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MALTA NURSING AND MIDWIFERY JOURNAL

MALTA UNION OF MIDWIVES AND NURSES

Ħarġa Nru. 40 - Settembru 2008

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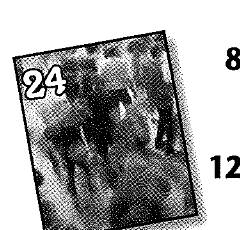

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Il-fehmiet li jidhru f'dan il-ġurnal mhux neċessarjament li jirriflettu l-fehma jew il-*policy ta' l-MUMN.*

L-MUMN ma tistax tinżamm responsabbli għal xi ħsara jew konsegwenzi oħra li jiġu kkawżati meta tintuża nformazzjoni minn dan il-ġurnal.

L-ebda parti mill-ġurnal ma tista' tiġi riprodotta mingħajr il-permess bil-miktub ta' l-MUMN.

Ċirkulazzjoni: 2250 kopja.

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.

Ritratt tal-faċċata: Stephen Gatt

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Editorjal

Għadhom kif għaddew l-Olimpjadi u wieħed seta' jara x-xogħol li għamlu dawn l-atleti matul il-ħames snin preċedenti. Tħarriġ, kontra tħarriġ sabiex matul l-Olimpjadi setgħu jagħtu *performance* tajba. Għalkemm wieħed jammira l-wirja finali, wieħed japprezza u jfaħħar it-tħarriġ ta' qabel. B'hekk biss jista' wieħed jasal li jidher quddiem il-pubbliku u jkun jista' igħid li għamel dak kollu li seta'.

Ħsibt ftit, għax wara kollox biex nikteb hekk ikolli nagħmel, u qabbilt din is-sitwazzjoni ma' l-Isptar Mater Dei. Dan mhux ħames snin kellu tħejjija, imma nsomma... Però nibża' li ma nistgħux nidhru quddiem il-pubbliku u ngħidu li għamilna dak kollu li stajna. In-nuqqas ta' ħsieb ta' kif kellu jitmexxa dan l-isptar, hekk imsejjaħ *'state of the art'*, għalija huwa tal-mistħija. Forsi hemm min igħid li qed inħawwad, jew ma nafx x'qed ngħid, però il-verità titkellem waħida. Kif jista' wieħed jispjega li wara dawk is-snin kollha sabiex nibdew naħdmu f'Mater Dei, ħadd ma beda jaħseb bis-serjetà biex isir reklutaġġ ta' Nurses u Midwives, biex ikollok ħaddiema biżżejjed biex tmexxi. Ma jistax wieħed igħolli l-immaġini ta' l-isptar u ta' kemm ser ikun qed joffri servizzi, jekk m'għandekx b'min taħdem. Huwa kollu għalxejn li jkollok il-magni jekk m'għandekx min iużahom.

X'qed jiġri..? Bħal ma jiġri dejjem, insewwu l-pannu bil-qargħa aħmar, u takkess iżjed lil dawk li diġa msallbin biex ilaħħqu max-xogħol li għandhom. Mentalità li sfortunatament ġarrejnieha magħna mill-isptar San Luqa u donnu ħadd minn dawk fil-poter ma jrid ifarfarha... għax komda. Wara kollox ftit li xejn tolqot lilhom.

Mentalità kattiva oħra hija li, dawk li qed imexxu jaħsbu li jistgħu jilagħbu kif iridu bin-nies li jiddependu minnhom. Jaħsbu li n-Nurses u l-Midwives huma pupazzi li tiġbdilhom l-ispaga u jagħmlu dak li jiġi ordant lilhom. Kemm kienu jitmassħnu huma stess meta kienu fi gradi inqas... però sewwa jgħid il-Malti li biex tkun taf bniedem x'inhu, agħtih pożizzjoni. Però sfortunatament dan it-tip ta' management insejjaħlu bla sinsla. Kulħadd irid jidher ħelu ma' ta' fuqu. Ibda min dik jew dak in-*Nursing Officer* li t/irid t/jakkwista xi tlett dipartimenti taħt idejha/idejh... u dan għaliex? Sempliċiment biex ikollna iżjed poter, u ftit li xejn nirrispettaw l-identità ta' ħaddieħor. L-iskrivan/a li j/trid i/tmexxi d-dipartiment hu/hi, u j/sseffsef, u j/tkun emmnut/a... u dan għaliex? Sempliċiment biex mingħalina tlajna xi skaluna oħra. U d-deċiżjonijiet jittieħdu fuq dawn il-kriterji... u r-rota tkompli ddur sakemm jitqaċċat il-fus. U l-iżjed li jbatu jkunu l-pazjenti, għax dawk li jkunu fil-poter hemm jibqgħu... imexxu kif kienu jagħmlu dejjem.

La bdejna fuq il-logħob, inkomplu hekk. Min ma jafx kemm hi ta' ħsieb il-logħba taċ-ċess? Hekk għandha tkun it-tmexxija ta' l-isptar. Hekk kif waqt il-logħba toqgħod attent kif tilgħab biex tħares lir-re u lir-reġina, hekk għandna nmexxu biex inħarsu d-drittijiet tal-pazjenti tagħna, biex wara kollox nagħtuhom dak kollu li jinħtieġu bi dritt. Ma tistax tilgħab bl-addoċċ għax, apparti li titlef il-ħaddiema, tkun qed tpoġġi lill-pazjenti fil-periklu. Il-ħaddiem mhux pupu... ma jista' ħadd jippretendi li n-nurses u l-midwives jagħmlu l-mirakli. Diġà huma ħafna dawk li qed iħossuhom imkissra għax ħadd ma jismagħhom, għax ħadd ma jidher li qed jipprova jagħmel xi ħaġa... kemm ser indumu sejrin hekk? Ħaddiem imdejjaq ma jista' jagħtik xogħol tajjeb... u ma nistgħux nibqgħu ngħidu għax l-ambjent ta' l-isptar huwa isbaħ u mingħalina li b'hekk qed insolvu xi ħaġa. Ma nistgħux nibqgħu li ma kull problema li tinqala', insolvuha billi nsallbu jew nagħmlu l-ħajja infern għal xi nurses u midwives. Ma nistgħux insolvu l-problema ta' dipartiment billi nkissru nurses u midwives oħrajn. L-ewwel, għax kellek bżonn, jintbagħtu nies f'dipartiment, tgħallmu u bdew jaħdmu, wara ftit żmien jibda paroli ta' ċaqliq biex jiġu akkomodati talbiet ta' xi wħud li huma aktar influwenti. Din mhix etika... din hija farsa... din hija logħba tal-poter... il-liġi tal-ġungla donnha qed tirrenja f'Mater Dei...

Messaġġ tal-President

Diskors tal-President ta' l-MUMN fl-okkażjoni tal-ftuħ ta' l-Uffiċċju Ċentrali ta' l-Union nhar il-5 ta' Settembru, 2008

E.T. President ta' Malta, Onor. Ministri u Deputati Parlamentari, mistiedna distinti, kollegi u ħbieb.

F'isem in-Nurses u l-Midwives f'pajjiżna, nixtieq nirringrazzjakhom talli lqajtu l-istedina tagħna għall-ftuħ ta' dawn il-*premises* ġodda. Mill-ewwel ngħid grazzi lill-Membri tal-Kunsill tal-MUMN li għamlu din il-ħolma realtà.

Premises bħal dawn jirriflettu t-tkabbir u d-diversità li din l-Union qeda tgħaddi minnhom biex tlaħħaq mhux biss ma' l-att trejdunjonistiku, imma wkoll ma' l-aspett akkademiku u dak soċjali; it-tlett sisien li fuqhom tinsab mibnija din l-Union.

Kif ħafna minnkom jafu, l-MUMN twaqqfet fl-1996. Minn dak iż-żmien sa llum qatt ma ħarisna lura. Il-ħidma u s-servizzi li l-MUMN qed toffri lill-membri tagħha huma xiedha tad-diversità u t-tkabbir li l-MUMN għaddejja minnhom.

Fil-bidu tat-twaqqif tagħha, l-iskop tal-ħidma ta' din l-Union kien ħafna jffukat biex insaħħu u niġbru n-Nurses u l-Midwives tagħna ġo għaqda trejdunjonista waħda. Ridna noffru lil kull Nurse u Midwife vuċi li twassal mhux biss il-problemi tal-professjoni, imma tkun f'pożizzjoni li tiżviluppa l-professjoni tagħha biex taġġorna mal-ħtiġijiet tal-lum. Dan ix-xogħol, fl-1996 kien beda jsir ġewwa garaxx żgħir, li kien mikri lill-MUMN fil-Fgura.

Meta fis-sena 2000, l-MUMN ħadet fi ħdana r-rwol ta' assoċjazzjoni, barra l-aspett trejdunjonistiku, bdejna naraw sfidi ġodda. L-MUMN saret ukoll assoċjazzjoni ta' Nurses biex b'hekk stajna nirrappreżentaw lill-istess Nurses u Midwives Maltin fuq aspetti edukattivi u professjonali. Stajna wkoll nipparteċipaw f'diversi fora internazzjonali biex inkunu f'sitwazzjoni li nikkontribwixxu fuq *standards* u *policies* marbuta maż-żewġ professjonijiet.

Illum l-MUMN hija affiljata ma' numru konsiderevoli ta' organizzazzjonijiet internazzjonali. Dawn l-affiljazzjonijiet irriżultaw f'numru ta' sfidi u opportunitajiet bħal meta l-*European Federation of Nurses Associations* żammet il-laqgħa tagħha f'pajjiżna, u kif ukoll l-*European Midwives Association* fejn ix-xahar id-dieħel ser iżuru Malta sabiex jorganizzaw il-laqgħa annwali tagħhom. Affiljazzjoni oħra importanti hija dik ta' l-*International Council of Nurses* fejn ser torganizza f'pajjiżna, l-ikbar kungress tan-Nurses bejn il-5 u s-7 ta' Mejju, 2011. Dan il-Kungress li għalih jattendu ma' l- 4000 Nurse minn madwar id-dinja kollha ser joffri sfidi, mhux biss għall-MUMN imma saħansitra għall-Gvern, u kif ukoll għall-intrapriżi privati. Dan kollu ser jikkontribwixxi għall-ekonomija ta' pajjiżna. Irnexxielna nxandru isem pajjiżna u ta' l-MUMN fuq l-livell internazzjonali, u dan bis-saħħa tan-Nurses. Fi kliem ieħor bl-Ingliż - *We are making History.*

Għalhekk, bil-koperazzjoni tal-Ministru tas-Saħħa u Politika Soċjali twaqqaf kumitat biex naraw li pajjiżna jisfrutta din l-opportunità u fl-istess waqt isir riklam għal Malta. Irridu nassiguraw li nħallu mpressjoni mhux biss tajba, iżda li tisboq f'kull aspett għaliex konvinti li, kif jiġri wara kull Kungress, in-Nurses li ġejjin minn 131 pajjiż madwar id-dinja, ser imorru lura f'pajjiżhom u jitkellmu fuq l-esperjenza tagħhom f'pajjiżna.

Għalhekk din l-Union trid tipprepara wkoll għal din l-isfida u *premises* bħal dawn ser ikunu denji biex in-Nurses li jkunu hawn Malta ser jaraw, li n-Nurses u l-Midwives ta' Malta u Għawdex, għandhom *premises* li tixraq id-dinjità tal-professjoni tagħhom. *Premises* bħal dawn iħabbtuha ma' *premises* ta' ħafna organizzazzjonijiet tan-Nurses u l-Midwives f'pajjiżi ferm ikbar mill-popolazzjoni tagħna. Għalhekk b'wiċċna bil-quddiem, nawguraw li l-futur tal-MUMN u x-xogħol li twettaq fil-qasam tas-saħħa jkun dejjem ta' fejda, kemm għall-ħaddiema li jaħdmu f'dan is-settur imma wkoll għall-pazjenti u ommijiet tagħna li jixraqilhom kull servizz ta' l-ogħla kwalità.

Filwaqt li nirringrazzjakom li lqajtu l-istedina tagħna u ngħaqqadtu magħna f'din il-ġurnata memorabbli għalina, nistieden lill-E.T. Dott. Edward Fenech Adami sabiex jagħmel l-indirizz tiegħu u wara jiddikjara dawn il-*premises* miftuħa.

Paul Pace
President

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4giveness

One of the main pastoral issues that I habitually come across in my pastoral ministry at Mater Dei Hospital is undoubtedly forgiveness. By listening to other people's stories I came to realize that everyone has something to forgive to someone or other people. Since forgiveness is so prevalent in the experience of being human, I slowly started to comprehend that forgiveness is the bread and butter of being a human person created in the likeness and image of God. Without forgiveness there is no human life. As Josh McDowell said: "Forgiviness is the oil of relationships".

The more I pondered on the various experiences I heard during my ward rounds, the more I became aware that it is in fact difficult, if not impossible, to define exactly what forgiveness is all about. Does it mean a "letting go of the past", as the American psychiatrist Gerald Jampolsky suggested? Or is it forgetting what has happened to us as if it did not occur at all? Thanks to my theological reflection on my pastoral ministry I came to acknowledge that it would be pastorally wise to refrain myself from giving a concise definition of the term. Rather I consider it appropriate to humbly present the conclusions that I was able to gather from the experiences I was privileged to attend to.

To forgive does not mean to forget. It is practically impossible to completely obliterate negative experiences that we underwent. Even if the experience per se can be forgotten, its effects remain there to remind us of what we have been undergoing. The Hungarian psychiatrist Thomas S. Szasz used to say: "The stupid neither forgive nor forget; the naive forgive and forget; the wise forgive but do not forget." Having said that, we need to acknowledge the fact that although the pain inflicted upon us was great indeed, yet that very pain can be a potentially powerful resource for our lifelong learning. In that matter, pain acts as both an astute and unkind teacher.

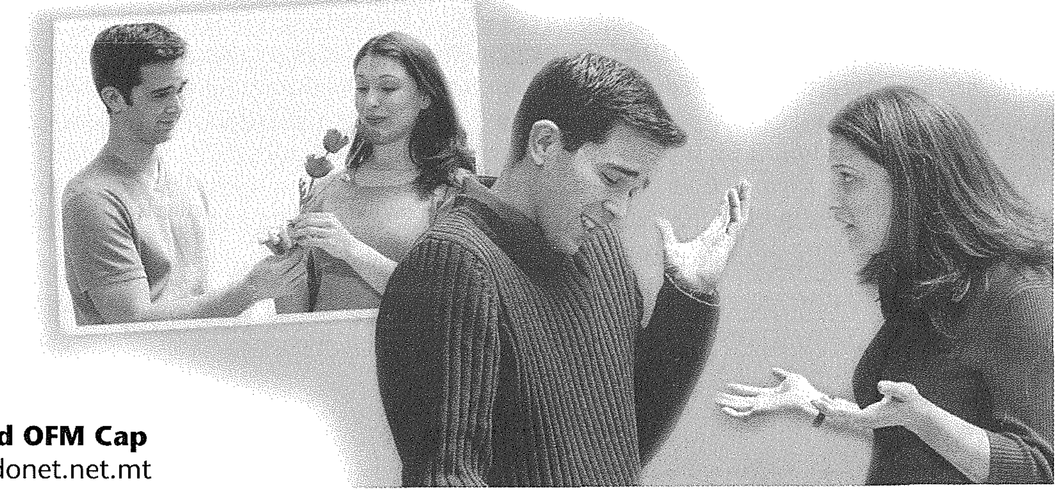
When we forgive those who hurt us we never condone of what happened to us. If we were abused, maltreated, or neglected we never say that it was right. We call spade a spade. We never hold acceptable what is in itself unacceptable.

Furthermore, forgiveness does not mean not holding responsible those who hurt us. Those who acted irresponsibly still have to deal with the consequences of their irresponsible actions. If not they keep abusing and maltreating other people as they did to us.

Forgiveness does not impede us from talking over those feelings which are troubling our minds and hearts. Real forgiveness has nothing to do with playing the martyr by swallowing what we are feeling. We need to debrief with someone whom we trust in order that we can start our way of healing. Respecting ourselves by honestly acknowledging what we feel is the basis for an authentic forgiveness.

Many people have the wrong impression that forgiveness means a one time decision. Everyday life shows that this is a pure myth. The human mind keeps recalling that it was unjustly injured. In a certain sense it is futile to set a day to forgive. Forgiveness is a painful, arduous, and scary process in which painful past experiences need to be confronted and as a result of that uncomfortable revisiting old wounds are slowly healed.

In the aforementioned reflections what comes to the fore is the realization that by not forgiving we are not reaching out. We choose to become the prisoners of our own anger, frustration, resentment etc. Lewis B. Smedes said: "To forgive is to set a prisoner free and discover that the prisoner was you." If we undertake the journey of forgiveness we start noticing that our internal healing is taking place. Josh Loth Liebman observes: "We achieve inner health only through forgiveness - the forgiveness not only of others but also of ourselves". Since in Jesmond Tutu's view, "without forgiveness there is no future," let us undertake with courage and determination the forgiveness journey fully conscious with Paul Boese that although forgiveness does not change our past it has the power to enlarge our future. And if it does so it renders prophetic the exhortation given to us by the Russian moral thinker, novelist and philosopher, Leo Nikolaevich Tolstoy: "Let us forgive each other – only then will we live in peace".



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forgiveness

Kelmtejn mis-Segretarju Ġenerali

F'dawn l-aħħar ftit xhur, mill-aħħar ħarġa tal-Musbieh lil hawn, seħħew numru ta' eventwalitajiet, uħud minnhom pożittivi oħrajn ta' xejra pjuttost negattiva.

Barra l-ftuħ ta' premises ġodda, kien ta' sodisfazzjon kbir li lħaqna ftehim mal-Ministru Dalli sabiex in-Nurses u l-Midwives kollha li jaħdmu roster DDNRO ma jkunx hemm differenza bejnithom f'dawk li huma extra duties tal-46.6hrs. Mill-1 ta' Jannar 2009 kulħadd ser ikun l-istess, l-extra duties ser jispiċċaw.

Bqajt skantat mhux ftit meta ġejt infurmat li Nurse sabet ras ta' ġurdien fil-platt bejn il-ħaxix meta marret tiekol fil-canteen ta' l-istaff fl-Isptar Mater Dei. Din il-Union ħadet il-prekawzjonijiet mill-ewwel kemm fuq in-Nurse partikolari u wara wkoll fl-interess tal-membri kollha li jaħdmu f'dan l-isptar. Ħdimna flimkien, il-Unions kollha fuq din il-materja. Kulħadd kien ta' l-istess prinċipju. Issa qed inħarrsu l-quddiem sabiex jerġa jibda s-servizz ta' l-ikel. Mhux faċli għalina li noħorġu nixtru minn barra għaliex taħli l-break kollu sakemm tmur u tiġi.

Laħqu n-Nurses il-ġodda (madwar 50) u ġew reġistrati 20 Nurse barrani. Raġġ ta' tama imma malajr jintilfu bin-nuqqas li hawn. Jinħtieg li jsir aktar sforz mill-Gvern sabiex jinġiebu 100 Nurse barrani ieħor u fl-istess waqt inbiddlu r-regolamenti ta' l-Università sabiex nħajru aktar żagħżagħ Maltin. Ma nistgħux inkomplu aktar naħdmu x-xogħol ta' tnejn u tlieta. Qed nitfarrku u numru ta' Nurses qed jitilqu biex isibu xogħol postijiet oħra fosthom anki barra minn Malta. Ma nistgħux nistennew aktar. Kull ġurnata qed tnixxi d-demm fil-work force. Sur Gvern ejja ha niċċaqalqu fuqha aktar din!

Ilna ftit xhur naħdmu mal-Gvern fuq il-partimers sabiex dawn ukoll jibdew igawdu mill-career progression u wara anki mill-process tal-Bridging. Nistqarr li hemm koperazzjoni bejn kulħadd u tidher li nstabet il-formola addatata u ġusta. Mhux process faċli imma konvint li nasslu wkoll.

Għaddiet sena u nofs minn meta laħaq Gvern ġdid bil-wegħda li seħħ riforma fil-Kura Primarja. S'issa, wara tmintax-il xahar għadu ma seħħ xejn bis-sugu u fl-istess waqt għandna l-Isptar Mater Dei qed iffur bil-pazjenti. Ma nistawx inkomplu nipposponu aktar. Din hija parti kbira mis-soluzzjoni ta' nuqqas ta' soddod fl-Isptar Mater Dei. Meta ġie ppjanat dan l-isptar kien maħsub li miegħu jkun hemm sistema effiċjenti fil-Kura Primarja. Hemm dokumenti sħaħ tal-Gvern li jixhdu dan. L-MUMN għandha ħafna x'tikkontribwixxi fuq din il-materja.

Irnexxielna wkoll inċaqalqu l-proċess tal-promozzjonijiet fil-gradi ta' Nursing Officers u Deputy Nursing Officers. Nistqarr li dan huwa suġġett li jinkwetani għaliex dejjem ser tħalli togħma morra f'bosta membri però minn naħa l-oħra, minn ikun qrib li jieħu l-promotion, il-Union għanda d-dover li tejnu biex jakkwistha.

Illum naħseb li għedna biżżejjed. Qatt ma niġba nirringrazzjakom ta' l-għajnuna u support kontinwu tagħkom. Mingħajr kull wieħed u waħda minnkom l-MUMN ma hi xejn.

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THEATRE NURSES OR OPERATING DEPARTMENT PRACTITIONERS?

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Theatre Nursing is viewed by most nurses, nurse managers and nurse educators as being too realistic and task – oriented, giving little value to the actual caring skills embedded in the very essence of nursing.

A number of research studies, however, indicate otherwise. Interviews with Theatre Nurses both in the United Kingdom and locally show that theatre nurses provide similar nursing care to patients as their colleagues in wards. (Mardell, (1998), Basset & Basset, (1999), Hind et al, (2001), Camilleri, (2004). Caring for the unconscious patient, maintaining patient safety, infection control measures, maintaining patient dignity, acting as patient's advocate and relieving patient's anxiety by providing patient information and consent to procedures and frequent activities performed by Theatre Nurses (Mardell, (1998), Camilleri, (2004). All this seems to suggest that the role of nurses in theatre is important to maintain patient safety.

Misperceptions on the role of Theatre Nurses and the lack of specialised training often results in poor recruitment of nurses in operating theatres. This results in lack of nurses which sometimes compromises patient safety in theatre.

In the United Kingdom Operating Department Practitioners (O.D.P's) were introduced to address this problem. The shortage of Theatre Nurses, presently, locally gave rise to a number of speculations by several professionals regarding the introduction of these O.D.P's locally. The main role of the O.D.P's in the United Kingdom is to take up those non-nursing duties being performed by nurses so that nurses can dedicate more time to direct patient care.

However, the absence of a present job description of Theatre Nurses locally, will make it difficult to identify those tasks which can be appropriately delegated to these O.D.P's (Camilleri, (2004), Baxter, (1997), White & Coleman, (2000), Hind et al, (2001).

Another measure which should be taken before attempting to introduce such Practitioners before locally is their training. In the United Kingdom O.D.P's follow a fulltime two-year course, were they are trained to assist in all phases of intra-operative care i.e. ; Scrubbed up roles, Anaesthesia & Recovery. In view that locally nurses cannot undertake specialised training in Theatre Nursing this will create tension between the two. Since nurses rightly-so, will view O.D.P's as a threat to their job because of the specialisation of the latter. Hence it is suggested that local nurses presently working in theatres will be given the opportunity to specialise in theatre practice before introducing O.D.P's (Camilleri, (2004).

Another important role of Theatre Nurses is that of the administration of drugs especially those under the Drug Misuse Code commonly known as DDA's (White & Coleman, (2000). Nurses form part of recognised register which implies that the nursing profession often regulates itself. In the United Kingdom such an official register for O.D.P's does not exist and hence O.D.P's cannot be held responsible for the administration nor handling of such drugs.

Theatre Managers, thus have an added responsibility on the allocation of O.D.P's to make sure that legal issues are not compromised. In fact research in the United Kingdom, shows that O.D.P's are rarely given recovery duties, though they are trained to work in this field (White & Coleman, (2000), Baxter, (1997). This is because post-operatively patients may require the administration of opiate analgesia. This indicates the need for a job description of O.D.P's should they be introduced. Such a job description will outline those tasks theses O.D.P's can do within the legal framework covering operating theatres practice. This will also serve as a guide for theatre managers in the allocation of daily staff.

Hence, whilst at first glance it appears that the introduction of O.D.P's is a cost-effective solution to the present shortage of Theatre Nurses a number of other issues should be considered first. Mainly these include:

1. The set-up of an official job description of theatre nurses.
2. Specialised, recognised training for nurses presently working in theatres.

These are aimed to safe guard the present role of theatre nurses because Theatre Nurses are a must if ~~patient safety intra~~-operatively is to be maintained.

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Minimisation of Infection Risk to Patients in Anaesthesia

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The primary aim of infection control is to preclude the spread of infection by health professionals and patients. Health professionals have the obligation to safeguard high personal criteria of infection control, thus ensuring that these standards are also followed by their colleagues. Kumar (1990) claims that infection control policies in hospitals are mainly based on rooting out the origin of infection, breaking the mode of dispersal and altering the individual's immunity. Health care professionals working in any particular part of the hospital are to abide by the policies and make sure that all practitioners are aware of their appropriate use. Patients expect a sanitary environment in hospitals and are entitled to be treated and cared for in a satisfying, clean and protected setting. McKay and Farley (2006) stress that patient's protection is more closely supervised than ever before. Such protection is possible thanks to the participation of the health care professionals, patients themselves, governments and consumers.

Operating theatres are active environments that function behind closed doors and are continuously changing. Both nurses and doctors beside other health professionals have the responsibility in assuring the highest possible safety levels for all patients. Operating theatres are normally set to keep infection risks at a minimum to patients, where at the same time, all this depends on adequate theatre cleanliness and an effective ventilatory system as recommended (Kumar, 1990). A key source of infection comes from individuals and very often-clinical needs and operational requirements increase the risk of transmission (Wicker and O'Neil, 2006). Recommendations for infection control are normally designed for a particular department, focusing mainly on its area of practice. Microbiological tasks and the supervising of operating rooms should be in accordance to national proposals (Association of Anaesthetists of Great Britain and Ireland [AAGBI], 2002). An area that entails much consideration towards patients' infection control measures is undoubtedly in the Anaesthetic practice. In fact, the American Society of Anaesthesiologists [ASA] (1999) specifies that the recommendations are aimed generally on both hospital acquired infections and infections developed at the workplace. These proposals are normally compiled to enhance quality patient care and safety in the workplace altogether. The Australian and New Zealand College of Anaesthetists [ANZCA] (2005) stresses on health professionals to protect themselves from any contact with blood and body fluid by making use of all items that fall under the term 'standard precautions', such as gloves, face masks, gowns, goggles, eye shield, over shoes and aprons where such use is deemed necessary. Unerman (2006) determines that this term indicates the use of various items which allow a better approach to protection.

Whereas a surgeon and his team need to guarantee the deterrence of infection in operating theatres, the same goes for the anaesthetist and his/her nurse assistant throughout the practice of anaesthesia. This may be possible if appropriate levels of sterility, disinfection and decontamination are adequately followed after the use of a particular instrument. The Hong Kong College of Anaesthesiologists [HKCA] (2002) proclaims that;

- Decontamination happens when infective and undesirable substance is removed from the facade of an object.
- Disinfection occurs when microorganisms are removed but omitting spores.
- Sterilisation takes place when all microorganisms are removed.
- Asepsis is the avoidance of coming into contact with microorganisms.

Hand Hygiene

Lack of hand hygiene helps in the spread of infectious agents in health care. To attain maximum reduction, the hands should be washed thoroughly ensuring that all parts are covered with hand hygiene products. Hand washing using soap and water, Zaragoza et al (1999) minimises considerably the risk of microorganisms of the hands. Martin (2005) justifies that this procedure should be carried out before and after patient contact. Hand washing is the process of cleaning the hands with the aid of water and hygiene products with the aim of eliminating microorganisms and dirt (Wikipedia, 2007). Hand washing is also significant for preserving the skin as a whole. On a daily practice one can also make use of alcoholic hand rubs, where these are normally situated in a wall-mounted dispenser in order to facilitate mode of use. Wearmouth (2004) stresses that when using alcohol hand rubs, hands should be dirt free. Alcohol-based hand rub causes less irritation to the skin than soap (Martin, 2005). On a normal day the practice of hand washing lacks due to various implications that arise from time to time. The factors mainly responsible for poor hand washing include the ever persisting heavy workloads and fast turnovers of patients in theatre,

and another is that the health professionals themselves might see their hands to be clean hence not feeling the need to go through the hand washing procedure. This perception is what normally creates danger to the patients and staff themselves especially when knowing that anaesthesia involves invasive procedures. The New Zealand Anaesthetic Technicians' Society [NZATS] (2004) implicate that another important issue that staff should be aware of is that cuts on the hands are to be well covered with water resistant plasters for their own safety and that of their patients. The Hong Kong College of Anaesthesiologists [HKCA] (2002) stresses the importance of handwashing by the anaesthetic team before handling a new patient or equipment, and on completion of procedure.

Aseptic Technique

Perioperative medical staff safeguards valuable rules of aseptic technique, sterile field and patient care (Wicker and O'Neil, 2006). Unerman (2006) defines the term aseptic technique as the procedure where all contagious bacteria are eliminated from living tissues. For one to carry out invasive procedures, such as vascular cannulation and central vascular catheterisation, one needs to adhere to the aseptic technique measures. When these methods are followed adequately, infection rates tend to go down (McKay and Farley, 2006). Pace (2006) declares that health professionals need to make use of gloves where interventions may have the risk of blood spills. Both nurses and doctors should be well trained on how to deal with spillages safely and have access to adequate equipment regarding a safer management (Wearmouth, 2004). Patients going through these procedures are normally scared of the 'unknown' and need reassurance. One familiar practice that is used on a daily basis throughout the hospital is the insertion of a venflon, where Pace (2007) declares that 40% of patients undergo the experience of venflon insertion in any acute setting. Because this is a daily routine for both admissions to hospital and surgery, it is easy to neglect the importance of using basic asepsis such as proper handwashing and gloving. Patients are normally informed about whether or not any local anaesthetic is to be given prior to the actual incursion. Another step explained to the patient concerns the infection control measures to be taken during the procedure. This includes the guarantee of using sterile and new disposable equipment where necessary. The cleansing of the area to be worked upon by the anaesthetic team is also explained to the patient as in most cases, where invasive procedures are carried out, patients are generally awake. Invasive operations by the anaesthetic team are usually carried out in the anaesthetic room where specific equipment is prepared for a particular intervention. The washing of hands and putting on gloves play a crucial task when caring for intravenous devices (Pace, 2006). When procedures are carried out in a hurried and sometimes carelessly way, apart from the human suffering that infections may cause, the International Federation of Infection Control [IFIC] (2003) states that this malpractice augments healthcare costs due to delaying patients' discharge. This will also add to patients' frustrations and discontent. Other invasive procedures which are carried out in this area include both spinal and epidural procedures.

Needle Stick Injury

When carrying out such interventions, it is vital that all staff is aware of the risk of percutaneous injuries or better known as needle sick injuries (NSI). The local infection control unit claims that a large number of these incidences could be avoided but normally these occurrences materialise due to negligence (Infection Control Committee, 1998). Many of these injuries go unreported for various reasons. Abela (2005) remarks that practitioners after being inflicted, very commonly check through the patient's file and if no obvious risk factor is found then they assume that the patient is not of a threat. The use of sharp containers is evidently important as this reduces the incidence if the method is used well. Medical practitioners sometimes under the misconception of wearing gloves take unnecessary risks which can still lead to infliction. On the other hand, others choose to wear a double pair of gloves as a form of more security. Tanner and Parkinson (2006) declare that double gloving is nowadays becoming more common as it reduces the risk of cross infection between the staff and patients. Studies show that a majority of these injuries happen when sharps are utilized and during their discarding (U.S. Department of Health and Human Services [DHHS], 1998). Several notices remind staff in general on both the hazards and the proper use of any sharp in use. These are normally found in the format of colourful posters which are generally supplied by the local infection control unit, and their particular aim is to educate theatre staff and help to safeguard each from any unpleasant injuries. Anaesthesia incorporates multi needle use throughout each procedure, so awareness on not to re-sheath or twist needles and when to discard of the sharps container, when two thirds full, should be commonly acknowledged, but unfortunately in daily practice it is frequently disregarded. Necessary equipment such as sharps containers and protective attire are to be supplied and made ready for use in all clinical areas.

Anaesthetic Apparatus

Anaesthesia equipment may be open to possible infectious matter during regular use. This can occur when in direct contact with the patient's skin, mucous membranes, discharge and blood (ASA, 1999). Generally, items used in the anaesthetic field are made of a disposable nature. This is important to be noted, as this material cannot be reused after it has already come into contact with patients. This is generally emphasised by the manufacturer on the product's outer label. The ANZCA (2005) also points out that the users are

to dispose of non-reusable items. Devices, such as an endotracheal tube and a nasopharyngeal airway, which are used for both oral and nasal intubations may contaminate with contagious organisms as soon as they reach the upper airway. Tubing that has to be connected to the anaesthetic machine, such as an adult and a paediatric circuit need to be changed daily, as these make up part of the airway system of the patient and which come into contact with mucous membranes. In order to prevent contamination towards the ventilation system, a bacterial/viral filter is regularly used for each patient. Its function helps in safeguarding the anaesthetic machine from contamination by microorganisms as the patient exhales (Wharton and Wood, 2004a). The bacterial/viral filter is then discarded soon after extubation.

Intubation Equipment

The intubation equipment also plays an important role in infection control. Face masks in particular, which come in a variety of sizes, come into close contact with the patient's secretions, and as Wharton and Wood (2004b) state that blood, saliva and gingival fluid from patients, should be regarded as infective. Face masks and angle pieces, (the latter that connects the breathing system to the mask), are to be washed with hot water and soap followed by disinfection according to the manufacturer's literature.

Laryngoscopes are recognized as becoming contaminated while in use (AAGBI, 2002). A laryngoscope is a tool which is mainly used by the anaesthetist to examine the larynx and to assist in the insertion of the endotracheal tube. It is made up of a handle which contains a battery and a blade (Fig. 2) that incorporates a bulb. The light lights up the larynx view Wicker and O'Neil (2006), which enhances the intubation, hence avoiding the risk of blood spills due to mucosal abrasions. ANZCA (2005) declare that disinfection of laryngoscopes should take place before each use. One should be particularly aware that residue around the light source is totally excluded prior to reuse. This will prevent the risk of cross infection from one patient to another. After use, each has to be stored separately from unused items.

Drugs for Injection

Drugs that are prepared in various syringes prior to surgery, are put on a clean tray on the anaesthetic machine surface (AAGBI, 2002). It is utterly important that syringes are not left lying around with no needle attached to it, as this may enhance the chances for contamintion. Each syringe is not to be used on multiple patients, as this might get into contact with blood borne pathogens that might endanger the patients to follow. It is also recommended that intravenous infusion be set up for a single use on an individual patient only (HKCA, 2002). Singe use vials are to be discarded after use, and the multiple-use vials which are punctured when withdrawing the drug to be used, practitioners should clean the rubber bung aseptically beforehand. This practice is another point where staff should be aware of their actions as this procedure is carried out routinely, then one tends to be lax and this is where danger takes over. AAGBI (2002) emphasises on the importance of the immediate throwing out of drugs which tend to be visually soiled.

The Anaesthetic Machine

The anaesthetic machine is a major form of equipment situated in an operating theatre. Throughout its function there is no need for any infection control measures regarding the inner circuits, but it is well emphasised, (AAGBI 2002;ANZCA 2005) that the ventilator itself and the bellows need to be cleaned and disinfected on a regular basis. All monitors and the anaesthetic machine itself are to be cleansed daily with a disinectant, where this helps in the prevention of dust which might hinder in keeping the operating room safe from microorganisms. IFIC (2003) accords that cold water is mostly favoured for the cleansing as it gets rid of most of blood stains and other microorganisms.

Environment

The ventilation system is also important when it comes to infection control measures in anaesthesia. Airborne contamination in an operating room is not to be present, so with the aid of a good and efficient ventilatory system this is reduced to a minimum. Unerman (2006) claims that room air, comprises of microorganisms which are mainly found in the human respiratory passage, where coughing, sneezing and conversing increase the risk. Many organisms are known to live in dust. Wearmouth (2004) indicates that nurses are to see that all equipment employed is spotless and fit before use, adding that many organisms, including Methicillin-resistant Staphylococcus aureus (MRSA) reside in debris. The local infection control unit regularly checks the air present in the operating room, in order to analyse whether any microbiological elements are present. Kumar (1990) states that each operating room should have an air change rate of about 20 times an hour. This function is of great importance because due to air changes, the chance for any bacteria to produce is minimal. In order to reduce airborne contamination, general movement around the operating theatre is to be cut down. Doors are to be closed at all times in order to maintain a constant air pressure in the operating room and other rooms adjacent to it. Practitioners are to be also aware of air pollutants that arise from inhalation gas agents used throughout surgery. These are considered hazardous and one ought to ensure that the scavenging system in the operating room is functioning well the whole time.

By making part of the anaesthetic team, one should be able to take prompt decisions relating to both patient care and safety towards members of staff in general.

Updating one's knowledge on environmental and social changes is considered an asset and having a know how on the advances and developments in the functioning of an operating theatre Unerman (2006). Both training and education are needed on the workplace making sure that all health practitioners understand the procedures and acknowledge what infection control policies are expected. Written guidelines help better in recognising areas of uncertainties and will surely be of use in minimising unforeseen dangers towards patients or staff.

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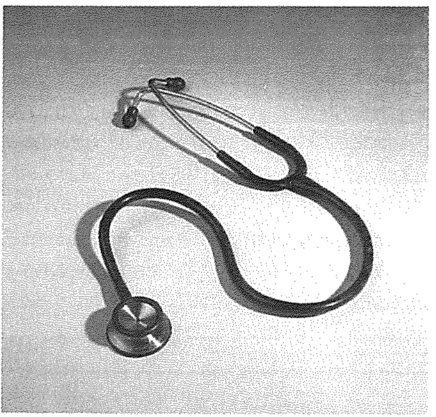

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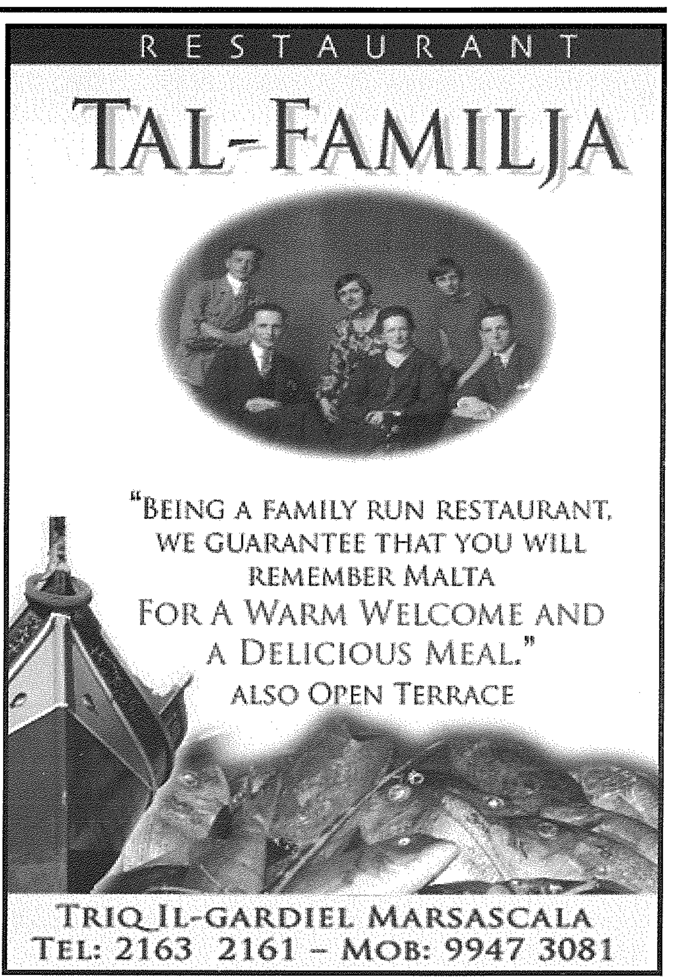

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Positive practice environments for health care professionals

Positive Practice Environments

Today there is a global health workforce crisis – one marked by critical imbalances. Many countries are faced with the challenge of shortages of dentists, doctors, nurses, pharmacists, physiotherapists and other health workers. In some countries these shortages co-exist with underemployed and unemployed health professionals, because of funding shortfalls, planning inadequacies and geographic imbalances between the supply of health providers and the demand for their services. The reasons for the crisis are varied and complex, but key among them are unhealthy work environments and the poor organisational climate that characterize many workplaces. The ongoing underinvestment in the health sector, coupled with poor employment conditions and policies (such as exposure to occupational hazards, discrimination and physical and psychological violence; insufficient remuneration; unfavourable work-life balances; unreasonable work loads, limited career development opportunities, etc.) have resulted in a deterioration of working conditions for health professionals in many countries. There is clear evidence globally that this has a serious negative impact on the recruitment and retention of health professionals, the productivity and performance of health facilities, and, ultimately, on patient outcomes.

There are key elements in the workplace that strengthen and support the workforce and, in turn, have a positive impact on patient outcomes and organisational costeffectiveness. These factors, when in place and supported by appropriate resources (both financial and human), go a long way in ensuring the establishment and maintenance of an effective health care professional workforce and, ultimately, the overall quality of health systems. Establishing positive practice environments across health sectors worldwide is of paramount importance if patient safety and health workers' wellbeing are to be guaranteed. All health sector stakeholders, be they employer or employee, private or public, governmental or non-governmental, have their respective and specific roles and responsibilities to foster a positive practice environment. They must work in concert if Quality Workplaces for Quality Care is to be achieved.

Positive Practice Environments Defined

Positive Practice Environments (PPEs) are settings that support excellence and decent work. In particular, they strive to ensure the health, safety and personal wellbeing of staff, support quality patient care and improve the motivation, productivity and performance of individuals and organisations[1].

Elements of Positive Practice Environments

Positive practice environments are characterised by:

- Occupational health, safety and wellness policies that address workplace hazards, discrimination, physical and psychological violence and issues pertaining to personal security;
- Fair and manageable workloads and job demands/ stress;
- An organisational climate reflective of effective management and leadership practices, good peer support, worker participation in decisionmaking, shared values;
- Work schedules and workloads that permit healthy work-life balance;
- Equal opportunity and treatment;
- Opportunities for professional development and career advancement;
- Professional identity, autonomy and control over practice;
- Job security;
- Decent pay and benefits;
- Safe staffing levels;
- Support, supervision and mentorship;
- Open communication and transparency;
- Recognition programmes; and
- Access to adequate equipment, supplies and support staff[2]

Benefits of Positive Practice Environments

The beneficial effects of positive practice environments on organisation performance in general, and health service delivery, health worker performance, patient outcomes and innovation in particular, are well documented.

Positive changes in the work environment result in a higher employee retention rate, which leads to better teamwork, increased continuity of patient care, and ultimately improvements in patient outcomes[3].

A review of performance in more than 3000 UK businesses[4] identified "high performing organisations"- and one of their characteristics was that they "Value quality rather than quantity, and keep the focus on the long-term and on outcomes; establish a climate of employee relations that is characterised but not codified by pride, innovation and strong interpersonal relations: and understand that collective mechanisms support this".

WHO has identified an "enabling work environment" as one of the four components in strengthening management and leadership of health systems delivery[5].

PPEs demonstrate a commitment to safety in the workplace, leading to overall job satisfaction.

When health professionals are satisfied with their jobs, rates of absenteeism and turnover decrease, staff morale and productivity increase, and work performance as a whole improves.[6]

Maintaining a level of autonomy over their work allows staff to feel that they are respected and valued members in their places of employment.

Research demonstrates that nurses are attracted to and remain at their place of employment when

opportunities exist that allow them to advance professionally, to gain autonomy and participate in decision-making, while being fairly compensated.[7] A richer mix of qualified nurses is linked to reductions in patient mortality, rates of respiratory, wound and urinary tract 3 infections, number of patient falls, incidence of pressure sores and medication errors.[8]

Physicians get high satisfaction with their work if: a) they have good working conditions, b) they can help patients, and c) if they can utilize advances in health technology.[9]

Effective teamwork is essential to the work in health care organisations.[10] It improves the quality of work life as well as patient care.[11]

Cost of Unhealthy and Unsafe Workplaces

Unhealthy environments affect health professionals' physical and psychological health through the stress of heavy workloads, long hours, low status, difficult relations in the workplace, problems carrying out professional roles, and a variety of workplace hazards. The costs of these unhealthy and unsafe workplaces for health professionals have been well documented:

Evidence indicates that long periods of job strain affect personal relationships and increase sick time, conflict, job dissatisfaction, turnover, and inefficiency.

A survey of Swiss primary care practitioners reported that one third presented a moderate or a high degree of burnout, which was mainly associated with work-related stressors.[12].

A study in Finnish hospitals reported that workplace bullying of staff is related to an increase in sickness absence[13]. Another by the same research team reported that poor teamwork seems to contribute to physician sickness absence rates.[14]

Research on pharmacists in South Africa[15] reported that stressors that had high severity ratings included the unavailability of medicine frequent interruptions, high levels of workload and insufficient salaries.

A study of nurses in the United States, Canada, England, Scotland and Germany showed that 41% of hospital nurses were dissatisfied with their jobs and 22% planned to leave them in less than one year; findings confirmed the relationship between workplace stress and nurses' morale, job satisfaction, commitment to the organisation and intention to quit[16].

A study of emergency care physicians in Canada reported[17] that the resource factors that have the greatest impact on job satisfaction include availability of emergency room physicians, access to hospital technology and emergency beds, and stability of financial (investment) resources.

A study of physiotherapy interns in Nigeria[18], reported that whilst most were satisfied with the support from their senior colleagues, many were grossly dissatisfied with their salaries (91%), equipment available (79%), and office environment (58%).

A survey of physiotherapists in Zimbabwe[19] highlighted that 78% reported experiencing work-related musculoskeletal disorders (WMSDs), and that one in four physiotherapists took sick leave or required treatment because of WMSDs.

Overworked nurses may display slower reaction times, less alertness to changes in patients' conditions, and medication errors, which translate into adverse risks to patients[20].

Physicians express dissatisfaction when facing high levels of bureaucracy and loss of self regulation.[21]

The demands on health professionals' time is being challenged by various non-clinical factors, (i.e. indirect services such as arranging community resources, travel to/from the patient, case management, documentation, tracking statistics and other administrative duties) which compete with direct hands-on therapy time required to achieve positive patient and system outcomes.[22]

High turnover, a symptom of a poor work environment is likely to lead to higher provider costs, such as in recruitment and training of new staff and increased overtime and use of temporary agency staff to fill gaps[23]. Turnover costs also include the initial reduction in the efficiency of new staff and decreased staff morale and group productivity. One study of turnover costs in the USA estimated that total turnover costs for a hospital system employing 5000 employees was between $US17 and $29 million.[24]

Making Positive Practice Environments a Reality

Developing, promoting and maintaining positive practice environments is multifaceted, occurs on many levels of an organisation and involves a range of players (e.g. governments, employers, professional organisations, regulatory bodies, unions, education institutions, etc.). For their part, health professionals and their representative organisations can advance the development of positive practice environments by:

Improving the recruitment and retention:

- Continuing to promote the role of health professionals.
- Defining the scope of practice so that health professionals work to their full potential for patient care. This legal framework can then be used to raise the awareness of other disciplines, as well as the public, of the profession's competencies and evolution.
- Lobbying for professional recognition and remuneration.

Support research which focuses on why workers will stay, rather than why workers leave. This has been termed "job embeddedness"; i.e. the extent to which the individual worker is "embedded" within the organisation.[25]

Developing and disseminating a position statement on the importance of a safe work environment.

Promoting the use of staff surveys as a monitoring tool of health well being and motivation of staff. The Healthcare Commission in England conducts an annual health check of National Health Service employers, which includes a survey of staff well being and organisational performance indicators. These findings are published annually.[26]

Building capacity of health professionals and others involved in health sector management and policy-making positions.

Ensuring that the health professional voice is heard

- Strengthening health professional organisations
- Having access to decision-making bodies.

Supporting research, collecting data for best practice, and disseminating the data once it is available.

Encouraging educational institutes to enhance teamwork by providing opportunities for collaboration and emphasising teamwork theory.

Working with management and government to ensure that the principles of PPE are fully embedded. For example, the UK government Cabinet Office has promoted an overall rewards strategy framework which includes an "Enabling Environment", covering Physical Environment, Tools and Equipment, Training for Current Role, Sound Work Processes, and Safety/Personal Security[27].

Presenting awards to health care facilities that demonstrate the effectiveness of positive practice environments through recruitment and retention initiatives, reduced drop-out rates, public opinion, improved care and patient satisfaction.

Establishing alliances across different health professional groups and health sector stakeholders, e.g. patients/consumer associations.

Ensuring that other disciplines are involved in the development of policies for safe work environments.

Developing a Call to Action detailing core elements of a positive practice environment that organisations and individuals can sign up to and support.

Raising awareness, understanding and support of all relevant stakeholders about the positive impact healthy and supportive work environments have on the recruitment and retention of staff, patient outcomes and the health sector as a whole.

For further information, please contact: icn@icn.ch

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ICN/PC/OF/June 2008
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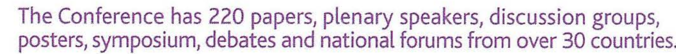
HORATIO: EUROPEAN FESTIVAL OF PSYCHIATRIC NURSING THE AGE OF DIALOGUE

Wed 5th - Sun 9th Nov 08
Corinthia San Gorg Hotel,
St George's Bay,
Malta

FIRST ANNOUNCEMENT

CONFERENCE THEME

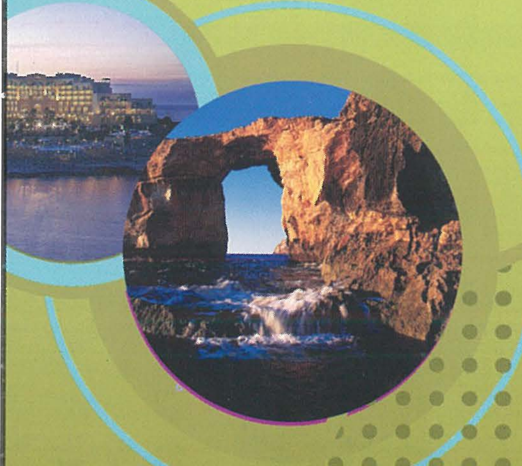
The theme of this unique event is the dialogue that takes place between psychiatric nurses, in their own clinical areas, across cities and towns, national and international borders. The aim is to share their experiences, helping each other to develop their understanding of their work and supporting each other in their professional endeavours.



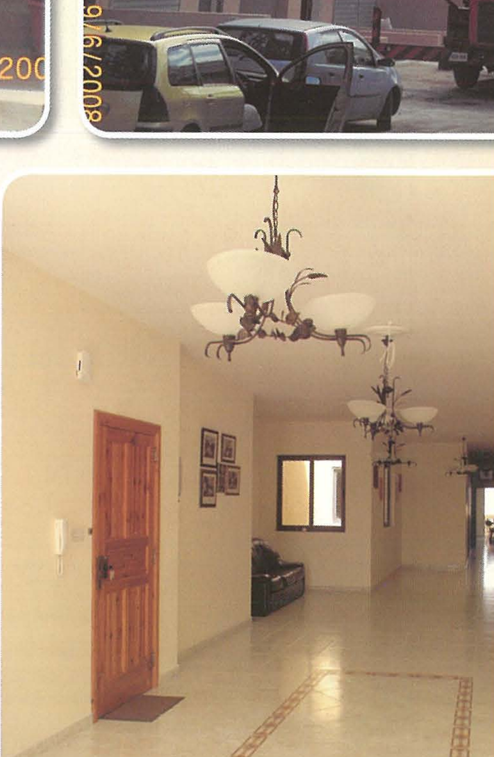
The Conference has 220 papers, plenary speakers, discussion groups, posters, symposium, debates and national forums from over 30 countries.

The Festival activities include films, competitions, guest interviews, auctions, music, art and poetry - all with the theme of mental health.

We are limited to 600 delegates only – don't miss out on this amazing event!



From diary
Mid-djarju tagħna...



L-MUMN IŻŻANŻAN PREMISES ĠODDA

F'dawn ir-ritratti qed naraw l-għamara ħierġa mill-premises ta' Birkirkara u meħuda fil-premises il-ġodda tal-Mosta. Kienet deċiżjoni għaqlija tal-Kunsill li jixtri premises akbar u ta' ħtieġa għal bżonnijiet tal-lum. Issa jistgħu jiltaqgħu erbgħa kumitati fl-istess ħin kif ukoll attrezzati b'sala mdaqqsa fejn jistgħu isiru laqgħat għall-attivisti, seminars u korsijiet skond il-ħtieġa.L-E.T. il-President ta. Malta għoġbu jinnawgura dawn il-premises. Barra minn hekk ġew organizzati tlett ijiem ta' Opening Days fejn numru sabiħ ta' membri attendew biex jaraw il-premises tagħhom. Prosit u Awguri lil kulħadd.

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

GROWING DENTAL HEALTH ISSUE HIGHLIGHTED BY GSK REPORT

GlaxoSmithKline (GSK) launched an industry report identifying tooth erosion from dietary acids as an issue for Twenty-First Century dental care. The report reveals that acid erosion could be as much of a threat to teeth in this Century.

Almost everybody with natural teeth is likely to develop some signs of acid erosion, which affects all age groups. It is the increasing longevity of teeth today combined with the modern diet that means the effects of wear, including erosion, are more prevalent and as such are demanding a greater degree of the dental practitioner's preventative and restorative skills.

The report entitled *'Acid Erosion: A growing issue for 21st Century dentistry'* explains that while the dental community is aware of the issue, the majority of patients will not have heard of acid erosion or realise that it is happening to their teeth. GSK believes that education is the best starting point to address the issue, and sees the dental community as key to this process.

The report incorporates research and analyses from key opinion leaders in the dental industry, including Dr Adrian Lussi and Dr David Bartlett, discussing the causes and effects. The most significant factors linked with the progression of acid erosion are foods and drinks associated with the modern diet, with acidic items including wine and many fruits.

Signs of acid erosion, as detailed within the report, can include a slight twinge when consuming hot or cold food and drinks; teeth with a slight yellow appearance as the dentine shows through; and a rounded look on the surface of the tooth. The later stages can include darker discoloration on the teeth; transparency at the occlusal edges; small cracks on the edges of the teeth; severe dentine hypersensitivity; and small dents on the chewing surface.

The report goes on to explain small steps that can be taken to minimise the effects of acid erosion, as David Alexander, Medical Marketing Director at GSK explains:

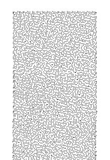
"As a leading oral care company committed to improving oral health and well-being, GlaxoSmithKline is working to raise awareness of the effects of acid erosion with dental professionals and the public at large. The aim is to ensure that steps are taken to identify the early signs and protect teeth as our lifestyles evolve."

GSK first raised the issue at the FDI World Dental Congress in Montreal, where it hosted a symposium entitled 'Worn Out and Hypersensitive! A Fresh Look at Erosion and Abrasion'. The symposium saw a panel of world-class experts discuss the causes of tooth wear, its links to dentin hypersensitivity, differential diagnosis as well as its prevention and treatment.

Epilepsy & the Nursing Profession...

Is there awareness on our Islands?

Unfortunately the public's attitude, as well as that of most professionals is one of unawareness of certain issues associated with persons with epilepsy. Epilepsy is still not often talked about in public. Ignorance means that that seizures are still unrecognized and mishandled. Everyone's misconception and fears promote misunderstanding and prejudice against people with epilepsy.This stigma can be very **damaging to people living with epilepsy.**



Any epileptic should be made aware that:
*"**You are not an epileptic.***
You are a person with epilepsy.
Epilepsy is part of your life.
***It is not your whole life.**"*

As professionals we must bear in mind that we have to face the person with epilepsy, his family, attitudes by the public and most often the lack of knowledge about the subject. Apart from this, other aspects create obstacles and hinders the actual care and support to persons suffering from epilepsy. Since in Malta we have no national registry which is kept updated, it is difficult to obtain accurate statistics. In U.K. 1 in 133 have epilepsy. If we take the same ratio in Malta we might have about 3000.

It is a fact that the daily life for people with epilepsy is affected. Many epileptics experience their first seizure before the age of 20. Epilepsy is generally not the kind of condition that gets worse with time. Most adults live a normal life span. People with severe seizures that resist treatment might have, on average, a shorter life expectation and increased risk of cognitive impairment, particularly if the seizures developed in early childhood.

Through my experience of working in the Health Department and involved with teaching Nurses in Malta since 1971, as well as doing philanthropic work, little is known by the general public as well as the so called professionals that exist in our Islands. I say so called professionals because if they were professional, they should at least be aware of certain issues. Please ask honestly yourselves how much you really know about epilepsy in relation to the Maltese Scenario.

Let us start by having a look at the ***Psychological and social issues associated with epilepsy.*** *Some issues we need to understand are:-*

1. *How does epilepsy affects one's life?*
2. *What's the public's attitude to epilepsy?*
3. *What impact can epilepsy have on social relations & employment?*
4. *What effects can epilepsy have on family and friends of the person with epilepsy?*
5. *What can I do to manage my seizure and cope?*
6. *What about my relationship with my doctor and others?*

Other aspects to be noted in relation to our cultural knowledge about the subject, are the very unpredictability of seizures, in terms of their nature, timing, severity and the situations in which they occur. They can cause social difficulties associated with discrimination, rejection, overprotection by family members who may impose unnecessary restrictions leading to isolation when it comes to dating, sexuality, marriage, fearing a negative response, trying to keep their epilepsy a secret from others as well as limitations (i.e. to drive in active epilepsy, which can also affect their ability to be socially active and independent). Employers have misconceptions and apprehensions about their disorder. The question of when one should disclose his epilepsy **generate great deal of anxiety**.

Those finding a job, may be employed in jobs below their qualifications and experience in spite of established laws.

Psychologically one has a feeling of uncertainty. Society's lack of understanding is a burden that is strongly felt. Individual's anticipation of how others will react is most worrying plus having low self-esteem, self-confidence, feelings of anger, frustration. Embarrassment and feelings of vulnerability which may lead to increased levels of anxiety and depression.

The **impact on the family** is a major issue. Parents pass through feelings of fear, grief, guilt, anger and frustration. They find difficulty in dealing with uncertainty of seizures, prejudice and ignorance. They tend to become overprotective and restrictive. On the other hand **siblings** may feel left out, afraid or be made to feel responsible for the safety of their brother or sister. Those with epilepsy in a relationship, may encounter lack of sensitivity and understanding. Also maintaining friendship may be difficult as the disorder may challenge ongoing social activities by its very nature.

Sufferers on the other hand (apart from those with Intellectual Impairment or other ailments that renders them dependent) are to become more knowledgeably about their epilepsy. They need to join support group/s who in turn built a support chain network. Taking active role to manage/cope with their epilepsy is a must. They need to study oneself... emotions, stress and feelings as their control can reduce seizures. Concentrating on things one cannot do rather than one can is of great importance. Maybe here, a counselor will be very useful. Eating a balanced diet, sleeping sufficiently, using relaxation techniques, having medication appropriately are all aspects that can be of help to prevent seizures. Monitoring one's seizures is very important. Some people with epilepsy can learn how to recognize when a seizure is coming and find interventions (like conjuring up an image, breathing deeply and slowly, or grabbing an affected part of their body) which may prevent a full seizure from coming on. Obviously good medical care based on partnership between doctor and the patient and / or family is essential.

Are we aware about facts associated with Epilepsy? Here are but a few:-

- *Epilepsy can be inherited, result from birth defect, birth or head injury, brain tumor or infection of the brain. For 50% of people with epilepsy, a cause is not found. It can begin from birth or occur for the first time in old age. It is not contagious.*
- *75% have their first seizure before they turn 18*
- *Not every seizure is an epileptic seizure.*
- *About 1 in 200 suffers from recurrent epilepsy...if we include infants who suffer from seizures caused by fever and adults who have only had one seizure, the figure rises to about 1 in 80.*
- *Epilepsy can strike at any age. The information hereunder from EFA Publications shows, that some age groups are more susceptible to others :*
- Age groups first seizure occurring 0 %
  0 - 9 47%
  10 - 19 30%
  20 - 29 13%
  30 - 39 6%
  40 + 4%

50% of all cases develop before 10 years of age

- Seizures last from a few seconds to several minutes. In rare cases can last longer ... example: A tonic – clonic seizure typically lasts 1-7 minutes. Absence seizures last from 30 seconds to 2-3 minutes. Status Epilepticus refer to prolonged seizures – medical emergency. In most cases seizures are very short and little first aid is required.
- Epilepsy is the most common chronic brain disorder in every country in the world. More than 50 million people suffer from epilepsy. incidence depends, in a period of 1 year, on the age of the individual. About 1 out of 3 people with epilepsy develop the condition by the age of 18. More than half of all people with epilepsy develop symptoms before the age of 25.
- In UK 450,000 have Epilepsy (40 million worldwide).
- In USA Epilepsy affects 2.5 Million Americans. More than 180,000 people are diagnosed every year.
- 1 in 131 affected.
- 1 in 242 children& young people under 18 has epilepsy.
- 1 in 91 aged 65 and over have epilepsy.
- 1 in 50 will develop epilepsy at some time in their life. 1 in 20 will have a single epileptic seizure.
- Epilepsy is more than 3 times as common as multiple sclerosis, Parkinson's disease and Cerebral Palsy.
- 1000 epilepsy related deaths a year, approx 600 of which re attributed to sudden unexpected death from epilepsy (SUDEP)
- More mortality than asthma.
- More lives claimed than (HIV) Aids and cot death.
- Up to 70% of people with epilepsy could achieve, full seizure control through medication.
- 3% eligible for surgery... backlog exist and 300-500 new cases yearly.
- 70% of people who have epilepsy surgery become seizure free.
- 25% newly diagnosed are over the age of 60.
- 1 in 10 who have a stroke will develop some form of epilepsy.
- 9 in 10 who develop epilepsy in later life are found to have a physical cause in the brain for seizure.

- Misdiagnosis in UK are between 20-30%
- 30% of people with learning disabilities have epilepsy. 50% with severe disability have epilepsy.
- More than 1-5 people with epilepsy have learning or intellectual disability.

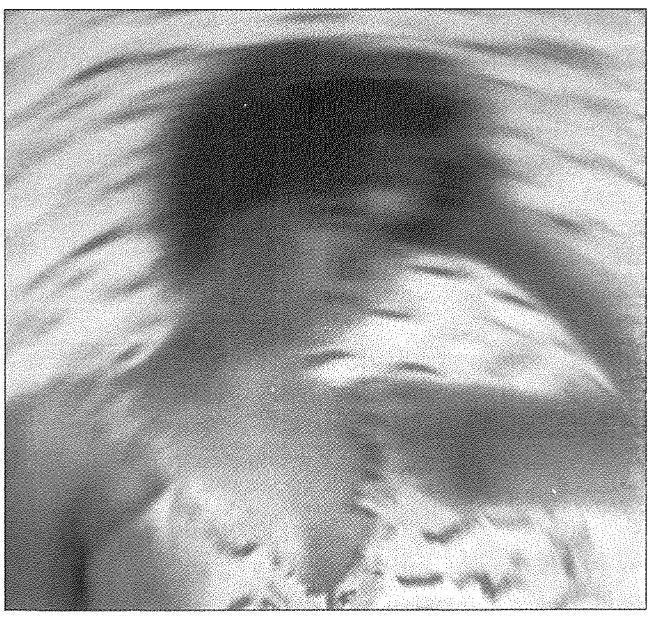
Triggers of seizures differ for everyone. Some include flashing lights, stress, lack of sleep, menses, alcohol/ drug use and some over the counter drugs.

Freeman and Vining (1997) note that it is actually safer for a woman with epilepsy to drive, than for a man without epilepsy to drive. Seizures only account for 1-10,000 car accidents, while 6-10,000 are attributed to natural deaths and 2,500 of 10,000 associated with alcohol use.

We must remember that a seizure occurs when electric signals in the brain misfire. Having a seizure does not mean that a person has epilepsy. Seizures can be triggered uner certain conditions, such as life-threatening dehydration or high temperature. But when a person experience repeated seizures for no obvious reason, that person is said to have epilepsy. Famous creative people like Joan of Arc, Ludwig van Beethoven, Michelangelo and Julius Ceaser all had epilepsy.

It is of great importance that parents become educated so as they know that it is not a curse, that their child is not retarded or violent, that their child probably will not become brain damaged and that their child will most likely be able to live a normal life with all the dreams they had hoped for.

Thompson and Upton (1994) state that the affected child will gain more attention and resentment takes place from the other siblings. Siblings should be given a chance to express their feelings, which may include fear and guilt. A 12 year old has a better ability to understand and willing to adhere to the therapeutic plan the doctor has created. Good communication / relationship with health care providers and parents is essential to successful treatment of epilepsy,without depriving the child from the most fulfilling and less restrivtive life. This will prevent many problems including low self-esteem, social isolation and future seizures. As a child grows up, new issues may crop up and may be more difficult to deal with. Adolescence is already a difficult time.



Dating is an issue... often the person with epilepsy does not say anything until relationship becomes serious, unless of course the epilepsy is severe. Issues of sexual activities complicates matters at times and increases the teenager's responsibility concerning the control of their epilepsy. The partner need to know how to handle a seizure.

Epileptics on anti epileptic medication (AEDs) may effect the efficacy of birth control and therefore increase the risk of pregnancy. Many AEDs are potential teratogenic causes physical defects in embryo) and so both the partner and the person with epilepsy must be aware of this. 90% have a chance to have normal healthy baby andthe risk of birth defects is about 4-6%. Risk of Epileptic parents having children with epilepsy is 5%.

In Malta we need to better the poor & fragmented services for people with epilepsy, raise public and professional awareness. It is imperative to pilot and redesign any existing services and new standards for treatment set on care of people with long-term neurological conditions. A National guidance policy on the management & treatment of epilepsy must be formulated / updated.

Interdisciplinary aspects: Constructing a team is of utmost importance. It is still the doctor which is the first contact and who assess the need for a team approach. Team may find **it difficult to agree on goals for the patient**-cohesive teamwork. We must look at the nature of the problem and quality of life.

Persons with epilepsy, would benefit more by a **comprehensive individual profile assessment.** Planning of care must be based on appropriate information, advice, support and interventions to achieve maximum seizure control with minimum side effects. Enhancing the quality of life is a major issue and we need to work with clients/families/ relatives considering their wishes and choices.

"To-day people with epilepsy are still trying to prove themselves to the world. With the right attitude and support, they should be able to prove themselves successfully"

A study was done in 7 European Countries called ***DISABKIDS.*** It was a 3 year project, study was on 4-16 year olds and experienced 1 of 9 different disabilities. The main objective was to test the performance of a cross-culturally developed disease-generic quality of life measure for children with chronic diseases in a multi clinical study. From the Disabkids study (European group) areas of concern were :

1. *School*

Stigma was present... there was a need to develop skills to deal with stigma. Worst thing for kids was having to tell others about their epilepsy. Mothers often had to go to child's school to explain. Teachers understanding was there but none explained about epilepsy. Bullying and teasing present. Cognitive effects of the medicine on schoolwork. I ask... ***how much of this takes place in Malta?*** Parents have concerns/worry about stigma, bullying and teasing – it is more common in secondary than junior schools. Cognitive effects of the medicine on schoolwork... school achievement can be affected. Optimal treatment and co-operation of the schools minimize the risk of the child of falling back at school.

2. Family

Parents tend to raise the issue of **sibling rivalry** as they spend more time with the epileptic child. Siblings may even feel that they are stigmatized because of their brother's/sister's epilepsy. Working with siblings to better understand epilepsy and to talk about it in a more positive way with their friends, could solve some of the problems. The core members of the team must be in constant contact with families and these points are very relevant for all to digest. This way we will be able to assist, support and educate ourselves and others.

Family disharmony is another issue. Everryone in the family needs time to come to terms with epilepsy. Help and support both now and in the future is essential. It is in everyone's interest that all family members are pulling the same direction.

Dealing with the family problems requires **multi-disciplinary interventions.** I feel that in Malta we all should strive more so that our listening, communication and observation skills be put to good use. With epileptic, it is essential that what we observe is monitored. Multi-disciplinary interventions involves family support, child behaviour and psychological counseling. Where problems exist, the type of input that is needed requires that all professionals involved are **agreed upon the messages to be sent** and are participating in the process. **No one is to work in isolation.** Clinicians who do not pay attention to family relations may make incorrect judgements about the causes for **behaviour deviance or poor seizure control.**

3. Medicine

Medication is a major issue. For the 8-12 year olds, the problem with medicine tends to be described as due to **taste.** For the adolescent, there is less concern with taste and more with **the routine of taking the medications daily**. Concerns for parents are the long-term effects of the medication. Maybe if concerns are present a **Neuropsychological evaluation** might be appropriate. Parents are concerned with the issue of the possibility of antiepileptic drugs that are increasingly used by older children. Reassurance and advice must be given from both medical and social psychological perspective so as to avoid problems.

I ask you... is information/awareness with regards issues concerned with persons with epilepsy lacking in our Islands? Can you honestly say that as a citizen, you have an understanding on the subject and its associated care and support?

Previous studies have reported that over ***50% of families are dissatisfied with the information they receive*** (Curran,S. 1986). We must remember that the **perception of limited support may represent a facet of depressed mood that could lead to problems for the child**. Here I would like to state that:-

> *"Depression in epileptic adults is one of the socila issues with epilepsy. In 1995, the prevelance of depression in adult epilepsy fluctuated from 34 to 78% (Journal of American Academy of Child and Adoleccest Psychiatry, Sept 1999: Davis W.Dunn). Along with depression, mood swings, irritability, arrogance and explosive bursts of anger are present."*

I ask once more... Do we at present have such a team to cope with these issues? Is work carried out in isolation? Can more be done?

May I point out that one of the most valued services that can be offered in Malta is the availability of the **Specialist Epileptic Nurse.** This concept could be pushed forward by all concerned. With the availability of the Specialist Epileptic Nurse, more support could be given by contacting him/her as and when it is needed. The Nurse will be able to bridge the gap between the medical and the social spheres.

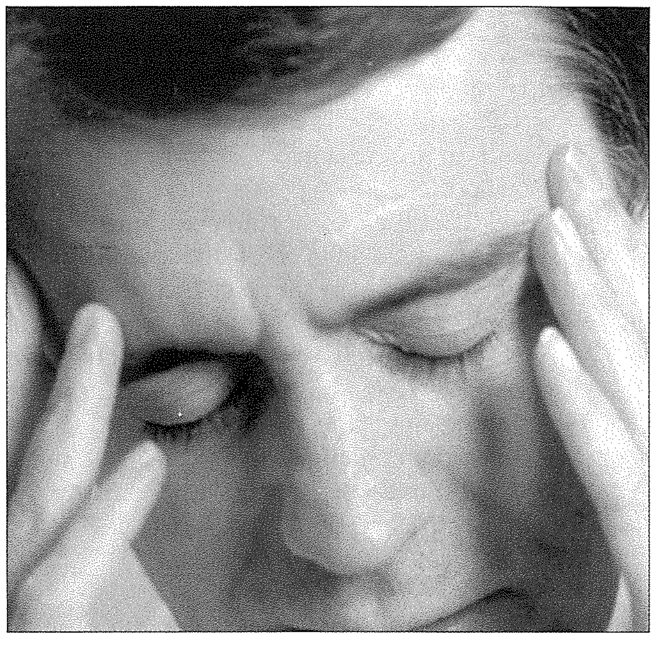
There seems to be a move from the multi-disciplinary team-work of most health care services towards an **interdisciplinary** and **perhaps trans-disciplinary team**, thus sharing skills and experiencies in solving complex clinical problems. (Young, CA. 1998). Such a blended approach has been shown to have very high rates of approval by patients (Barolin, GS., Sebek, K.1997). This type of approach lends itself in involving the patients more in the decision making process which in turn may involve the team working more with epilepsy associations and self-help groups.

We need to develop new ways of working with

young people with epilepsy. We must work to improve self-confidence, exchange experiences and information, have informal mutual help and eliminate prejudice. Interaction both on a national and international level will lead to more knowledge about epilepsy and social skills necessary for life. Doctors, nurses, psychologists, social workers, care providers, sports trainers, teachers and those affected themselves (who are the professionals, in the sence that they know most about themselves) can work together. Problems as they emerge could be dealt with immediately and efficiently because we **all have a common and shared goal.**

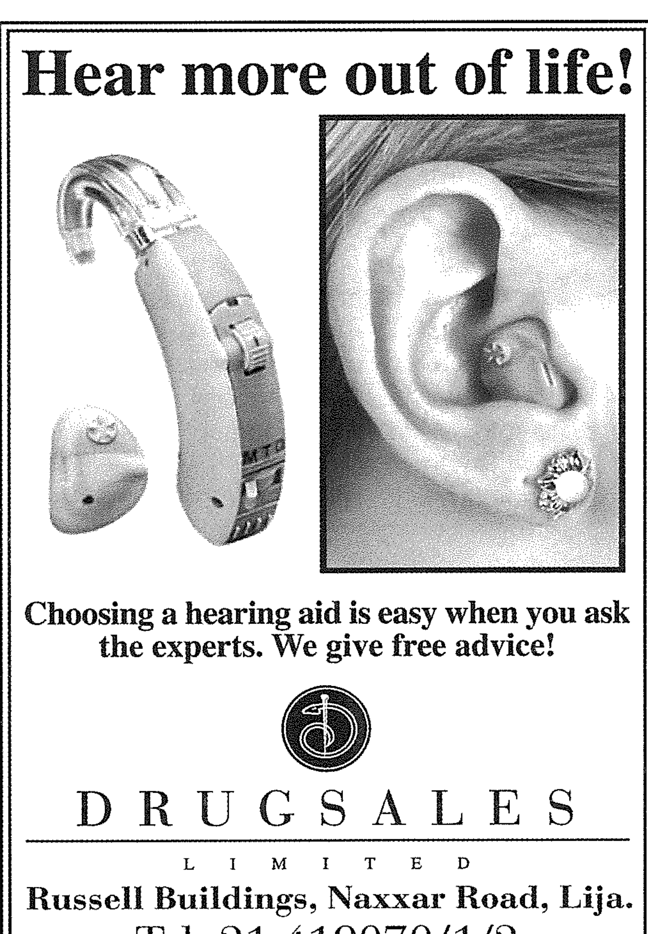
If someone has a seizure, stay calm, help but not force the person to lie down on his side and put something soft under his/her head. Take away glasses, loosen tight clothing, don't restrain, move objects especially sharp ones away, stay with person. Talk with person in a calm, reassuring way after a seizure, observe events and be able to describe what happened before, during and after the seizure. **Do not place any object into the person's mouth at any time.** Status Epilepticus (i.e. a conditionin which there is a rapid succession of epileptic fits) is a medical emergency.

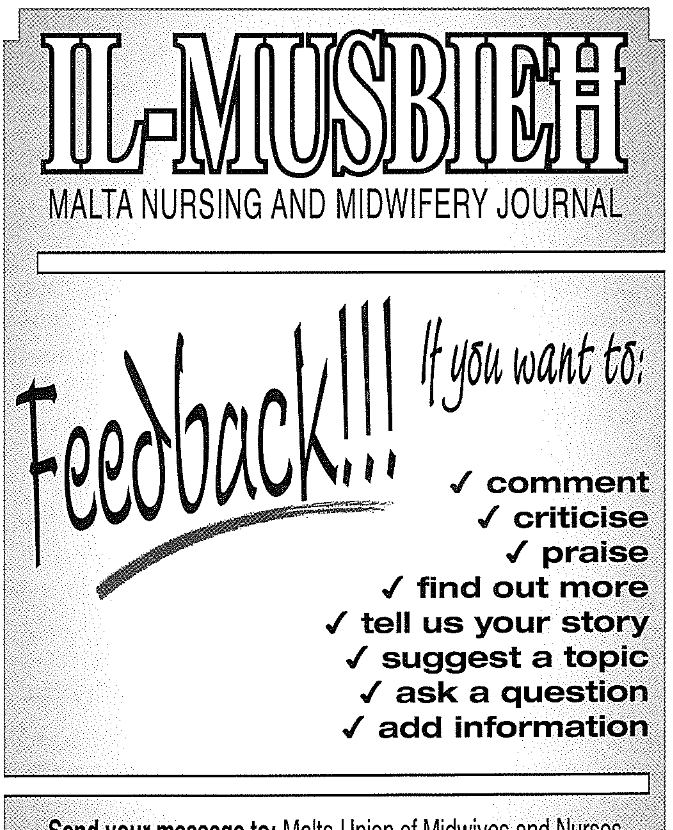
Epilepsy is a multi-faceted condition. Many disciplines need to be blended together in solving problems. We must develop a significant positive cultural change in outcome. So as to be effective, we

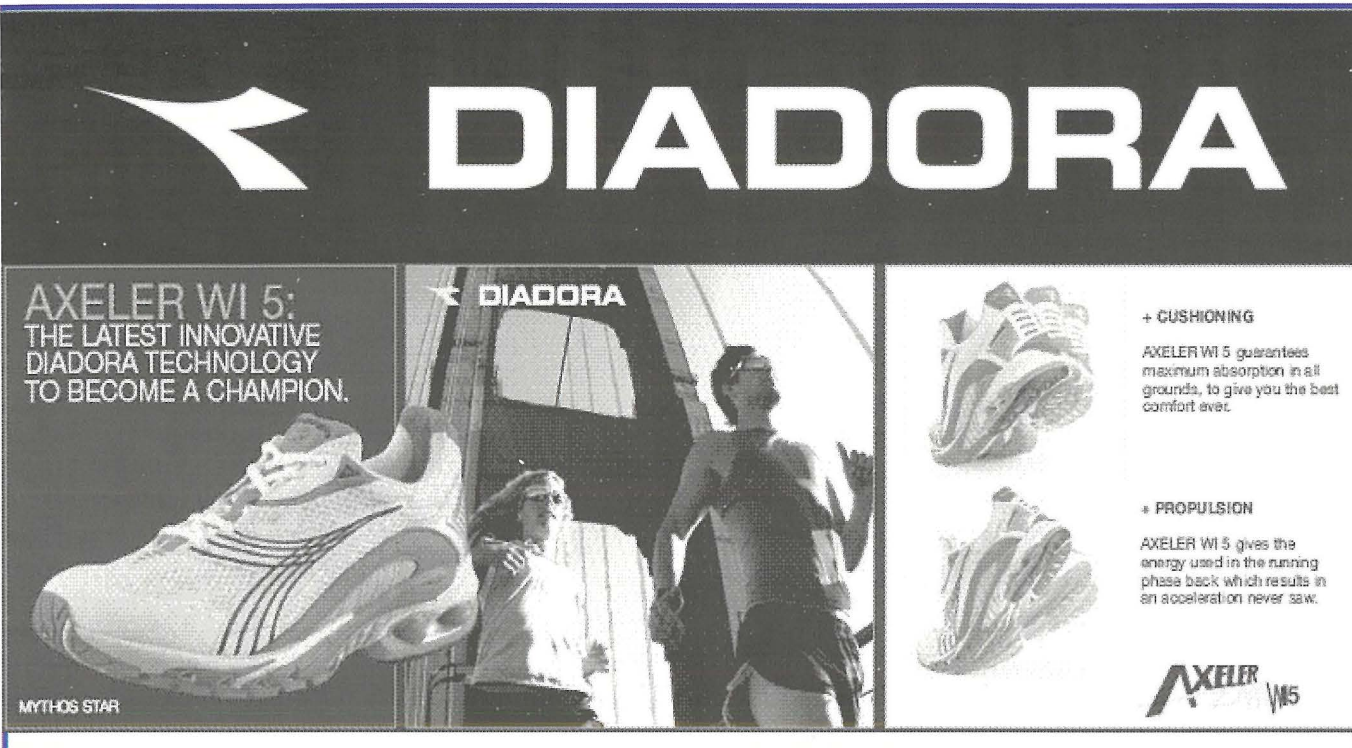


need to have a trans-disciplinary approach. Epilepsy sounds frightening, but manageing can be simple. If you have epilepsy, follow your treatment plan. Get plenty of sleep, eat right and exercise to reduce stress and stay in shape.

We as professionals as well as the public in general, by its understanding can do all this by treating the whole child and the family and not just the seizures. We can do this by **putting the child with epilepsy at the centre of what we do.**







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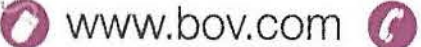

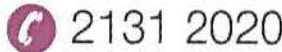

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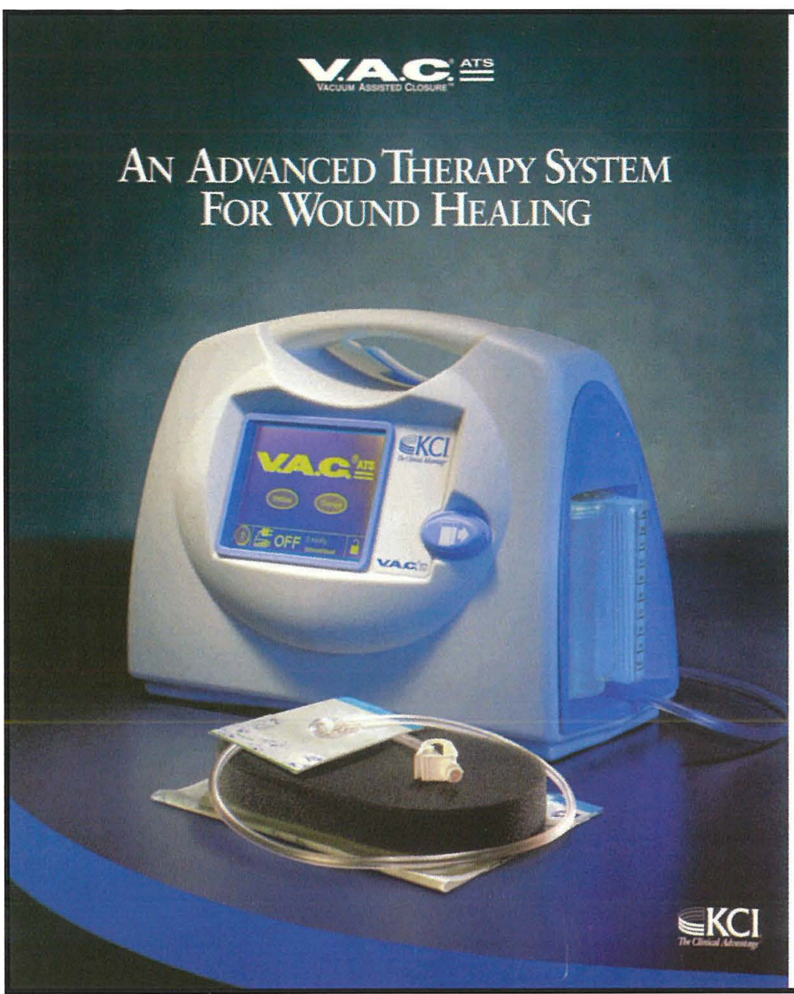

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An Exploration of the Care-Giving Experiences of Maltese Co-resident Carers with Older People (part 1)

Mariella Galea BSc. Nursing (Hons), MSc Nursing (Salford), *Professional Development Facilitator, Primary Health*

The increased prevalence of family caregiving towards the older people is a relatively recent phenomenon in Malta; stemming from major social and demographic changes occurring throughout the second half of the century. Being a heterogeneous group, family carers have different needs and experiences in their caregiving role. Thus, if health services are to be planned effectively, it is fundamental that their viewpoint is considered.

Research on the caregiving role and its impact on the lives of the Maltese family carers is still in its early stages and relatively few studies have been conducted so far (Busuttil, 1998, Grixti 1999, Micallef 2000). Moreover, these studies tended to focus more on the negative consequences of caregiving. Only one national study has ever been conducted in Malta on caregiving. This was conducted by Troisi and Formosa (2004). Despite the fact that 100 family carers of older people were indeed interviewed for this study, it largely focused on the use of health services that are available in the Maltese community. Thus, a local study was conducted that specifically explored the caregiving experiences of 15 Maltese co-resident carers of older people. These were chosen from a random sample of registered carers within a community nursing association. Before discussing the study findings, it is worthwhile to explore the literature review that revolves around the caregiving experience of family carers of older people.

Caregiving research has developed from the 1980s and was mainly conducted by feminist researchers. They highlighted the cost of caring and the sacrifices that women had to do in order to stay at home to care for an older person. Researchers such as Gilleard et al (1984) and Zarit et al (1986) measured these costs, labelling them as caregiver burden or strain. Jarvis and Worth (2005) agree that during the last decades, caregiving research mainly focused on the measurement of burden experienced by family caregivers, particularly women caregivers as measured by indicators of frustration, guilt, resentment, fatigue and time strains. An important advance occurred when study designs began to include non caregiving control groups, so that by comparing groups, researchers could attempt to isolate the effects of caregiving from those of the daily stressors of life.

Carers may take a wide variety of tasks, over different spans of time. Thus, a single carer category may mask the heterogeneity of carers and this further contributes to the dilemma of who can be addressed as the primary carer. Even the word 'carer' in itself may lead to misunderstanding since even the carer himself may not consider himself as such. A spouse may consider attending to his wife's daily needs and assisting her in dressing, bathing, etc as part of his marital commitments and not as part of caregiving *per se*. This was confirmed in a quantitative study by Jarvis and Worth (2005) where

they sent a questionnaire to identify the carers in a Scottish general practice. It was found that out of a total of 3, 704 replies, only 403, that is 11%, identified themselves as carers.

Often the selection of the primary carer is done in terms of the succession of caregivers based on kinship ties. Spouses are usually the first choice of carers, followed by adult daughter children and sons. Oyebode (2003) found that when there is a widowed parent with adult children, care is more likely to be provided by daughters even when there are also sons. When there are only sons in the family, care is more likely to be provided by the daughters-in law. Indeed, the stereotypical view of an informal carer is that of a middle aged daughter who is in paid employment and cares both for her children and an older person.

Several world-wide studies indicate that caregiving can be quite detrimental to the carers' well being. An Australian study conducted by Broe et al (1999), where 630 caregivers, aged 75 years and over participated, showed that full time carers had lower life satisfaction than part-time carers. An Irish study conducted by Cohen (2002) where the sample size consisted of 50 carers, also showed that high burden scores due to caregiving were associated with poorer quality of life and poorer well being amongst the carers. Another study, consisting of 327 carers, 259 of which were women was done in Canada by Gallicchio et al (2002). The same instrument used in the Irish study was utilised, and high burden scores were also reported, especially among the female carers.

Despite being a strenuous activity, Mudge (1995) found that spouse carers reported lower levels of stress than non-spouse carers. However, when interpreting results regarding the levels of stress experienced by the spouse carers, some factors need to be considered. Even though spouse carers may perceive caregiving as stressful, they may be unwilling to report it, perhaps for fear of seeming disloyal to their spouse. Another reason why non-spouse carers may perceive caregiving as being more stressful could be because while spouses have already reduced the number of other commitments in their lives, non-spouse carers such as married daughters may have other responsibilities in their lives.

Despite the negative aspects being attributed to caregiving, Tarlow et al (2004) conclude that the positive aspects of caregiving may act as buffer to reduce the stresses of caregiving. Rather then being overwhelmed by the work, carers may experience a sense of fulfilment because they view their caregiving as an act of love, they receive love and affection from the care recipient, develop positive attributes such as patience and tolerance and also gain satisfaction from meeting cultural and or religious expectations. The latter is especially significant in Malta since the majority of the Maltese regard the Roman Catholic Church and its values as a very important part in their lives.

From this literature review emerges a fundamental need of examining the care process from a more holistic perspective. Identifying ways how to promote the well being of both the carer and the care recipient is important. Using the appropriate methodological approach, this study aims to reach these exact goals. (to be cont.).

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Nursing would be a dream job...
...if there were no doctors. Gerhard Kocher

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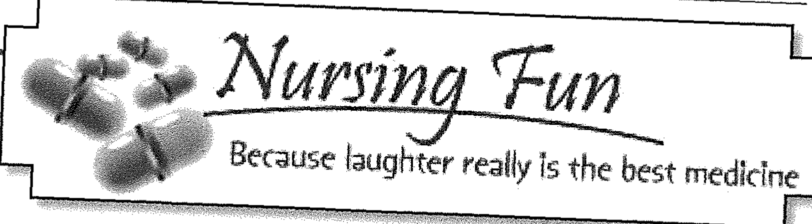


joke

Two guys were working at a sawmill one day when one of the guys got too close to the blade and cut off his arm. His buddy put the severed arm in a plastic bag and rushed it down to the hospital to get re-attached. The next day he goes to see his chum, and finds him playing tennis. "Incredible!", says his friend. "Medical science is amazing". Another month goes by and the same two guys are again at the sawmill working when the same guy gets too close to the spinning blade and this time his leg gets cut off. Again his buddy takes the leg, puts it in a plastic bag and takes it to the hospital to get re-attached. The next day, he goes down to see his chum and finds him outside playing football. "Incredible!", says his friend. "Medical science is amazing!"

Well another month goes by and again the same two friends are at the mill cutting wood when suddenly the same guy bends down too close to the blade and off comes his head. Well his friend takes the head, puts it in a plastic bag, and heads to the hospital to get it re-attached. The next day he goes to see his friend but can't find him. He sees the doctor walking down the hall and says, "Doc, where is my friend? I brought him in yesterday." The doctor thinks for a minute and says, "Oh yeah, some idiot put his head in a plastic bag and he suffocated."

WORKING ON NIGHT SHIFT: AN EMERGING HEALTH RISK

Most people have routine work hours with time left for recreation and rest. At night the body usually turns its attention to growth, repair, rest and recovery. Today experts are recognising the significant stress and biological changes due to continuous night shift work. Other associated effects are sleep problems, fatigue, gastro intestinal complaints, depression, anxiety and heart disease. Studies have also reported social problems associated with shift work such as high alcohol consumption – drug use – divorce and spousal abuse.

Humans are biologicallyprogrammed as a dayorientedspecies. The humanbody contains genetic codesfor critical life rhythms such asheart beat, breathing, bloodpressure, temperature,hormones and digestion thatrise and fall in predictable 24-hour cycles known ascircadian rhythms. Changesin its rhythms can lead tochanges in hormonal levelswhich may result in disturbedsleep and fatigue. In acute phases it may take days or weeks for the body to readjust.

We fall asleep as adrenal hormone levels and body temperature drop and we return to wakefulness as the levels rise again. Ability to concentrate, alertness and attentiveness decreases when this level is at its lowest point, typically occurring between 4-6 am. This is the vulnerability hours for shift workers as surgeons, nurses and anaesthetists. Accidents as Chernobyl, Titanic and Bhopal disasters all occurred in the early morning. Accidents and medical errors are more common on night shift.

Nurses may use the evidence to claim compensation. In certain countries, the additional stress and social disruption experienced by nurses working night shifts are compensated by "hardship" allowances (additional income). In others, access to longer rest periods or more frequent leave has been negotiated. In any case, nurses need to be aware of the higher incidence for accidents and adverse events during night shift hours. Source: Wellness Milestones –

Article by Sandra Tanajak – Director,
Council for Public interest in
Anesthesia.
AANA – News Bulletin – June 2007 – www.aana.com

Sew News - May08

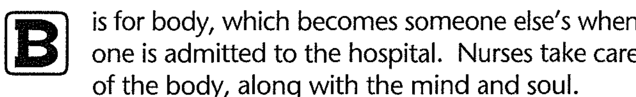
UK MENTAL HEALTH NURSES FACE ATTACKS

The joint Healthcare Commission and Royal College of Psychiatrists have released a report which shows that 46% of nurses working in mental health wards caring for patients of working age have been assaulted. This number rises to 64%for nurses working with older patients. According to the report most attacks occur on wards caring for people with such conditions as dementia, depression and schizophrenia. Fractures, dislocations and black eyes are among the injuries nurses reported.

The report calls for improvements to reduce the worrisome levels of violence in the workplace. Specifically, it recommends an increase in staffing levels and improved training for staff in the area of workplace violence.

Source: BBC (2008). Mental Health nurses face attacks

Sew News - May08



ABC's of Nursing

Nancy Girard PhD, RN, FAAN

A is for assessment. Nurses are great at assessing everything, e.g. patients, nursing care, each other, the work environment, and physicians.

B is for body, which becomes someone else's when one is admitted to the hospital. Nurses take care of the body, along with the mind and soul.

C is for charting, which is never ending. Student nurses need to be warned that when they are graduate nurses, they will probably have to chart on 10 different pieces of paper for every day - unless their hospitals use the other "C" word - computers.

D is for death, which nurses must face and work with, but should never give in to.

E is for endless, which is what nursing care activities mostly seem to be.

F is for finances, which is what keeps the hospitals open and the nurses employed. Most nurses know about hospital finances, especially when it impacts on the personal finances.

G is for goals. These are usually identified for the patient, but can be personal if the need arises.

H is for healthy, which nurses want to be because they don't want to be admitted to a hospital and have to be a patient.

I Is for Infection, also known as cystitis, which some researches claim nurses have more of because they never have time to go to the bathroom.

J is for joy, which nurses experience when their patients (both favorite and unfavorite) recover enough to go home.

K is for knowledge, which nurses have a lot of. They know about nursing, doctoring, diets, teaching, giving helping, caring facilitation, consulting, and fixing. They use most of it, so they try to keep getting it.

L is for laboratory reports, which have a tendency to show up on the wrong charts for the wrong patients at the wrong time, which nurses have to look out for constantly.

M is for movement, which nurses oversee so that patients either do or don't do, helping patients understand what and how to do or not do.

N is for needles. Nurses are concerned today because needles not only stick the patients; they may also stick the nurse with something that can be life threatening.

O is for orientation, which tells the new nurse that he or she is either going to fit or not fit into the hospital's culture. It is not too late to change your mind.

P is for priorities, which nurses must be great at setting whether it's patient care, preparing the operating room for surgery, or generating a budget.

Q is for questions, which nurses answer a million of a day from patients, families, other members of the healthcare team, nursing colleagues, or administration.

R is for risk taking. Nurses take risks daily to attain the optimum care they think their patients need.

S is for surgery. While nurses don't do the cutting, they do the preparing, planning, assisting and teaching, which contributes to the outcome.

T is for teaching, which is an original major function of nursing. Since today there is a shortage of nurses and an abundance of physicians, many physicians are identifying teaching as a medical function, which nurses should be aware of in order to not lose it.

U is for uniform, which used to always be white for nurses on the units and scrubs for nurses in specialty areas. But today, nurses may wear scrubs or street clothes on the units and nurses in specialty areas are wearing jump suit cover-ups, or space suits, which is why name tags are required.

N is for values, which nurses and administrators often seem to have differences in. This is okay as they can be worked out in the decision-making process.

W is for walking, which nurses must be sure the ambulatory patients can do before they are discharged. It also can be the miles that nurses walk each day just doing their job. (Some have guesstimated 20 miles a day on an average, busy unit.)

X is for x-rays, which nurses must be sure they don't get too much of, in order to ensure there are enough new little nurses to carry on the profession.

Y is for you, the most important person in nursing. The heart of nursing is giving of yourself, but be sure not to give it all away and have to leave nursing.

Z is for zoo, which is where nurses often say they work, but then, doesn't everybody?

An allergy is an adverse reaction to a protein in our environment, such as those found on pets, and in pollen or nuts. These proteins are called allergens and are normally harmless.

In people with an allergy, the body reacts to a specific allergen by releasing histamine from mast cells in the skin, lungs, nose or intestine. This causes inflammation and swelling.

Symptoms can include itchy skin, tissue swelling and wheezing. In severe cases it can lead to full-blown anaphylaxis or even death.

Common allergic diseases include hay fever, asthma, eczema and urticaria.

Some people get allergic conjunctivis, while others react adversely to medication, insect stings or latex.

Food allergy and intolerance to food additives are relatively uncommon causes of allergic reactions

Allergens to be aware of:

- Grass and tree pollens
- Dust mites (living in and feeding on house dust)
- Food (cow's milk, hen eggs, wheat, soya, seafood, fruit and nuts)
- Fungal or mould spores (in the bathroom and other damp areas)
- Medication (penicillin, aspirin, anaesthetics)
- Nickel, rubber, preservatives and hair dyes (skin contact allergens)
- Pet skin flakes or dander (cat, dog, horse or hamster)
- Wasp and bee stings

What causes allergies?

Some families have a predisposition to allergies, known as atopy. This has shown an epidemic rise over the past four decades.

The reasons why are poorly understood. We know some families are genetically programmed to develop allergies, but this can't be the full story. Things that promote allergies must have been added to our environment, while others that previously protected us against allergies must have been removed.

There's growing evidence our fight against infectious diseases and increased personal cleanliness may have interfered with the workings of our immune system.

Global warming has also had an impact, with changing patterns of natural vegetation and more profuse pollen production.

How allergies develop

At birth, the immune system switches to be either allergy prone (TH2) or non-allergy prone (TH1), depending on genetics and environment.

TH stands for T helper type white blood cells. TH1 immunity is good for fighting bacteria and viruses, and protecting against allergies. TH2 immunity is good at fighting parasite infections, but makes us more vulnerable to develop allergies.

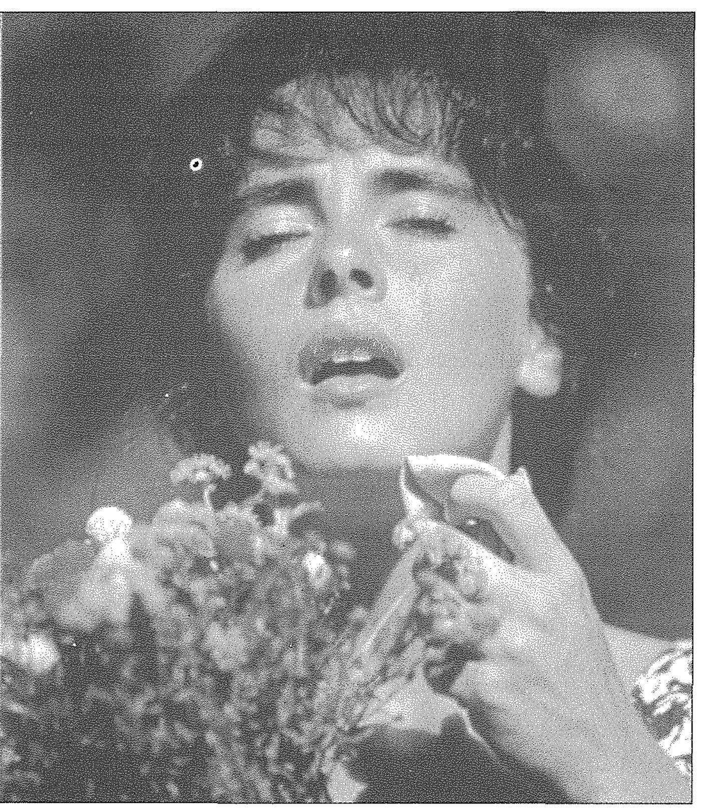
> *"If there's a family history of allergies, a child is much more likely to switch on TH2 immunity"*

If there's a family history of allergies, a child is much more likely to switch on TH2 immunity.

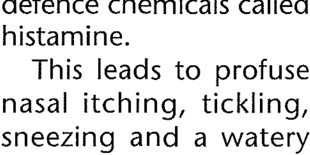
This promotes the manufacture of excessive amounts of allergy-related immunoglobulin E (IgE) in the bloodstream.

This IgE latches on to harmless allergens and triggers allergic reactions.

If an inhaled pollen micro-particle gets attached to IgE in the nasal membranes, for example, this combined IgE/pollen complex causes mast cells to release naturally occurring defence chemicals called histamine.



This leads to profuse nasal itching, tickling, sneezing and a watery mucus discharge.



Who's affected?

Atopy in parents or siblings is a strong indicator of allergy risk. Allergies are likely to occur in atopic families where there's early childhood exposure to certain allergens.

Men are more likely to become allergic and an allergic mother who smokes puts a child at even greater risk.

Statistically:
- Children from non-allergic families have a 12 per cent risk of developing an allergy
- If one parent has allergies, this risk increases to 20 per cent
- If both parents have allergies, the risk is more than 40 per cent
- If both parents have the same allergy (such as asthma, hay fever or eczema) the child has a 70 per cent risk of having the same allergy

Other factors that may promote allergies include:
- Birth by caesarian section
- Frequent courses of antibiotics
- Coming from a smaller family, with just one or two children
- Passive cigarette smoke inhalation
- Being overweight - obese children are more prone to asthma

"A baby's environment during the first year is important"

A baby's environment during the first year is important. Early low-dose exposure to dust mites, pollens, pets and certain foods increases the likelihood of becoming allergic.

On top of that, our relatively affluent lifestyles - centrally heated homes, regular use of antibiotics and processed or exotic foods in our diet - seem to encourage allergy.

Can it be avoided?

A number of factors reduce your risk of developing allergies:
- Being born into a family with no history of allergies
- Being breastfed exclusively for the first four months of life, with a mother who avoids egg, nuts and cow's milk while breastfeeding
- Early exposure to good probiotic bacteria in the infant diet
- Plenty of vitamins C and E, and omega-3 polyunsaturated oils
- Having two or more older brothers and sisters
- Living on a livestock farm and getting grubby playing in the farmyard

Although breastfeeding hasn't been convincingly shown to reduce inhalant allergies or asthma, it transfers protective IgA antibodies to the baby and delays the potential onset of cow's milk allergy by deferring the introduction of cow's milk formula.

Allergic march

The term 'allergic march' is used to describe the progression from one manifestation of allergy to the next over a period of time.

For example, many children under age three have eczema and food allergy. As this improves, they develop asthma. Then, as their asthma begins to settle down, they start to be troubled by allergic rhinitis and hay fever in their teenage years.

Multiple allergies

A small group of highly atopic individuals develop severe allergies from an early age. They may have infantile food allergies (commonly cow's milk, egg and nuts) usually associated with extensive eczema.

Many have cross-reactions to other foods - latex allergy may react with avocado, banana, kiwi and chestnuts, for example. They then develop childhood allergic asthma, allergic rhinitis and remain highly allergic to numerous foods and environmental allergens.

They need ongoing supervision at a combined allergy care clinic under the care of a consultant immunologist, dermatologist, dietician, chest physician, paediatrician and ear, nose and throat specialist.

The vast majority of people with allergies have only a few allergies, which are well controlled by specific allergen avoidance and regular long-term allergy preventer medication.

There's another group of people who apparently react to traces of everyday household and industrial chemicals, but their symptoms aren't typical of allergies.

Often non-medically qualified practitioners will confirm these 'sensitivities' using unproven testing methods.

People can become so incapacitated by fear of a reaction they're no longer able to work or leave their homes. In many instances, there's some past psychological trauma and what they're experiencing isn't an allergy.

• • *This article was last medically reviewedby Dr Adrian Morris in September 2007.*
First published in September 1999.
http://www.bbc.co.uk/health/conditions/allergies/aboutallergies_what.shtml

PSI affiliate leader elected to Paraguayan Parliament

PSI

Aida Robles, a candidate of the popular Tekojoja movement, MPT (Life in Equality – founded in December 2006) and leader of the nurses' union SIDEHC, a PSI affiliate, was elected to the Paraguayan Parliament on 20 April 2008. Campaigning for the universal right to quality health care, education and housing, Aida has dedicated the last 22 years defending nurses' interests through SIDEHC. Aida Robles is the first ever woman trade unionist to be elected to the Paraguayan congress.

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