissues with compromised blood flow and oxygen supply.

Hyperbaric Oxygen in Wound Healing:

The greatest benefit of hyperbaric oxygen is achieved in situations where the nutritive flow and oxygen supply to the tissues is compromised by local injury and / or infection, but in which the local and regional vascular network, a pre-requisite for oxygen delivery to the tissues is intact or partly damaged. On the other hand hyperbaric oxygen possesses significant angiogenic potential in tissues suffering from chronic lack of oxygen due to a defective vasculature.

TYPES OF ULCERS:

Ulcers with Arterial Insufficiency:

Many of the peripheral vascular diseases are accompanied by ulceration of the skin of the legs or even gangrene. The primary treatment of refractory ischemic wounds of the lower extremities is surgical revascularisation, (including endarterectomy, bypass surgery including femoro-pedal bypasses if possible and endovascular procedures by intervention radiologist). However, HBOT may be of benefit in selected cases, especially when a wound fails to heal despite maximum revascularization. Hyperbaric oxygen therapy may promote healing or prepare a vascular bed for skin grafting.

The period required for healing can be reduced considerably if the ulcer is prepared with a course of HBOT before split skin grafting.

Venous statis ulcers:

The hallmark of the treatment of venous ulceration is local wound care and external compression. HBOT is optional in delayed wound healing with low pO2 that can be corrected by hyperbaric oxygen, adjunctive to operative and / or conservative treatment in high risk, immuno compromised patients.

Surgical intervention is reserved for patients who fail conservative management or for those with recurrent ulceration. Hyperbaric oxygen therapy has a limited role; it is indicated in highly selected patients in the preparation of a granulating bed over a debrided venous ulcer for eventual skin grafting.

Decubitus ulcer:

Decubitus ulcers are caused by pressure on the skin, which interferes with circulation on the point of contact. Prolonged immobilization in one position may lead to this within a few hours. These ulcers are usually located over bony prominences such as the sacrum, heel, and ankle.

Pressure ulcers are an age-old problem, which have been subject of many research studies, yet continue to plague patients and health care professionals with their relentlessness. Due to the increased numbers of frail elderly and the fact that many might suffer from multiple pathologies, the prevalence of decubital ulcers is almost certain to grow. The primary treatment for this condition is modification of the patient's environment, nutritional support and aggressive wound care. Surgical treatment may be requires. This includes ulcer excision with primary closure, skin grafting or flap rotation. HBOT is useful to improve the soft tissue envelope for reconstruction and when underlying osteomyelitis is present.

Diabetic Ulcers:

Diabetes is one of the most common causes of non- healing ulcers. Malta having one of the largest number of diabetic patients in Europe i.e. 15% of total population, had an admission rate of 54 patients (> 60 years) in 1999, and 46 patients (> 60 years) in the year 2000 into St. Luke's Hospital with peripheral circulatory complications due to diabetes. A major hindrance to successful wound healing in diabetic patients is the disruption of normal vascularity leading to compromised hypoxic tissue. This vascular insufficiency may range from severe, multisegmental large vessel disease to mild alterations in the microvasculature.

Diabetic foot ulcers are thus one of the major complications of diabetes, resulting in substantial morbidity and mortality. Hyperbaric oxygen is designed to increase oxygen delivery to local ischemic tissue by a variety of primary and secondary mechanisms, to facilitate wound healing. A number of retrospective studies showed that a defined course of intermittent tissue concentrations of oxygen resulted in:

A. Reduction of amputation rates.
B. Increase in number of wounds that were completely healed.
C. More rapid healing rates.

Fig:3 New Haux Chamber at M.D.H. Hyperbaric Unit.

Cost effectiveness of HBOT:

Another important aspect that should be considered is the personal and economic cost in these situations. The personal and economic costs are staggering. Most importantly the actual money spent might be insignificant compared to the lost productivity of these patients and the great emotional impact it has on them. Among possible emotional reactions to amputation one can find: grief, anger, sadness, uncertainty, depression, mania, psychosis, anxiety, body image changes and sexual difficulties. In most cases the predominant experience of the amputee is one of loss, not only the obvious loss of the limb but also the losses in function, self-image, career, and relationship. Financially HBOT may also lead to lower costings per person, In Malta at St.

Luke's hospital the cost of an amputation is LM 250 with a cost of Lm85 daily for Hospitalisation. The length of stay varies from weeks to months if the patient is admitted for ulcer care, and from 8-12 days if admitted for amputation operation only. Another very high cost is the prosthesis and rehabilitation. The cost for each hyperbaric session is Lm250, and normally each patient is treated for 40 times. This cost is greatly reduced to the fact that each session can accommodate 8 patients at a time, reducing the cost to slightly over LM 31 a session for each patient. Another important aspect is that the patient can attend for sessions from home not only reducing the cost of hospitalisation but also reducing the chances of a patient staying in hospital for long periods thus leading to institutionalisation.

A course of HBOT is not only cost effective in appropriate chosen patients but can render life something worth living for especially in those patients who avoided amputation. This leads one to determine the impact of leg ulcers on the patient's quality of life and how HBOT can reduce this suffering.

Quality Of Life of Leg Ulcer Patients:

Although we have seen that much is done on the various methods of treatment of leg ulcers little is taken into account on the effects of the condition on the patients' lives. The most important themes to measure the patients' quality of life are the way their ulcers interfere with their physical, psychological and social life.

The most important physical effect that is met with in most patients with leg ulcers is pain, Second to pain is sleeplessness, which in turn can be a major source of exhaustion and worry. A very important issue is that of impaired mobility, increasing dependency of the patients.

The physiological effects, being that of a feeling of hopelessness, helplessness and loss of control, most people have a negative expectation about the future, stay inactive and are unable to set goals.

When a person's network of social relationships is reduced, loneliness is likely to be the result. Loneliness can become a vicious circle, proceeding from powerlessness to social isolation to reduced self-esteem. Loneliness is painful, and it often affects a person's whole pattern of living. HBOT does not only help with the wound healing process, but by doing so will contribute to giving our patients a better quality of life to look forward to, thus adding life to years.

Education:

By medical standards, the field of hyperbaric medicine is still young. That means there are many health care professionals who are simply not familiar with HBOT. Therefore doctors are not likely to prescribe a treatment with which they are not familiar. HBOT is not a drug that manufacturers can patent and sell, and it does not attract money for advertisements, in clinical journals and magazines. We must encourage health professionals to research the subject in medical libraries and Internet. Medical and nursing schools should introduce hyperbaric medicine in their curriculum. Only then will we have a widespread acknowledgement of the subject.

Research:

- The future needs for research are numerous. One area that needs more research is to investigate the viability of HBOT in its regards to it's cost effectiveness.
- Another study may be about the degree to which HBOT can influence the patient's care and rehabilitation reducing the probability of institutionalisation.
- Other studies could be performed to investigate the attitudes of health care professionals towards HBOT.

Conclusion:

I would like to make it clear that HBOT is not a magical cure for all. HBOT is a very useful treatment, but like all treatments, it has its limitations. The patient's overall physical condition, along with the severity of his/her disease or injury, must be taken in account. Not every patient will have a positive result. It must be said that in many cases of HBOT failure, HBOT was the treatment of last resort. All other treatments had been tried before HBOT, and all had failed. Unfortunately some hyperbaric medicine's critics refer to these failures. It is important for all health care professionals to understand that, as with all treatments, HBOT is more effective when used in a timely manner.

Patients with leg ulcers suffered negative effects in the physical, psychological and social areas of their lives. Pain, the lack of effective help and a reduced quality of life permeated their lives.

HBOT can not only help to heal the leg ulcer, but by enhancing more personal independence in daily activities, or easing physical, social and psychological pain provided an excellent boost to improve the quality of life for these elderly patients.

RAPPORT TA' ĦIDMA TAL-FLORENCE NIGHTINGALE BENEVOLENT FUND FI ĦDAN IL-MALTA UNION OF MIDWIVES AND NURSES[1] - 2007

Tibdil fil-Kumitat

Billi fl-elezzjonijiet li saru f'Marzu is-Sur George Saliba ġie elett fil-kunsill tal-MUMN, dan kellu temm il-kariga tiegħu bħala *chairperson* u membru tal-kumitat tal-*Florence Nightingale Benevolent Fund* (FNBF). Minfloku bħala chairperson inħatar Josef Trapani li sa dak iż-żmien kien is-segretarju. Is-Sur Joe Galea iddaħħal fil-kumitat u nħatar bħala s-segretarju l-ġdid.

Il-Kumitat tal-FNBF għalhekk issa hu magħmul hekk:
Chairperson: Josef Trapani
Segretarju: Joe Galea
Teżorier: Frans Agius
Uffiċjal għar-Relazzjonijiet Pubbliċi: George Fenech
Membri: Marvic Azzopardi, Carmen Abdilla, Antoinette Formosa

Laqgħat

Matul is-sena saru b'kollox sitt laqgħat. F'kull laqgħa il-kworum intlaħaq mill-ewwel u kważi kważi qatt ma kien hemm iktar minn membru wieħed assenti. Il-laqgħat ta' l-FNBF ġeneralment ikunu maqsuma fi tnejn:

- Il-Parti Amministrattiva li fiha jiġu diskussi l-affarijiet prattiċi fit-tmexxija ta' dan il-fond fosthom l-aspett finanzjarju, it-tfassil ta' attivitajiet u pubblikazzjonijiet
- Diskussjoni dwar it-talbiet ġodda għal għajnuna li jkunu waslu mill-aħħar laqgħa.

Minħabba n-natura sensittiva tal-każijiet id-diskussjonijiet ħafna drabi kienu twal u ġieli mqanqla. Iżda dawn dejjem saru b'mod serju ħafna u finalment dejjem intlaħaq qbil unanimu. Għalhekk janke matul din is-sena qatt ma kien hemm bżonn jittieħed vot biex tittieħed deċiżjoni.

Għajnuna lill-Membri

Matul l-2007 kien hemm 21 membru tal-FNBF li ngħataw għajnuna finanzjarja. B'kollox ingħataw Lm8,266 (€19,260) f'benefiċċji. Madankollu l-kumitat għamel ħiltu biex ma jirristrinġix il-għajnuna tiegħu għall-aspett finanzjarju biss u fejn kien possibbli sar kuntatt mal-membri. Barra minn hekk diversi membri għamlu użu mis-servizz ta' *counselling* professjonali mill-Fondazzjoni Richmond li jiġi offrut bi prezz sussidjat ħafna lill-membri tal-FNBF.

[1] Dan ir-rapport ma ġiex inkluż fil-ħarġa ta' Diċembru ta' Il-Musbieħ minħabba li fi żmien il-Milied l-FNBF jiċċirkula newletter għall-membri tiegħu.

Iċ-Ċerimonja ta' l-Irtirar

Fi Frar ġiet organizzata l-attività annwali f'ġieħ il-membri tal-FNBF li jkunu rtiraw mis-servizz. Din is-sena saret fir-Razzett l-Antik f'Ħal Qormi. L-attività nfetħet b'diskorsi qosra mill-President tal-MUMN u miċ-*chairperson* tal-FNBF. Imbagħad inqara profil qasir dwar kull wieħed mill-membri li kienu rtiraw matul is-sena ta' qabel u dawn ingħataw rigal ċkejken bħala radd ta' ħajr tas-servizz tagħhom. Wara sar riċeviment għall-pensjonanti ġodda u l-irġiel u n-nisa tagħhom.

Konferenza

Għat-tieni sena konsekuttiva, l-FNBF organizza konferenza. Din is-sena l-konferenza saret f'April fis-Sala Oracle tal-Lukanda Dolmen fil-Qawra u l-attendenza kienet qawwija ħafna. It-tema għall-konferenza ta' din is-sena kienet *Stress and the Nursing Profession* u għaliha kienu mistiedna bosta kelliema kwalifikati u b'esperjenza kbira. Il-mistieden ta' l-unur kien l-Onor. Mario Galea, infermier u membru parlamentari.

Pubblikazzjonijiet

Matul din is-sena, l-FNBF żamm il-kuntatt mal-membri kollha billi bħas-soltu ħejja u qassam żewġ ħarġiet tan-*newsletter*, waħda fis-sajf u l-oħra fi żmien il-Milied. Minbarra tagħrif u aħbarijiet dwar l-FNBF fit-tieni ħarġa ġie inkuż ukoll artiklu minn waħda mill-membri dwar kundizzjoni partikolari u għaqda li din ħolqot għal min ibati minnha.

Barra minn hekk, il-kumitat ipproduċa wkoll djarju li din id-darba fih żdiedu xi paġni ġodda. Sfortunatament, minkejja li l-materjal kien intbagħtilhom kollu sa nofs Ottubru, l-istampaturi damu ħafna ma lestew ix-xogħol iżda bi sforz kbir id-djarju u t-tieni *newsletter* xorta waslu għand il-membri qabel il-Milied.

Pjanijiet għas-sena l-ġdida

Il-Kumitat mistenni jkompli għaddej bil-ħidma tiegħu matul is-sena 2008 li bħas-soltu se tiffoka fuq l-għajnuna finanzjarja, psikoloġika u soċjali lill-membri li jkunu għaddejjin minn mumenti iebsa. Bħal issa qed isiru t-tħejjijiet biex għal nofs Frar issir l-attività ta' għoti ta' memento u riċeviment għall-membri li rtiraw matul l-2007. Iktar tard għandha ssir konferenza oħra.

Il-kumitat fi ħsiebu wkoll jirriattiva l-proġett ta' tħejjija ta' fuljett ta' għajnuna għall-membri li jkunu se jsiefru biex jingħataw trattament barra minn Malta. Il-kumitat jixtieq ukoll jagħmel użu aħjar mill-websajt ta' l-union billi fost l-oħrajn itella' xi tagħrif dwar l-FNBF kif ukoll li jagħmilha possibbli għall-membri li jniżżlu l-formoli ta' l-applikazzjoni direttament mill-Internet. Matul l-2007 sar attentat biex isir dan iżda sfotunatament, għalkemm intbagħat ħafna materjal, dan baqa' ma ttellax fuq il-websajt. Il-kumitat jisħaq li l-kunsill tal-MUMN għandu, kemm jista' jkun malajr, isib mezz biex jaġġorna regolarment il-websajt biex imbagħad il-fergħat bħall-FNBF ikunu jistgħu jużaw is-servizz tiegħu wkoll, dejjem biex il-membri jkunu jistgħu jinqdew aħjar.

Josef Trapani
Chairperson

> “Constant attention by a good nurse may be just as important as a major operation by a surgeon.”
>
> Dag Hammarskjold

Xi qrajt...

Joe Camilleri
N.O Resuscitation Nurse Specialist
❑ joseph.f.camilleri@gov.mt

FLORENCE NIGHTINGALE - MUDELL GĦALL-INFERMIERA

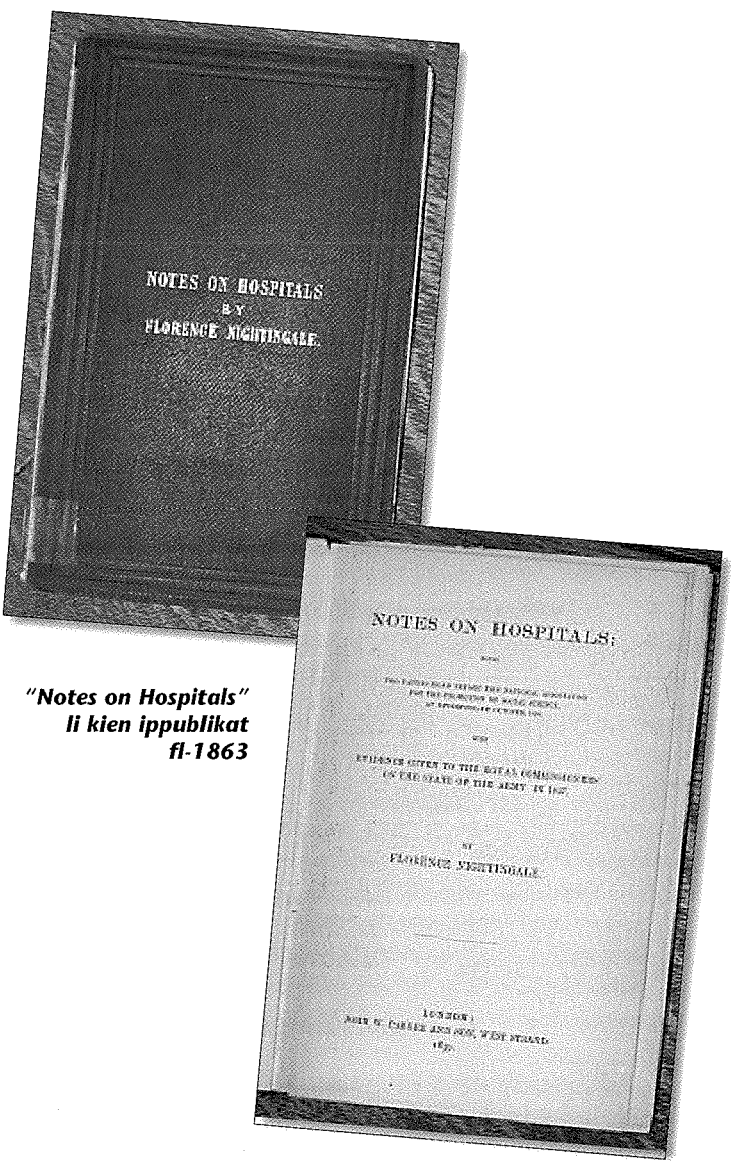
Florence Nightingale ta' età kbira mixħuta ġo sodda għal żmien twil

Fl-1862 ittieħdet azzjoni biex jinbena post għall-anzjani u l-morda minflok l-Ospizio l-qadim tal-Belt Valletta. Il-pjanti għal dan l-Isptar kienu magħmulha minn T.H. Wyatt ta' Londra bl-assistenza tal-Kontrollur ta' l-Istituzzjonijiet tal-Karita', l-Onorevoli F.V. Inglott.

Florence Nightingale kienet waħda min-nies li ġew ikkunsultati u esprimiet il-fehma li, "l-pjanti kienu tajbin tant (ħafna aħjar minn kull sptar ieħor għall-irġiel u għan-nisa li jien qatt rajt) li d-diffikulta' hi, kif ser insib xi ħaġa ħażina fihom. Ma stajtx niskopri mqar ħaġa waħda sanitarja nieqsa."

F'ittra oħra lis-Sur Wyatt hija kitbet: Hija ta' konsolazzjoni li nkun naf li ser ikun hemm Sptar Ċivili fid-Dominji Ingliżi li seta' jkun ta' eżempju." Għalhekk hija ssottomettiet suġġerimenti varji bil-ħsieb li jagħmlu l-ħajja ta' l-infermiera fl-Isptar aktar tollerabbli, u nsistiet li l-infermiera ta' bil-lejl kellha jkollha kamra għall-kwiet fejn setgħet torqod waħidha matul il-jum u fejn l-*iscullery*, jekk kellha tintuża bħala kamra ta' l-Infermiera ta' matul il-jum, kellha tkun komda u kbira biżżejjed. Hija saħqet ukoll li l-infermiera kellhom ikollhom *wc's* għalihom biss.

Is-Sinjorina Nightingale inkludiet kopja tal-pjanti għal dan l-isptar fil-ktieb tagħha "Notes on Hospitals", li kien ippublikat fl-1863. Din id-dar għall-Anzjani u għal dawk b'mard inkurabbli, li żmien wara, jiġifieri fl-1940, ġiet imsemmija: "San Vinċenz de Paule", kienet ġiet miftuħa fit-3 t'Ottubru, 1892. Waħda mis-Swali f'dan l-isptar kienet imsemmija għal Florence Nightingale.

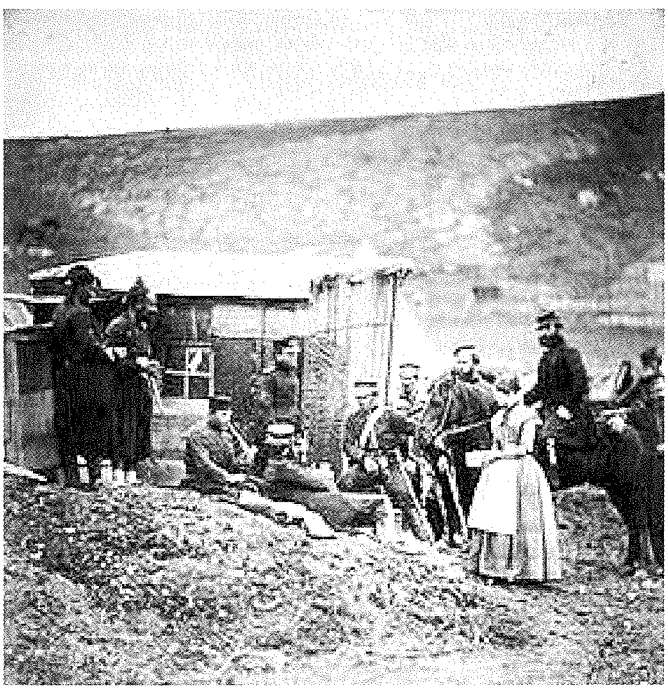


"Notes on Hospitals" li kien ippublikat fl-1863

Minħabba l-bżonn tal-faċilitajiet mediċi Maltin waqt il-Gwerra tal-Krimea, il-Gvernatur, Sir William Reid, fuq il-parir tal-awtoritajiet mediċi Militari f'Malta, fl-1857, kien wissa l-Gvern Ingliż li l-Isptar Militari fil-Belt Valletta ma kienx addattat u emfasiżża l-bżonn għall-bini ta' Sptar Militari ġdid. Din il-proposta ta' Sptar Militari ġdid issemmiet fil-ktieb "Notes on Hospitals" miktub minn Miss Nightingale, li kien ġie ppublikat l-ewwel darba fl-1859.

Fit-tielet edizzjoni tal-ktieb tagħha, li kien iġib id-data ta' l-1863, Miss Nightingale issuġġeriet li Sptar Militari Ġenerali kellu jieħu post l-isptar tal-Belt Valletta. Is-sit magħżul għal dan l-isptar kien fit-tarf ta' Triq Melita, faċċata tal-port ta' Marsamxett. Il-ktieb kien jinkludi d-disinn u l-pjanti kollha li kienu ġew ippreparati mill-arkitett T.H Wyatt fuq l-insistenza tal-Gvern Malti, għalkemm, kif jidher minn nota fil-marġini ta' kopja fil-ktieb ta' Miss Nightingale li jinsab fil-librerija Nazzjonali ta' Malta, li l-pjanti, originarjament kienu magħmulha mil-Kontrollur ta' l-Istituzzjonijiet tal-Karità, Dr F.V. Inglott u li kienu ġew mogħtija proporzjonijiet arkitettoniċi mill-Arkitett is-Sur Wyatt. Dan l-isptar il-ġdid baqa' biss proposta u qatt ma ġie mibni.

Numru ta' rekluti Maltin inkitbu biex iservu fil-Krimea. Ħafna Maltin oħra ġew impjegati mad-Dipartiment ta' l-Ordinanza u Kummissarjat biex jagħmlu xogħol ta' segretarji fit-Turkija, mijiet ta' *muleteers* kienu ngaġġati fil-Land Transport Corps, filwaqt li numru ieħor ta' Maltin kienu mpjegati bħala ħaddiema ta' l-id u biex jgħinu fil-kċejjen fl-isptarijiet.



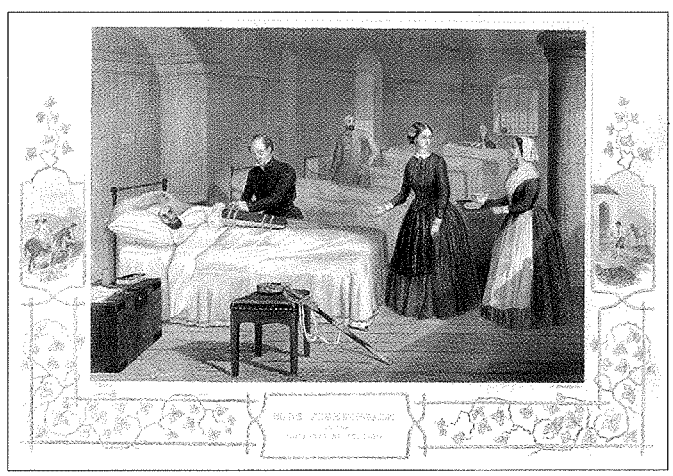
Il-Gwerra tal-Krimea

Mill-esperjenzi li kellha Miss Nightingale ma' dawn ir-rekluti Maltin, kulltant, xogħolhom kien altru milli sodisfaċenti. Hija kienet irċeviet ammont kbir ta' kontribuzzjonijiet mill-Ingilterra għat-truppi, imma kien ferm diffiċli biex wieħed jiċċekkja dawn il-proviżjonijiet minħabba li "l-Maltin, il-Griegi u l-ħaddiema Torok li kienu jaħdmu madwar l-Isptar kienu kollha disonesti, minghajr eċċezzjoni". F'okkażjoni waħda, żewġ ħaddiema Maltin li kienu jaħdmu ġol-kċina, instabu li kienu ħbew affarijiet mill-Free Gift Store f'kamarthom stess. "Is-sodod tal-Maltin instabu li kienu magħmulha kollha kemm huma minn turruni t'affarijiet misruqa". Maltin oħra li kienu ngaġġati kienu jinkludu sitt tobba:

"l-Maltin, il-Griegi u l-ħaddiema Torok li kienu jaħdmu madwar l-Isptar kienu kollha diżonesti, mingħajr eċċezzjoni"

it-tobba P. Grillet, A. Bellanti, A. Arpa, V. Muscat, F. Ellul u S.L. Pisani , kif ukoll il-Kan. Paolo LeBrun. It-tabib S.L.Pisani serva ma' Florence Nightingale fi Scutari. Fl-ittra tagħha lil Dr Pisani, Miss Nightingale mhux biss irringrazjatu għas-servizzi tiegħu fl-isptar tagħha fi Scutari, iżda ħeġġet lill-awtoritajiet militari biex jagħti s-servizzi tiegħu bħala Kirurgu militari.

Meta, fis-26 ta' Mejju, 1856, hija kitbet lill-Gvernatur ta' Malta, Sir William Reid, Miss Nightingale stqarret li "Jien kelli l-opportunita' li nara kif kien jaħdem meta servejt taħtu u dejjem smajt lis-superjuri mediċi ġewwa Scutari jitkellmu tajjeb ħafna fuqu u fuq kif kien iwettaq xogħolu u dwar l-attenzjoni li kien jagħti fil-każi li kien ikollu taħt idejh meta akkompanja lil Dr. French fi Scutari f'Ottubru, 1854."



Florence Nightingale ġewwa Scutari

Dr. Pisani, wara kellu karriera professjonali eċċezzjonali meta leħaq għal post ta' Professur ta' l-Anatomija u Storja, tal-Qbiela u Ġinekoloġija u tal-Kirurġija fl-Università ta' Malta. Wara, kien ukoll imlaħħaq bħala l-Chief Government Medical Officer Malta, fl-1885.

Ir-ringrazzjament ta' Malta lejn Florence Nightingale u lejn l-interess tagħha lejn dawn il-Gżejjer għandu jkun imħallas billi ssir ri-evalwazzjoni tal-kundizzjonijiet tal-infermiera tal-lum u l-kunċetti fid-dawl ta' l-ideat ta' kif infermiera għandha tkun.

Ħajr: R. Camilleri

Ritratti:

- http://www.uncp.edu/home/rwb/crimea_nightingale_scutari.jpg
- http://www.uncp.edu/home/rwb/crimean_war_fenton.jpg
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- http://www.countryjoe.com/nightingale/writings.htm

L-ISTORJA TAL-ISPTARIJIET ĊIVILI U ĠENERALI MALTIN

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

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L-Isptar Ġenerali ta' Għawdex

L-ewwel sptar f' Għawdex sar b'akkwist ta' Francesco Bonnici fit-22 ta' Frar 1454. Dan il-post li ntuża bħala sptar għan-nisa fqar u morda, u kien iddedikat għal San Ġiljan (magħruf ukoll bħala l-Isptar ta' San Ġwann l-Evanġelista, ta' San Kosmu u San Damjan, u l-Isptar Santu Spirtu) u fl-1575 kien jikkonsisti fi ftit djar ħdejn il-bieb taċ-ċittadella tar-Rabat/Victoria. Fit-3 ta' Mejju 1783, l-ewwel ġebla għal sptar ġdid ġiet inawgurata ġewwa r-Rabat/Victoria. Dan l-isptar il-ġdid bl-isem ta' San Ġiljan kien jakkomoda ħamsin pazjent u kien jilqa' wkoll ommijiet mhux miżżewġa qabel il-ħlas. L-isptar kellu wkoll r-ruota biex jirċievi t-trabi. Fl-1838 ma baqax iservi bħala sptar iżda bħala s-Seminarju ta' Għawdex, dan meta l-Isptar ta' San Ġwann Battista kien imkabbar għaż-żewġ sessi. L-Isptar ta' San Ġwann Battista beda' jinbena fis-16 ta' Ġunju 1719 u fetaħ għaxar snin wara, fl-14 t'Ottubru 1729. L-Isptar ta' San Ġwann Battista għall-bidu kien idaħħal biss pazjenti rġiel u impjegati kellu żewġ tobba u kirurgu. Fl-1838, il-pazjenti xjuħ ġew trasferiti lejn l-Ospizio tal-Furjana f'Malta, biex iżidu l-ispazju għall-pazjenti nisa. Issa kien jiflaħ akkomodazzjoni ta' sittin raġel u ħmistax il-mara. Fl-1849 ġiet mibnija dar biswitha biex takkomoda xjuħ ta' fuq is-sittin u li kienu fqar u b'diżabilità. Fl-1887, l-isptar biddel ismu għal Sptar Victoria fl-okkażjoni tal-Ġublew tal-Majestà Tagħha r-Reġina. Espansjonijiet strutturali saru wkoll fl-aħħar seklu biex ilaħħqu ma' numru akbar ta' pazjenti. Fl-1937 in-numru ta' sodod li kien jiflaħ l-isptar kien ilaħħaq għall-84, 34 għall-irġiel u 50 għan-nisa. Ir-refuġju għax-xjuħ u l-invalidi li kien mibni miegħu fl-1851, kien jakkomoda 172 sodda. Fl-1946 kienet bdiet issir konsulta ta' kull xahar ġewwa l-Isptar Victoria, fejn l-istaff mediku fl-1957 kien biss ta' supretendent mediku, uffiċjal mediku wieħed u tabib li kien għadu kif jilħaq. Fl-1957 l-isptar ġie mfaħħar bħala sptar li jolqtok minħabba btieħi kollha siġar u fjuri li kellu. Is-swali kienu kbar, friski, antiki iżda komdi. Sodod kien hemm 26 għal każi ta'mediċina, 40 għall-kirurġija, 12 għall-maternita', 6 għall-ginekoloġija, u 10 għall-pedjatrija. Sptar ġdid bl-isem ta' l-Isptar

L-Isptar ta' l-Ibraġ li qiegħed biswit l-Isptar Ġenerali t'Għawdex

Craig, li wara inbidillu ismu għal Sptar Ġenerali ta' Għawdex fl-1989, kien inawgurat ġewwa r-Rabat/ Victoria fil-31 ta' Mejju 1975, u l-isptar il-qadim ġie utilizzat bħala poliklinika tas-Saħħa tal-Gvern u uffiċini oħra.

Sptarijiet tar-Reliġjużi

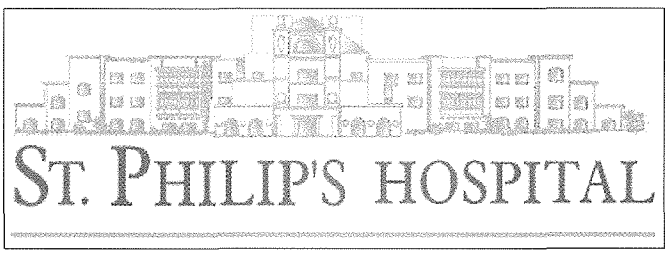
L-Isptar tal-Blue Sisters jew l-Isptar Zammit Clapp

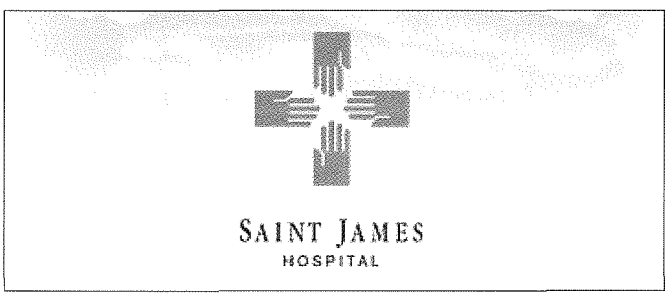
Il-bdil fl-atitudnijiet tal-morda speċjalment li wieħed ifittex sptar meta jkun marid seħħet fil-ħamsinijiet.

Dan wassal fl-iżvilupp ta' servizzi ta' sptar fil-kura privata immexxija mir-reliġjużi. L-ewwel sptar privat li nfetaħ f'Malta kien immexxi mill-Blue Sisters (Little Company of Mary) u kien issemma l-Isptar tal-Blue Sisters jew l-Isptar Zammit Clapp.

Fit-12 t'April 1959, s-Sorijiet Dumnikani inawguraw uffiċjalment sptar immaniġjat b'mod privat bl-isem ta' Sptar Santa Katerina ta' Siena ġewwa Ħ'Attard u kien jakkomoda 'l fuq minn 200 pazjent. L-isptar espanda s-servizzi tiegħu lill-pazjenti tal-maternità fl-1961. Fl-1980 l-isptar ġie mibdul f'dar tal-anzjani. Fl-1974 klinika żgħira bi 28 sodda bl-isem ta' San Duminku ġewwa r-Rabat/Victoria f'Għawdex immexxija wkoll mis-Sorijiet Dumnikani kienet toffri servizzi tal-maternità. Dil-klinika waqqfet is-servizzi tagħha f'Novembru tal-1976.

Sptarijiet Privati





In 1984 numru ta' *day clinics* infetħu f'Malta biex jispeċjalizzaw fil-maternità, fosthom St. James Clinic f'Ħaż-Żabbar u Klinika Vella f'Ħaż-Żebbug. Iż-żewġ kliniċi infetħu wara li għalqu l-isptarijiet immexxija mir-reliġjużi fl-1980. St. James Clinic bdiet bi klinika żgħira tal-maternità fejn wara espandiet is-servizz għal trattamenti multidixxiplinarji. Fil-fatt fl-1996 kiber għal sptar bi 17 il-sodda. Klinika Vella beda' b'żewġ sodod. Matul is-snin espanda s-servizz biex ikun jista' jipprovdi kmamar b'sodda waħda għall-pazjenti li jkollhom bżonn joqgħodu għall-lejl. *Unit* speċifiku ġie ddedikat għall-pazjenti tal-obstetrija u allura mhux ħdejn il-faċilitajiet tal-kirurġija. Faċilitajiet ta' klinika li toffri kmamar għall-konsulti għall-ispeċjalisti ta' kull tip u teatru tal-operazzjonijiet infetħu fl-1996 ġewwa St.Mark's Clinic fl-Imsida.

L-ewwel sptar privat f'Malta mibni apposta kien fl-1995. St. Philip Hospital huwa kkunsidrat bħala l-ewwel sptar mibni bi speċifikazzjonijiet ta' disinn *state-of-the-art.* Fl-1992 il-*letter of intent* li tapprova l-proġett ħarġet mill-gvern u sena wara kumpanija Maltija, il-Golden Shepard Group Ltd. ġiet iffurmata u reġistrata. Din il-kumpanija għaqqdet flimkien grupp ta' intrapriżi kbar Maltin flimkien mal-Inpendent British Healthcare PLC (IBH) li huma barranin. Is-servizzi ta' lukanda li ġew offruti huma kumparabbli ma' lukanda ta' ħames stilel. Il-75 kamra ta' b'wieħed bil-kmamar tal-banju en-suite huma kollha b'arja kkundizzjonata. Il-Unit tal-maternità għandha 25 sodda u qegħda viċin id-*delivery suite.* Fl-1996 infetaħ servizz apposta ta' antenatal, intrapartum u postnatal.

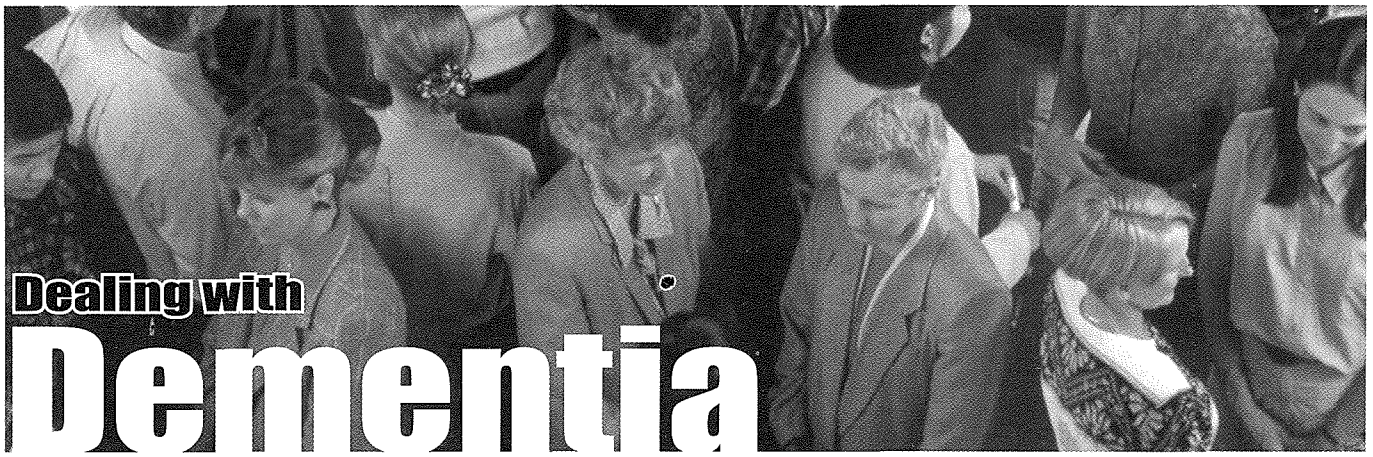
It-tieni sptar privat infetaħ fl-1996 ġewwa palazz tad-19-il seklu, il-Palazz Capua li ġie rrestawrat f'Tas-Sliema wara li l-gvern approva li jsir xogħol fuqu fl-1994.

Illum is-Saint James Hospital Group imexxi dan l-Isptar ta' 80 sodda fejn hemm ukoll klinika tal-għajnejn. L-isptar huwa mgħammar b'kull xorta ta' tagħmir teknoloġiku mill-aqwa.

Ikompli f'ħarga oħra

Referenzi:
C. Savona Ventura: Civil Hospitals in Malta in the last two hundred years. http://www.icon.com.mt/stphilips/malta/hospital2.htm

> “Nursing is an art: and if it is to be made an art, it requires an exclusive devotion as hard a preparation, as any painter's or sculptor's work; for what is the having to do with dead canvas or dead marble, compared with having to do with the living body, the temple of God's spirit? It is one of the Fine Arts: I had almost said, the finest of Fine Arts.”
>
> Florence Nightingale



Dealing with Dementia

Dementia is a brain dysfunction characterised by a decline in memory and intellectual function. An estimated 18 million people worldwide live with the condition.1 Although dementia is not a normal part of ageing, a person's chances of developing dementia increase as they get older. Since the world's population is ageing quickly, we can expect to see an increase in the number of people with dementia over the coming decades. Dementia is a cause of serious disability among those who live with the condition. It also has a wide-ranging impact on families and close friends, who can experience stress, frustration and exhaustion in caring for a loved one, as well as feelings of loss for the person they once knew. You may know someone with dementia or someone trying to cope in caring for someone with dementia. Many of us do.

Types of dementia

Alzheimer's disease is probably the bestknown type of dementia, accounting for more than half the number of cases. With Alzheimer's disease, brain cells shrink or disappear over time, affecting a person's behaviour and ability to perform day-to-day functions. Dementia can also be the result of Lewy body disease; 2 stroke; illness related to the Human Immunodeficiency Virus (HIV); Pick's, Huntington's or Creutzfeldt-Jakob disease; excessive alcohol use that causes vitamin deficiency; or imbalances in a person's metabolism. Most dementias, like that due to Alzheimer's and Lewy body disease, are progressive and can not be reversed. However, some types of dementia, such as that due to vitamin deficiency, may be reversible if caught and treated early.

What to look for

An early diagnosis is important if individuals with dementia are to receive the treatment and support they need for improved quality of life. According to Alzheimer's Disease International, the most common early symptoms of dementia are:

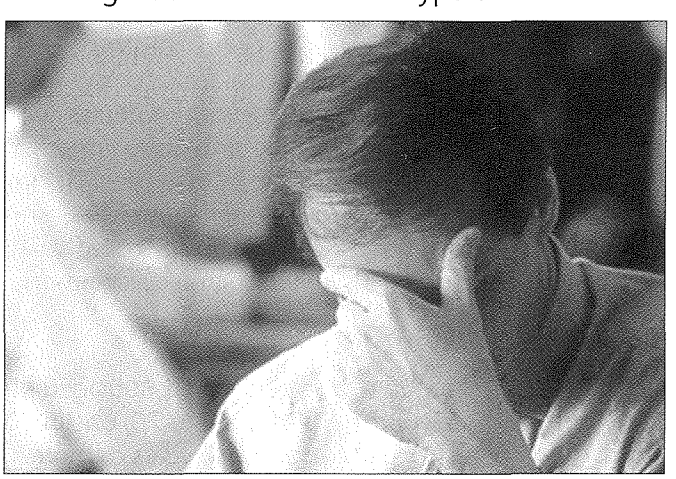
_ memory loss
_ difficulty performing familiar tasks
_ problems with language
_ disorientation to time and place
_ poor or decreased judgement
_ problems keeping track of things
_ misplacing things
_ changes in mood or behaviour
_ changes in personality
_ loss of initiative

If someone close to you exhibits one or more of these symptoms, it doesn't necessarily mean they have dementia. Their symptoms may be due to other causes. Still, if you have concerns that a loved one may have dementia it is important to discuss your concerns with a health professional. If indicated, a thorough evaluation can be initiated.

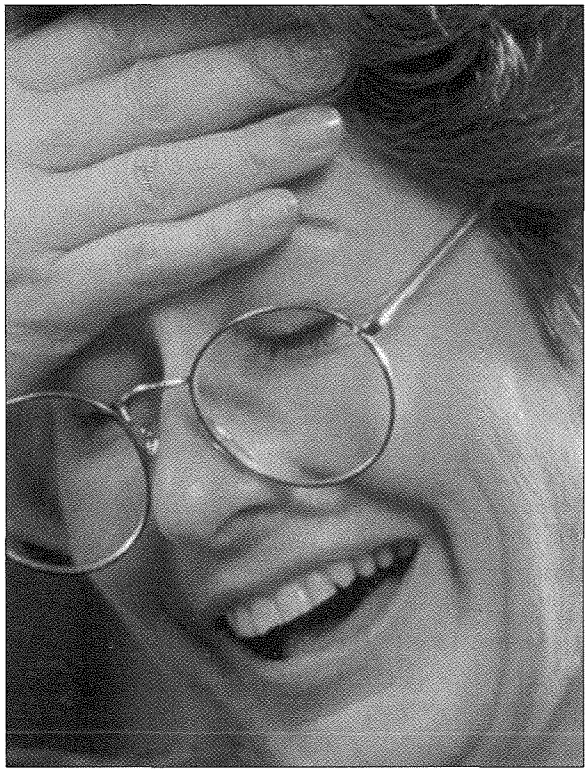
FACT SHEET No. 10 - 2005

Dementia

How is dementia diagnosed? There is no simple test for diagnosing dementia in an individual. A diagnosis is usually made after taking a careful history from a close family member or friend. The individual in question also undergoes a physical examination and their mental status is assessed. In some cases, technologies that show images of the brain are used to give weight to a diagnosis. No matter what type of dementia an



individual has, a diagnosis can help prepare them, as well as family and friends, for what lies ahead. Ideally, a diagnosis should emphasize an individual's abilities as well as their deficits.



Focusing on treatment and care

There is no cure for Alzheimer's disease or most other types of dementia, so treatment focuses on improving the individual's quality of life. This includes minimising symptoms and addressing their cause, wherever possible.

For example, drug treatments may be effective in controlling depression and agitation. In the early stages of dementia, it may also be possible to improve an individual's memory through the use of certain medications.3

Where care is concerned, the first step is to assess the needs of the individual with dementia, as well as those of informal caregivers, such as close family members and friends. The needs of people with dementia might include a safe living environment; access to supportive care from a range of professionals; respect; and protection from exploitation and abuse. Meanwhile, informal caregivers need to be included in care decisions; provided with information, education and training on dementia; given 'time outs' to de-stress and recharge; and acknowledged for their important and demanding role.

Helpful resources

If you suspect a loved one has dementia, or you find yourself caring for someone with dementia, it is important to remember that you're not alone. Health professionals can provide information and help direct you to appropriate resources. Alzheimer's Disease International can be a good starting point. This umbrella organisation is a link to over 70 national Alzheimer associations worldwide, as well as to regional groups for Europe and Latin America. Its website offers considerable information about Alzheimer's disease, as well as other dementias, and includes a special section called 'Help for caregivers'. You can access the site at www.alz.co.uk/alzheimers.

Statistics

– In the United Kingdom, one person in 1,000 aged 40 to 65 has dementia; one in 50 aged 65 to 70; one in 20 aged 70 to 80; and one in five aged 80 years or more.4

– Approximately 4.5 million Americans have Alzheimer's disease,5 with one in 10 individuals over 65 and nearly half of those over 85 affected.6 In one poll, one in 10 Americans said they had a family member with Alzheimer's and one in three people knew someone with the disease.7

– One in 13 Canadians over age 65 is affected by Alzheimer's disease and related dementias;8 specifically, one person in 50 aged 50 to 65 years; one in nine aged 75 to 84 years; and one in three over age 85 years fits into this category.9

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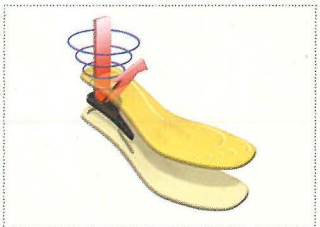

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