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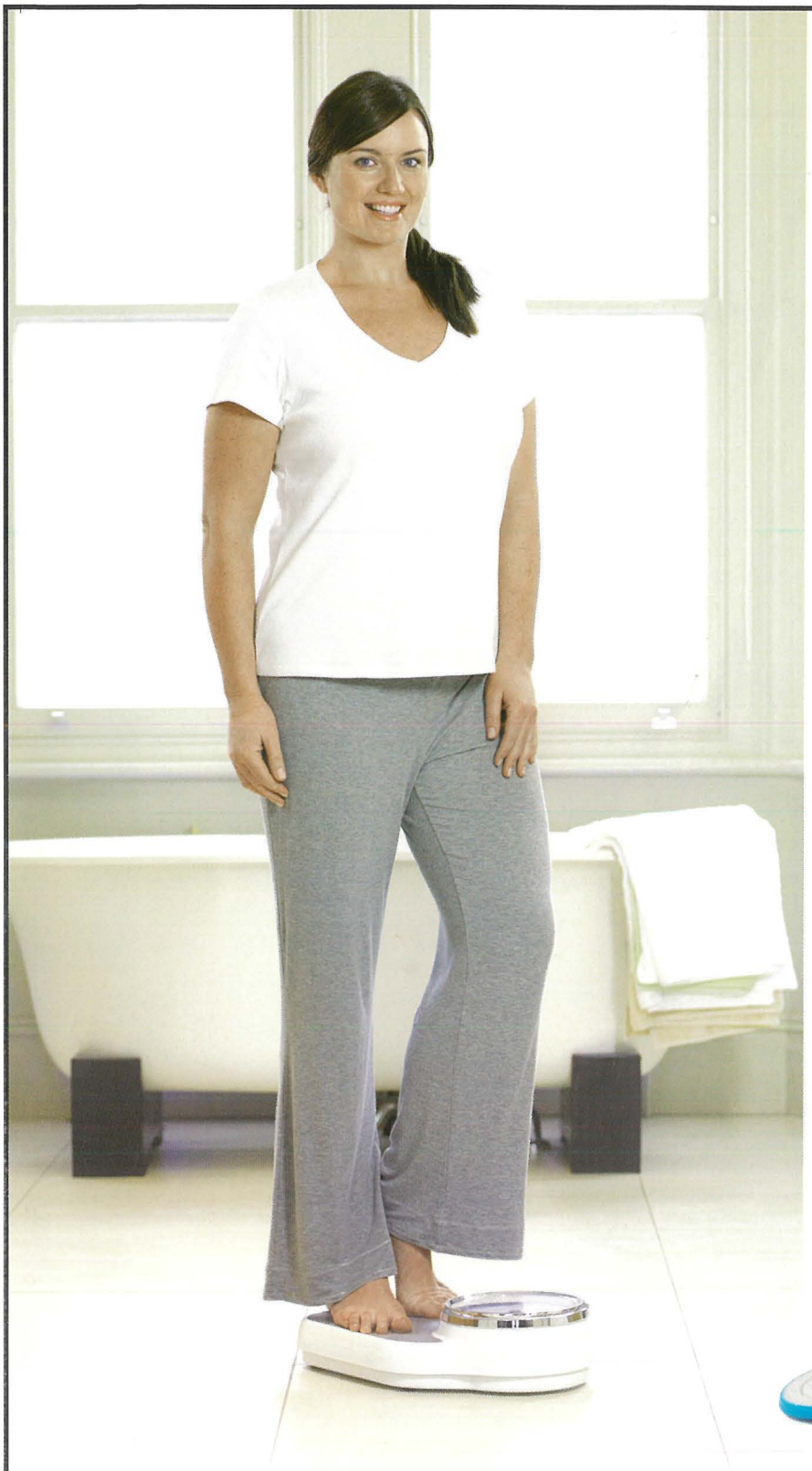
MALTA NURSING AND MIDWIFERY JOURNAL

MALTA UNION OF MIDWIVES AND NURSES

No. 43 - Gunju 2009

Rehabilitation of older people

- Baby-Friendly hospital
- Dimentia
- Post-Natal depression



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Product Information **alli** 60 mg hard capsules (orlistat) **Indication** Weight loss in adults BMI ≥ 28. **Dosage** *Adults (18 or over)* One capsule within an hour of each of three main meals. Max 3 caps/day for up to 6 months. Use with lower fat mildly hypocaloric diet. If no weight loss within 12 weeks refer to HCP. Diet and exercise should start prior to treatment. **Contraindications** Hypersensitivity to ingredients; concurrent treatment with oral anticoagulants or ciclosporin; chronic malabsorption syndrome; cholestasis; pregnancy; breast-feeding. **Special warnings and precautions** See HCP if on amiodarone or medication for hypertension, hypercholesterolemia or diabetes as control of these conditions may improve necessitating alteration of therapy. Risk of GI symptoms increases with fat consumption. Take multivitamin at bedtime. See GP if rectal bleeding. Oral contraceptive efficacy may be reduced if severe diarrhoea; use add... **Drug interactions** Ciclosporin, oral anticoagulants fat soluble... **Pregnancy and lactation** Do not use during pregnan... SPC for full details. Predominantly gastrointestinal eg, ... and transient, risk reduced by low fat consumption. ... liver enzymes, anxiety, hypersensitivity reactions incl... angioedema, pruritus, rash, and urticaria; ... **Marketing Authorisation Holder** Glaxo Grou... GNN **MA Number** EU/1/07/401/007 & 009 **Last r...** **alli** Summary of Product Characteristics. Gl... References [1]

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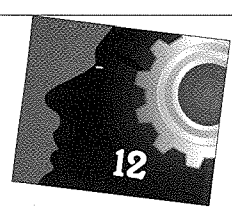

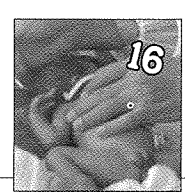

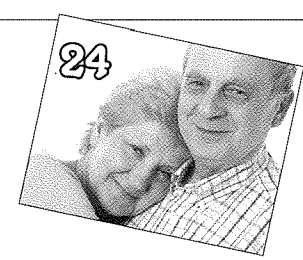

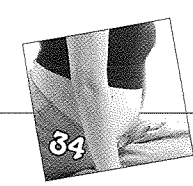

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editorial

Leadership, whether it is nursing, medical or healthcare leadership, is about knowing how to make visions become reality. The vision that many nurses hold dear to their hearts is one where patients are treated with dignity and respect at all times; where benefit of individual needs; and where the work performed by nurses and other carers is valued and respected. Achieving such a vision will require a concept shift in the philosophy, priorities, policies, and power relationships of the health service. Fundamentally, it will require the rhetoric of patient centered care to become a reality. We need to understand what leadership really means and implies.

We tend to misinterpret two notions, that is; leadership and management. I believe that leadership is a process that is ultimately concerned with fostering change. In contrast with the notion of management which suggests preservation or maintenance, leadership implies a process where there is movement – from wherever we are now to some future place or condition that is different. Leadership implies that change is not random –"change for change's sake" – but is rather directed toward some future end or condition which is desired or valued. Consistent with the notion that leadership is concerned with change, I view and I believe many nurses and midwives also view the "leader" basically as a change agent, i.e., "one who fosters change".

Leaders then, are not necessarily those who merely hold formal leadership positions; on the contrary, all nurses and midwives are potential leaders. Furthermore, since the concepts of leadership and leader imply that there are other people involved, leadership should be regarded as a collective or group process.

In short, my conception of leadership comprises the following basic assumptions:

- Leadership is concerned with fostering change.
- Leadership is essentially value-based.
- All nurses and midwives are potential leaders
- Leadership is a group process

Unfortunately we nurses and midwives, need to believe more in this idea of leadership. We need to encompass that leadership is a process and that nobody will start this process for us. We have all heard many people in high positions talking about change but we all know what kind of change we have seen till now. It is about time that we make ourselves heard not only by asking the MUMN to be our voice but by doing what we believe in our daily duties according to the areas we all work in. We are closer to the patients, and they look up to us for whatever they need. Let us all together start making small changes, attitudes, language, care, etc. and surely bigger changes will follow. Every nurse and every midwife can be a leader so it is up to us to make the first step forward. If all of us agree with the four points I mentioned earlier, change is truly possible. We all know what we want and what is truly needed, so wasting time is surely no necessity to put forward any type of change.

message *from the president*

Paul Pace President
mumn@maltanet.net

Summer would surely be bringing various new developments for nurses working in different sectors. These developments, which can bring along certain changes in our work practices, will be heavily scrutinized, not just by the MUMN council, but by each hospital committee which have been elected by you, as a member of MUMN.

The main reform which the Ministry of Health seems to have the intention of implementing is that concerning the Primary Health sector. A preliminary meeting has already been organized by MUMN for all nurses working in the Primary Health Care sector. I can reassure these nurses that MUMN will update them on all the "changes and developments" which will be taking place both in the short term and in the long term period. Whilst MUMN prides in delivering a good service to our nation, MUMN will see that the working conditions and injustices incurred in the name of "reform" will not be bestowed to the detriment of the nurses working in the Health Centres. It could be a time for change and such a time require each and every nurse to be under the umbrella of MUMN for a wider and stronger voice. MUMN would like to appeal to the Ministry of Health that a consultative approach is the best climate to reign in such meetings, and that MUMN would not be accepting a forced agenda which had been already set prior to the meeting.

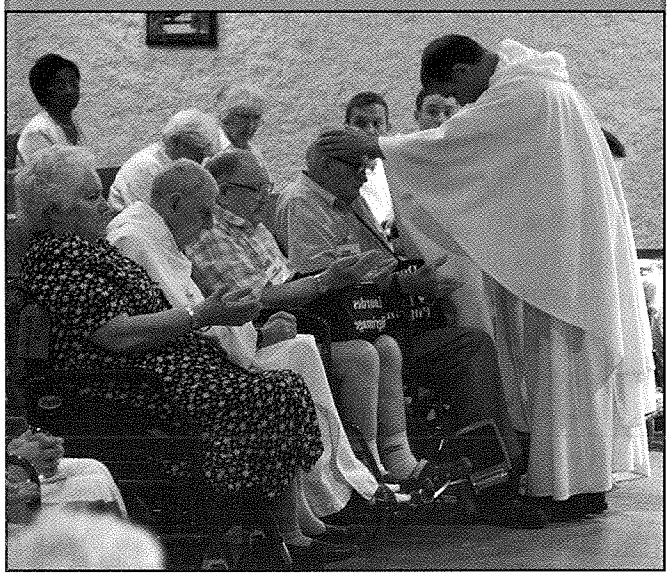
MUMN would be expecting developments in work practices which are currently being used in the Surgical, ENT and Ophthalmic Departments in Mater Dei Hospital. Such developments should reduce the stress and anxiety nurses are finding themselves in. During a meeting in the near future with the nurses working in the E/A department, MUMN intends to initiate meetings to address the issues which these nurses are facing on day to day basis.

SVPR and Mt. Carmel Hospital may be involved in the opening of new wards which are meant for elderly care. With these plans underway, MUMN would be highly vigilant to see that the already depleted staff does not suffer even more. MUMN is continuously supervising that the agreement reached with the Health Division on eliminating the extra beds at SVPR, is honoured and I would encourage our members to report to their hospital representatives any infringements which go against such an agreement.

These are the major highlights for the coming summer. But I can guarantee that these would not be the only ones, since there are always unexpected issues which rise at some moment or other. In July, MUMN would be handed over the organization of the next ICN congress, which is to be held in Malta 2011. This hand over would accelerate the work volume, which already had been initiated, for the organization of such a big event.

I would like to thank the Ministry of Health for the support and interest in making the Maltese nurses proud in the coming congress in South Africa. It would eventually bring to the Maltese islands, not just the biggest congress to be organized in Malta, but also a huge number of international expert nurses and which would definitely put Malta and MUMN on the nursing map.

An accompanied anointing of the sick



Jesus Christ came into the world so that whoever believes in him may have eternal life (Jn 1,15). The Son of God incarnate presented himself as the way, the truth and the life (Jn 14,6). The miracles he performed by the power of the Holy Spirit bore witness in front of everyone that he was the Messiah, the Son of the living God.

If it is true that it is Christ himself who ministers to those who believe in him through the sacraments of the Church, then it is he who strengthens the sick person in body and soul, via the sacrament of the anointing of the sick. By means of this sacrament the grace of strengthening, peace and courage to surmount the troubles that undergo people who suffer from serious illnesses or the frailty of old age is *ipso facto* given by the administration of the anointing. Having said that, why there are people who cannot experience this peace which this sacrament is supposed to give them?

Before answering this crucial question it is important to take into account the following consideration. The anointing of the sick strengthens the one who receives it when it is administered in a fruitful way. Therefore, it is not just a matter of administering this sacrament as if it is isolated from an interpersonal relationship with the sick person, his family, and the medical staff. On the example of Jesus who healed people in an interpersonal relationship he had with them, the priest, *in persona Christi*, is challenged to develop an warming personal relationship with the patient as well as with his familiar and medical entourage. He is invited to listen, let the afflicted person express his feelings, explore his verbal and non verbal content and accompany him in his efforts to integrate in himself the reality of his sickness, suffering and eventual death.

By being a warming and welcoming person, the priest becomes himself a living icon of the Word of God who became flesh and lived among men (Jn 1,14). An effective pastoral minister encourages the sick to be what he is in front of Christ. As Jesus emptied himself (see Phil 1,7) from everything that was his, also the priest is called to open himself up in order to deeply listen, empathise, and help the patient decipher the meaning of his life story. Due to Christ's own presence in the sick (Matt 25,36), the minister is to realize that he must decrease and the patient increase (see Jn 3,30). Compassion, understanding, kindness and a gentle challenge are the basics tenets of an effective pastoral care with the sick. Pastoral experience in the hospital arena consistently shows how this criterion is essential in a christified pastoral relationship.

Since all the family feels the need to be strengthened in this tough time of their life, it makes more sense if the anointing of the sick is celebrated when the patient is surrounded by his family. As God heals and strengthens the human person as a communion in the Trinity, Father, Son and the Holy Spirit, also the sick is fortified to better face his condition through a family support environment. How many reconciliations took place around a dying person? How many family members, touched by the terminal disease of their loved one, came to realize that after all it is only in a loving and forgiving attitude where real healing occurs, where life becomes worth living, and where being a Christian is concretely experienced. When effected in a hospital setting, even the staff members are to take their part in the celebration of the anointing of the sick. The medical staff needs the encouragement of the hospital chaplain in order to keep its motivation, work contentment and competency as high as they can be. A profound participation in the celebration of the sacrament from the medical staff paves the way for a serious re-consolidation of one's motives and attitudes of working in the medical profession. It also serves as a milestone in the pastoral companionship which a hospital chaplain is expected to give to the medical team due to the healing, comfort and strength it confers to the health carers.

A fruitful celebration of the sacrament of the anointing of the sick involves an interpersonal relationship with the patient, his family as well as the medical equippe beforehand. Let all of us priests, realize that our pastoral relationships with the sick are themselves sacramental, since they bring about the grace of Christ's presence with his faithful, "I am with you always, to the end of the age!" (Matt 28,20). Performed within a christified pastoral relationship, the sacrament of the anointing of the sick becomes more what essentially is, the conferral of the special grace of healing and forgiveness on the person experiencing difficulties inherent in the condition of grave illness or old age. In this way the whole relationship with the sick person, his family and the medical staff becomes a sign that signifies and confers a healing and forgiving grace. Thus, a sacramental relationship.

Fr Mario Attard OFM Cap
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messaġġ *mis-segretarju ġenerali*

Colin Galea Segretarju

mumn@maltanet.net

Reġa' wasal il-mument li naqsmu ftit ħsibijiet u nformazzjoni fuq dak li qed iseħħ fl-Union tagħna.

Bħal ma stajtu taraw l-*website* l-ġdida issa qed taħdem kif suppost. Għandna *website* moderna u li tilqa' għall-isfidi li kuljum niffaċċjaw. Nistieden lil kull wieħed u waħda minnkom sabiex tagħmlu użu minn din il-*website* b'mod frekwenti sabiex b'hekk il-mezz ta' komunikazzjoni bejnietna jkompli jissaħaħ.

F'dawn l-aħħar ġimgħat kulħadd kien xi ftit jew wisq imbezza' mill-aħbarjiet u l-informazzjoni li bdejna nirċievu dwar l-influwenza l-ġdida. Is-sitwazzjoni issa tidher li kkalmat xi ftit però hemm il-biża' li bejn Ottubru u Novembru din l-influwenza terġa tfaqqa' bil-kbir. Bħala Union, fuq din il-materja, kellna żewġ laqgħat mad-Diviżjoni tas-Saħħa, li nista' ngħid b'wiċċi minn quddiem, li maħniex kuntenti bil-preparamenti li qed isiru għall-istaff f'każ li din l-influwenza tfeġġ f'pajjiżna wkoll. Nisperaw li jkun hemm aktar laqgħat sabiex inserrħu moħħna li n-*Nurses* u l-*Midwives,* f'din l-eventwalità, ikunu protetti wkoll minn kull periklu.

Numru ta' *Nurses* u *Midwives* qed jiġu mressqa fuq każijiet ta' dixxiplina waqt il-qadi ta' dmirijiethom. L-aktar każijiet komuni huma meta nirrappurtaw *sick leave* u jiġi jżurna t-tabib tax-xogħol, il-bieb tad-dar ma jinfetaħx. Din il-Union għandha dubbji serji kemm verament f'kull każ it-tabib qiegħed jasal sal-bieb tad-dar. Qed ikun irrappurtat lilna li ħafna mill-każijiet ikun involut l-istess tabib u dan jipprejokkupana bis-sħiħ għaliex jista' ikun li qed ikun hemm xi forma ta' abbuż. L-MUMN, fil-ġranet li ġejjien, ser tressaq proposti lid-Diviżjoni tas-Saħħa sabiex tinħoloq sistema li biha nkunu żguri li t-tabib veru ikun ġej jżurek id-dar għaliex sa llum dan il-fattur ma jistax jiġi kkonfermat. Din il-Union hija kontra kull min jabbuża, kemm jekk ikun *Nurse* jew *Midwife,* kif ukoll jekk ikun tabib jew xi ħaddieħor.

Nixtieq ngħid żewġ kelmiet żgħar fuq dak li ktibt jien dwar Rudolph Cini fl-aħħar ħarġa tal-Musbieħ. Il-kummenti tiegħi ma kienu qegħdin bl-ebda mod immirati biex jgħatu appoġġ lil xi kandidat li kkontesta l-elezzjoni ta' l-MEP's f'isem partit politiku. Kulħadd llum jaf jien personali x'inhuma l-opinjonijiet politiċi tiegħi. Kienu mmirrati biss lejn Nurse bħalna li qed jikkontesta elezzjoni. Kieku kien hemm Nurse ieħor li kkontesta l-elezzjoni ma xi partit ieħor kont nistqarr l-istess kummenti.

Il-Kunsill tal-*Union* iddeċieda li jsejjaħ elezzjoni sabiex jinħatar *Group Committee* ġdid fl-Isptar Monte Carmeli. Nħeġġeġ lin-*Nurses* li jaħdmu f'dan l-isptar biex meta jirċievu n-nomina għall-elezzjoni, jagħmlu kuraġġ u jersqu 'l quddiem għat-twaqqif ta' *Group Committee* ġdid li jkun jirrapreżenta lin-*Nurses* ta' MCH. Mhux biżżejjed li ngergru, iżda huwa mportanti li fil-livell ta' sptar ikollna *Nurses* kapaċi u ta' rieda soda, żewġ karatteristiċi li jien naf li ħafna *Nurses* fl-MCH għandhom.

Bħal ma qed taraw l-MUMN qed taħdem bis-sħiħ fuq tlett fatturi. L-ewwel wieħed u l-aktar kruċjali huwa dak tas-*social cases.* Il-Gvern irid joħloq spazzju ta' madwar 100 sodda fis-sena sabiex l-Isptar Mater Dei ma jitlifx il-funzjoni propja tiegħu. Dan l-eżerċizzju jrid jibqa' għaddej kontinwament. It-tieni fattur huwa dak tal-Kura Primarja. L-MUMN ilha tisħaq fuq dan is-settur għal diversi snin. It-tielet huwa l-Isptar Mater Dei nnifsu, fejn minn meta fetaħ għad għandna sistemi li qed ixekklu t-tmexxija ta' dan l-istess Sptar. Hemm bżonn urġenti li l-Gvern iħares sewwa b'għajnejh miftuħa għal kull ma qiegħed iseħħ.

Dan ix-xahar, l-MUMN flimkien mal-Ministru Dalli ser inżuru Durban fejn ser ikun qiegħed jiġi organizzat il-Kungress ta' l-ICN sabiex mingħand l-awtoritajiet tas-South Africa nieħdu *over* it-tmexxija tal-Kungress li l-ICN imissha torganizza f'pajjiżna fil-5, 6 u 7 ta' Mejju 2011. Dan il-Kungress ser ikun opportunità li n-*Nurses* Maltin żgur mhux ser jinsew. Nixtieq nieħu din l-opportunità sabiex nirringrazzja lill-Ministeru tal-Politika Soċjali, il-Ministeru tal-Finanzi kif ukoll il-Ministeru tat-Turiżmu li bil-kontribuzzjoni finanzjarja tagħhom se jagħmlu din l-opportunità waħda possibli għalikom in-*Nurses* u l-*Midwives* Maltin.

The wait is over...

The clinically proven weight loss aid

alli® (orlistat 60 mg) is now on sale in pharmacies

GlaxoSmithKline

press release

alli – the weight loss aid that could help adults lose 50 per cent more weight than by dieting alone[1] – is now on sale in pharmacies in Malta and Gozo. For adults with a BMI of 28 kg/m² or more, **alli** works by stopping some of the fat eaten from being absorbed into the body, so for every 2 kilos they lose with a reduced calorie, lower-fat diet, **alli** can help users lose an extra 1 kilo. It is the first and only, EU-licensed, clinically proven weight loss aid available in Malta without prescription.

alli rewards the hard work of people willing to follow a reduced calorie, lower-fat diet, and, used in conjunction with the **alli** programme, it helps them adopt a healthy and sustainable diet and lifestyle. To support their weight loss and guide them towards their goals, **alli** users will receive a free starter guide, available from their pharmacists, which will include a food diary, and also have free access to an online support programme of information and tools (www.alli.com.mt) which include:

- a range of lower-fat recipes
- healthy menu options
- a BMI calculator
- tips on becoming more active

An **alli** interactive discussion forum, also part of the online programme, will encourage users to share their experiences along their weight loss journey, creating a supportive and motivated community of people wanting healthier lives. "Weight loss should not be viewed as a single destination, it is an ongoing process that requires support, guidance and encouragement," says psychologist Mac Andrews.

"Obesity is a growing public health issue with the World Health Organisation (WHO) calling it a problem of epidemic proportions.[2] Between 30-80% of European adults are overweight[3] with an estimated 400 million European adults needing to lose weight.[4] In Malta, more than 60% of the adult population is overweight (BMI 25-29.9) or obese (BMI Û30)," says Dr Antoine Schranz, Consultant Diabetologist and Endocrinologist.

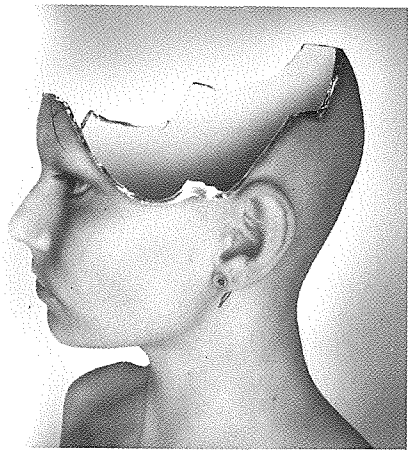
Modest weight loss of 5-10% of bodyweight brings significant improvements to physical health and emotional well-being. [5-7] "Gradual weight loss gives the most chance of success," says Dr Mariosa Xuereb, Consultant Cardiologist, and she recommends that for someone who is trying to lose weight it is important that one sets realistic healthy weight loss targets."

"Research has shown that consumers are spending millions of euros each year on fad diets, unproven 'miracle pills' and potentially unsafe weight-loss supplements, often without any scientific evidence to back them up. By making a licensed non-prescription product available, consumers will have the option of a proven therapy which can support them with their struggle for weight loss. For many, losing weight can become the catalyst to improvements in their overall health and self-esteem." says European obesity expert, Prof. Stephan Jacob from the Cardio-Metabolic Institute, Villingen-Schwenningen Germany.

Mary Ann Sant Fournier, President of the Malta Chamber of Pharmacists commented 'As Pharmacy becomes more involved in providing health and lifestyle guidance to customers and has worked successfully in tandem with other healthcare professionals in areas such as tobacco control, we welcome this opportunity to play an integral role in helping people lose weight using a non-prescription pharmacological weight-loss aid where indicated and to live healthier lives'.

Monica Abdilla, Country Manager, Consumer Healthcare, from GlaxoSmithKline, the manufacturers of **alli**, says "Obesity is a major concern of our society and people need help. **alli** is not a magic bullet. **alli** offers a clinically proven way to help people lose weight. **alli** has been well received by millions of people in the US since June 2007, and we are very excited about the number of people it could help in Malta achieve their weight loss goals."

Caring for People with Dementia



Rita Briffa

INTRODUCTION

As a nurse, I have spent the last seventeen years working in the primary health care sector primarily attending town clinics where the majority of our clients were elderly. The regular monthly visits of these clients to our clinics turned more into a familiar relationship than a clinical one. Month in, month out I could see the progression, sometimes quick and sometimes lengthy, of these elderly clients. The most common downward change was predominantly in their behaviour and ability to remember, talk and understand. These symptoms, compounded with instances vividly but sadly illustrated by their loved ones, were all suggestive of dementia. The management of dementia by community doctors is primarily based on the prescription of sedatives and hypnotics.

Although it is not the scope of this essay to describe all the physiological changes in the brain that bring about dementia, it's important to illustrate the progressive deterioration of the cognitive and intellectual functions that characterizes this condition.

COMMONEST TYPES OF DEMENTIA

As far as the eighteen century, different types of dementia have been attributed to researchers like the German psychiatrist and neuropathologist Alois Alzheimer [1](1864-1915) ,the discoverer of Alzheimer's Disease; German neurologist Frederic Lewy (1885-1950)[2] who discovered another type of dementia brought about by the presence of certain proteins (Lewy bodies) in the brain cells A Czechoslovakian neurologist and psychiatrist, Arnold Pick (1851 – 1924)[3] discovered another important type of dementia (Pick's disease) in which brain cells in localised areas die, a feature very different to Alzheimer's disease where the atrophy is more generalized In 1974, Hachinski et al[4] coined the term multi-infarct. In 1985, Loeb used the broader term vascular dementia. Recently, Bowler and Hachinski[5] introduced a new term, vascular cognitive impairment dementia.[6] Although dementia, whether at its early or late stages , affects everyone differently, people with any form or type of dementia exhibit common symptoms related to alteration in behaviour. (Alzheimer's Society, 2005) Dementia affects everyone differently and those affected will have good and bad days. Thus the care and support to these people will need to be tailored accordingly!

FOCUS ON THE INDIVIDUAL

The management of dementia has undergone striking changes and slowly moving from the far ends of the momentum, namely moving away from the medical model to the experiential model[7] .

Whilst the medical model views elders with dementia as primarily impaired and with confused behaviour, its intervention to bring such elders to 'normality' is solely through medication. Drug treatment of behavioural symptoms provides little benefit for most people besides posing significant risks resulting from side effects of such psychotropic drugs. Thus, care and environment revolves on the disabilities and behaviours of the elder person.

On the other hand, the experiential model focuses on the recognition of the retained strengths and abilities of the elder, on his growth and not his decline. The crux of this type of managing people with dementia is the interpersonal interaction that values individuality, personal identity and choice, even in the late stages of dementia. It transforms the environment surrounding the elder by infusing it with variety, spontaneity and meaning. Unfortunately the management of dementia still makes the elder transforms himself to the physical environment with the dangerous and inhumane situations of isolation and loneliness.

REQUIREMENTS FOR PERSON CENTRED CARE

The philosophy of moving away from the traditional to person-centred care is slowly but steadily being acknowledged by the carers, planners and policy makers. This shift requires important personal , organisational systems and external change.

The **personal change** is brought about when caregivers are given the opportunity to learn and grow and when such employees face their own beliefs about how person-centred care is given. During 2006, at St. Vincent de Paul Residence, a 10-hour training course in person centred dementia care organised by the Continuing Education Committee in collaboration with

the Malta Dementia Society was a ray of light that enlightened the entire multidisciplinary health care participants. This initiative spurred the Institute of Health Care to incorporate a new module on caring for the older adult in the Institute's Continuing Professional Development courses. These training courses gave the opportunity to all partakers to learn new dimensions in care as a result of the ageing process. This ageing process often mistaken for a disease, leads to inappropriate prescribing and makes the body more sensitive to the effects of commonly used drugs. When this natural process gives in due to decreased physiological reserve and the elderly is overridden by a disease or a combination of several disease processes, recovery rate is delayed and the incidence of complications becomes much higher than younger patients. Similarly, the rehabilitation process is a much longer one and there are special problems which may hinder rehabilitation in elderly. Apart from the intrinsic pathologies, polypharmacy and mental vulnerability like dementia or depression, the philosophy and low expectations from care professionals, hinder progress in rehabilitation of the elder adult patient. Positive results and improvement in rehabilitation are possible only when care is focused on supporting and enabling the older persons to achieve independence.

Caring for people with dementia is a challenging job that will get us thinking and thus growing. Seeing the person as an individuals first and focusing on who they are rather not just their dementia was the magic key towards making caregivers concentrate on what a person can still do, not just on what they cannot do. It was strongly emphasized that there is no 'one size fits all' solution to supporting someone with dementia.

AT THE DAY CARE ACTIVITY CENTRE

From its conception, the philosophy of care at S.V.P.R 's Day Care Activity Centre focuses on the person with dementia. Since the first visit to the Activity Centre, every person with dementia together with members of the family who accompany their relative, are warmly welcome by all and each member of the staff. This approach makes the patient and his relatives feel at home while alleviating the anxiety associated with meeting new people in an environment yet unknown. Our immediate goal is to get to know our client, who he is and what matters to him and most important, to build a relationship with the client to win his trust. Gradually he is introduced to engage in the various activities that are held there, while the staff observes the client through his behaviour thus understanding what he might be trying to communicate. Music and singing popular tunes are examples of the main activities organised at the Centre. Despite the fact that all clients are encouraged to actively participate, there may be the odd one who cannot stand noises or certain tunes which he may associate with past painful experiences. Such situations may trigger particular behaviours, thus the importance of understanding and recording every covert message that the client may be struggling to communicate through his actions (e.g. through facial expressions and body language), especially if verbal communication is somehow hindered.

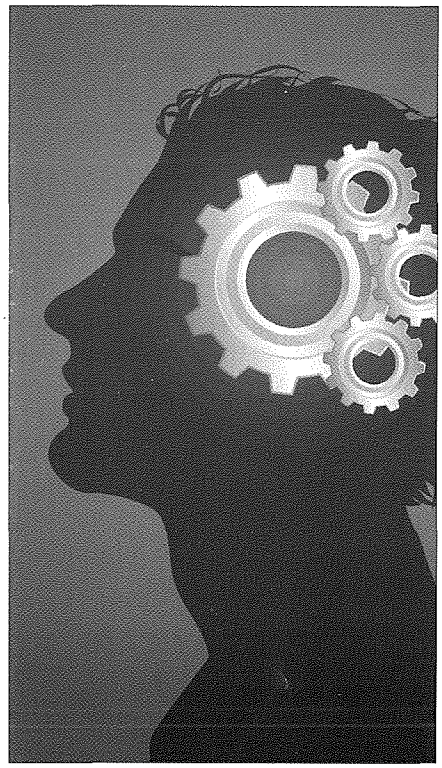
In order to understand better our clients, staff is encouraged to collect, record and update the life history information from the client himself (when possible), from relatives or through photos, letters or clippings. Such an exercise, which in itself is an activity for the client, has many positive benefits

in building relationships, getting to know what is important for the client, while at the same time maintains identity and recognises strengths and abilities.

This approach of person centred care which is being practised at the Day Activity Centre recognises that a person with dementia can still enjoy and express his feelings, feels comfortable and loved while experiences friendship and affection. The variety of activities carried out are planned to meet higher needs[8] including cultural and spiritual needs. Throughout the year, our clients were engaged in spiritual gathering, both at the Centre itself and at the Residence chapels. These varied from the daily attendance to Mass, congregational worships during the Advent and Lent seasons and Remembrance Day on the first of November. Our clients were engaged in cultural activities such as Carnival Day and Carnival costumes; 'Festa Maltija' with traditional Maltese food prepared and cooked by clients, with staff's assistance and Maltese folk singing (Għana Maltija) provided by clients and volunteers. This active engagement of the persons with dementia makes them feel useful and experience achievement whilst having fun and enjoy their remaining strengths and abilities. Persons with dementia may feel worthless if someone tell them that they are doing things wrong, thus even when they sang or played out of tune, they were still praised and encouraged by the staff. The assistance by the staff and the involvement of the clients during the cooking or potting (plants) activities serves to promote independence and self-esteem of the persons with dementia. The person with dementia may feel that all their independence has been taken away from them and that they have been put in a place they do not recognise or want to be in.

AWAY FROM THE DAY CARE ACTIVITY CENTRE

How can we extend the person-centred-care model currently applied at the Day Activity Centre to the wards? Are sporadic



continuing education courses enough to move away from the task oriented care which we have been providing for long years to residents with dementia? Who must be involved in this change? Are we to keep relying on the initiative, enthusiasm and dedication of a consultant geriatrician, almost abusing of his vision in seeing this great change in the care of persons with dementia? This challenge of providing person centred care to the ever increasing elderly with dementia could only be met with a solution of similar dimension. The setting up of a permanent Dementia Management body at St.Vincent de Paul Residence is being proposed. This body must have executive powers and its composition made up of representatives from the caring and medical professions together with representatives from the management and the Ministry of Health, Elderly and Community Care. To meet its objective, amongst others, such Body should deal with:

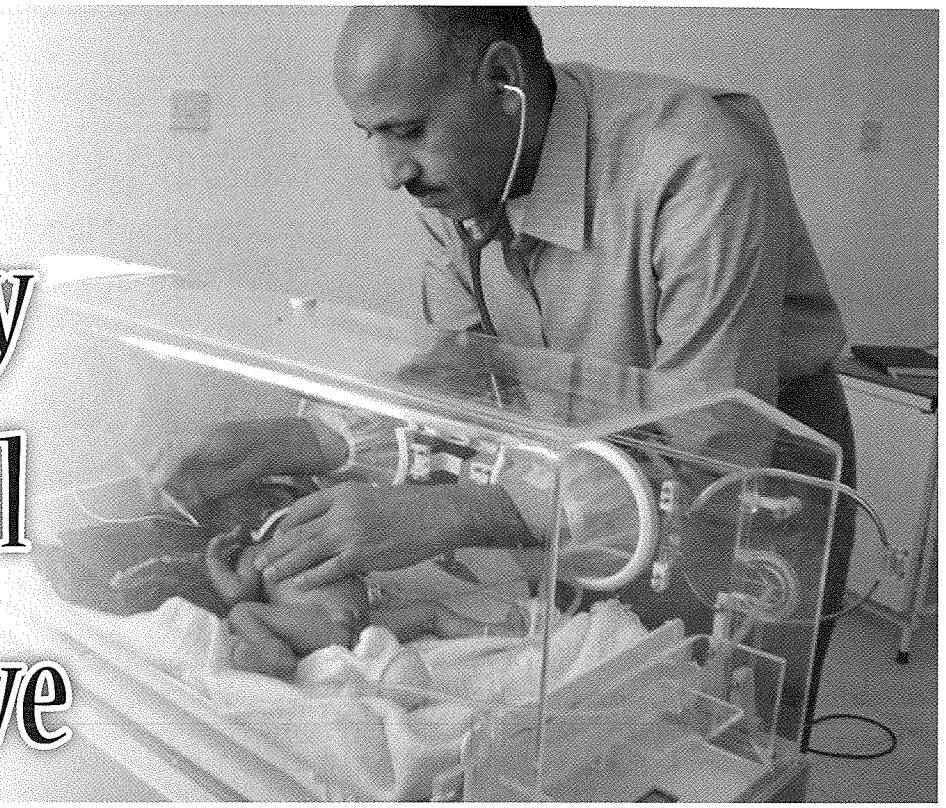
1. Drastic reduction in bed-compliment in ALL 'large' wards;
2. Increase in nursing, caring and paramedical staff;
3. Setting up of a Dementia Practice Development Unit;
4. Training of specialised Dementia care professionals, if necessary in specialised units abroad;
5. An all year round continuing education programmes for ALL staff involved in the management of residents with dementia.
6. Building of new units or wards with dementia specific design features including high levels of visual access, highly visible and signed toilet doors, increased lighting, age appropriate fixtures and fittings, and individualised personal space.

CONCLUSION

People with dementia are very vulnerable. They cannot usually complain about their care, and if they try to communicate through their behaviour the response is often to see it as a symptom to be suppressed. Their relatives are often frail themselves or feeling guilty that they cannot provide care. There are often few alternatives to institutional care, especially for patients with challenging behaviour. Units that look after people with dementia need more investment not just of money for staff and buildings, although these are important, but of time, skill, and energy. They need to be recognised as places where the highest level of skills are practised and sustained by continuous training; and where staff receive support, encouragement, and recognition and can move to easier work if they no longer have the passion required.

1 http://alzheimers.about.com/cs/caregivers/a/Alois_Alzheimer.htm
2 http://www.whonamedit.com/doctor.cfm/2182.html
3 http://www.whonamedit.com/doctor.cfm/1100.html
4 Hachinski, V. C.; Lassen, N. A.; and Marshall, J. "Multi-infarct Dementia. A Cause of Mental Deterioration in the Elderly." Journal of the American Geriatrics Society ii (1974): 207–210.
5 Hachinski VC, Bowler JV. Vascular dementia. Neurology. Oct 1993;43(10):2159-60; discussion 2160-1. [Medline]
6 Vascular Dementia - Kannayiram Alagiakrishnan, Article Last Updated: Aug 27, 2007, e-Web - http://www.emedicine.com/med/topic3150.htm#section~AuthorsandEditors
7 G.Allen Power, 2007http://www.iahsa.net/malta/programme/symposia.asp- Dementia
8 Beyond Drugs: A New Paradigm for Care
(Maslow AH: A theory of human motivation. Psychological Review 1943;50:370-396)

Baby Friendly Hospital Initiative

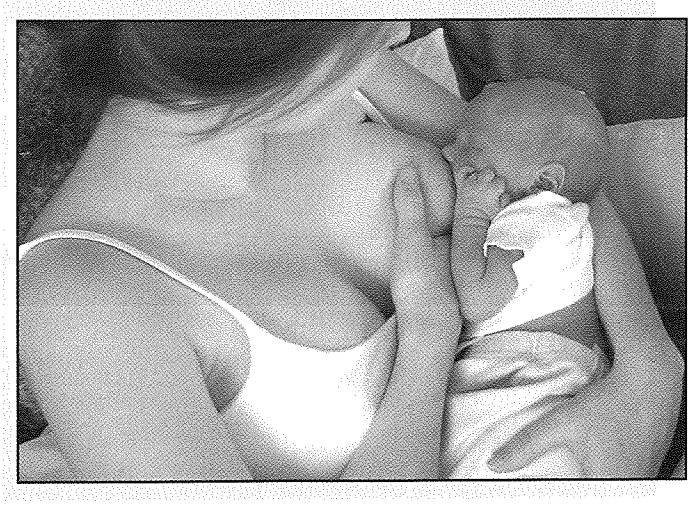


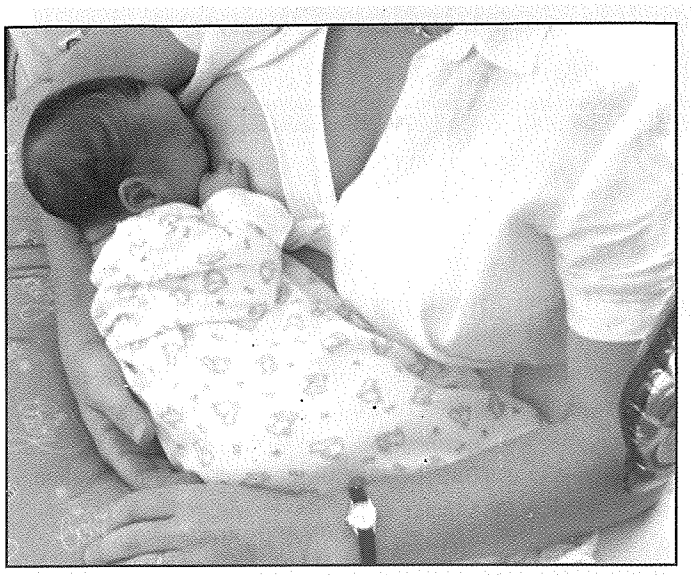
There has been significant evidence produced over recent years to show that breastfeeding has advantages for both baby and mother, even in industrialized countries. During the 55th World Health Assembly, a Maltese delegation endorsed the 'Global Strategy for Infant and Young Child Feeding' that aims to improve through optimal feeding, the nutritional status and developmental health of infants and young children. Since childhood obesity has been classified as malnutrition by WHO, this is also very relevant to developed nations, including Malta that has a very high rate of childhood obesity. Amongst other goals, this document set out to encourage the achievement and maintenance of 'Baby-Friendly' status within Hospitals.

The Baby-Friendly Hospital Initiative (BFHI) is a global movement devised jointly by WHO and UNICEF that aims to give babies the best start in life by creating a health care environment where breastfeeding is the norm. The main goals are to implement the 'Ten Steps to Successful Breastfeeding' as a standard of care and abide by the International Code of Marketing of Breastmilk Substitutes. The code aims to protect breastfeeding by ensuring the proper use of breastmilk substitutes when necessary, and that these products are appropriately marketed and distributed. A hospital designated as Baby-Friendly is considered to deliver a particular standard of maternity care. This status is not a reflection on the safety of giving birth in that facility, but rather an indication of the standard of care surrounding birth.

THE TEN STEPS TO SUCCESSFUL BREASTFEEDING

1. Maintain a written breastfeeding policy that is routinely communicated to all staff.
2. Train all health care staff in the skills to implement this policy.
3. Inform all pregnant women about the benefits and management of breastfeeding.
4. Help mothers initiate breastfeeding within a half-hour of birth.
5. Show mothers how to breastfeed and how to maintain lactation even if they should be separated from their infants.





6. Give newborn infants no food or drink other than breast milk, unless medically indicated.
7. Practise rooming-in – allow mothers and infants to remain together – 24 hours a day.
8. Encourage breastfeeding on demand
9. Give no artificial teats or pacifiers (also called dummies or soothers) to breastfeeding infants.
10. Foster an establishment of breastfeeding support groups and refer mothers to them on discharge from the hospital or clinic.

Becoming Baby-Friendly does not take away a woman's right to choose , and mothers that choose to bottlefeed are free to do so. However, it means that women who choose to breastfeed are fully supported by maternity staff and that bottlefeeding is not encouraged or introduced as a means to solve breastfeeding difficulties. Although there are many factors that can interfere with the support of breastfeeding mothers, lack of education plays a major role in this regard. Often, since health professionals learn 'on the job' and bad practices are frequently 'inherited', correct training that focuses on breastfeeding focused is a necessity.

In line with the government's endorsement of the Global Strategy, Mater Dei Hospital has started the process to become an accredited Baby-Friendly Hospital. The Breastfeeding Steering Committee (BFS Committee) has been formed, with representatives from the Maternity, Paediatrics, Obstetrics, Nursing Standards and Administrative Departments. This committee will identify what needs to be changed and address how to implement these changes to bring current breastfeeding practice to the WHO/ UNICEF-approved level. Once the committee has implemented change and performed a rigorous self-appraisal, an independent assessor from WHO will be invited to assess Mater Dei's Baby-Friendly status. This will require the WHO representative to monitor ward practices, question staff attitudes to determine their knowledge on breastfeeding and interview mothers to determine what recommendations they have been given.

To reach this goal, appropriate training is essential and a 28 hour course, entitled 'Breastfeeding Management for Maternity Staff', has been organized and will be introduced shortly for all midwives and nurses working with pregnant women and newborns. The course will be mandatory and time-in-lieu will be granted at an overtime rate. Following a pilot review of the course for the Committee itself, the first full course will start in February, and the same course will be repeated until all relevant staff have attended and completed the course satisfactorily. For those members of staff who may find morning attendance difficult, provision will be made for alternative arrangements at a later date.

Health care professionals play a critical role in the protection, promotion and support of breastfeeding. This should be an integral feature of a Baby-Friendly Hospital that provides an environment where quality support is given to breastfeeding, thereby making the difference during those crucial early days. To date, only Greece and Malta within the EU do not have any designated ' Baby Friendly' hospitals.. This initiative has been launched to address and reverse this situation and, although it necessitates a period of change, it's aim is to ensure an environment where mothers receive appropriate, accurate and consistent advice on how to breastfeed their babies.

The Baby-Friendly Hospital Award

Helen Borg, Infant Feeding Midwife and **Prof. Simon Attard Montalto,** Chairman Paediatrics, on behalf of the BFS Committee

Ministry for Social Policy

Public Health Regulation Division
Diviżjoni Regolazzjoni Saħħa Pubblika

Parliamentary Secretariat for Health

DH 2270/09 - DH Circular No: 171/09
16 June 2009

TO ALL NURSES

Call for applications for the issuance of warrants to nurses

Following the publication of Legal Notice 276/08, first level nurses are entitled to possess a warrant to practice their profession. However, only first level nurses who satisfy the following criteria shall be able to apply to the Council for Nurses and Midwives for a warrant:

a) first level nurses who hold a degree in nursing granted by the University of Malta or an equivalent nursing qualification obtained from any other university, college or nursing school recognised by the Council
b) have been registered with the council for a minimum period of two years
c) have been practising their profession of a nurses on a full-time basis for two years or their equivalent.

In the case of those first-level nurses who do not fulfil the conditions mentioned the preceding sub-regulation but who are in possession of a diploma in nursing granted by the University of Malta or an equivalent nursing qualification obtained from any other university, college or nursing school recognised by the Council, the warrant shall only be granted after five years from their registration with the Council and after practising the profession of nurse on a full-time basis for five years or their equivalent.

Nurses need to be in possession of such a warrant and therefore need to fill in correctly and completely the following:

a) Application form named "**Application for the issue of the nursing license**".
b) Nurses also need to submit proof (not applicable to public service employees) of their working experience with their current employer and/or former employer/s from the respective human resources department detailing the number of years worked as a nurse.
c) A copy of the first-level nurse registration certificate.

Nurses are to hand or forward the application form at the following address by not later than 31st July, 2009 to:

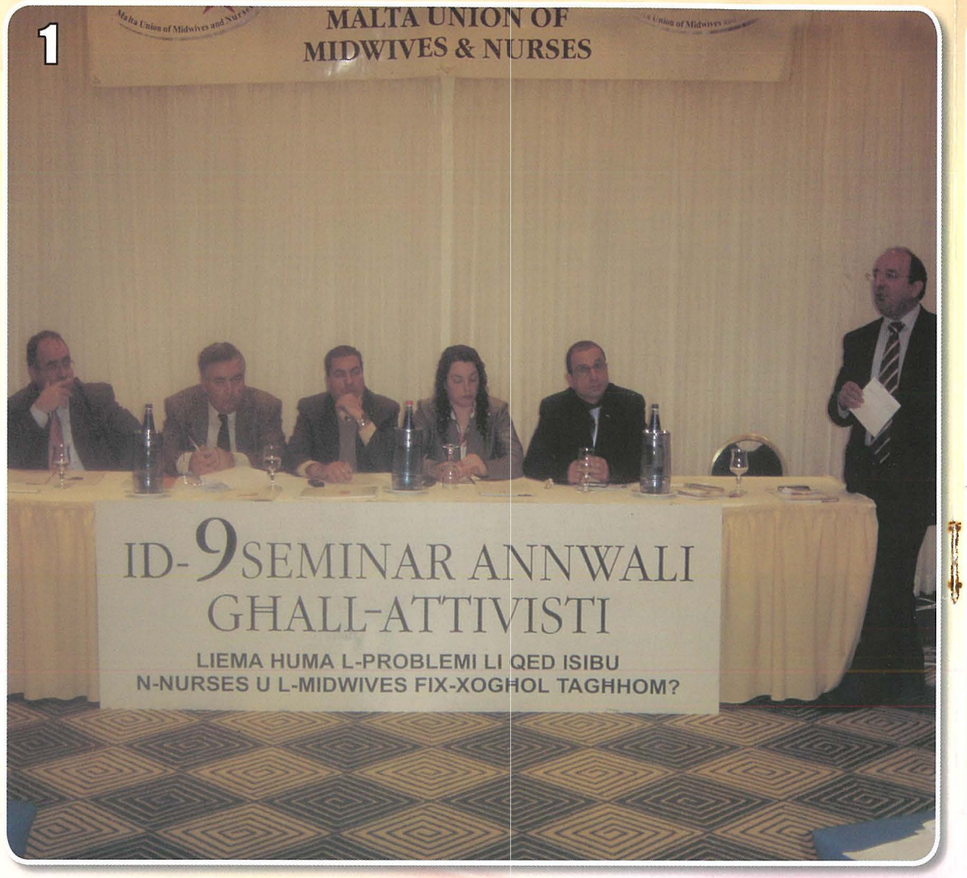
The Registrar
Council for Nurses and Midwives
Nurse Warrant Application
181 Melita Street, Valletta VLT 1129

Dr Ray Busuttil
Director General (Public Health Regulation)

Health Promotion & Disease Prevention Department · Department of Health Care Services Standards · Department for Environmental Health · DNSS Department of Nursing Services Standards · Awtorità dwar il-Mediċina

Palazzo Castellania · 15 Merchants Street · Valletta VLT 2000 · MALTA · Tel: (+356) 2299 2426, Fax: (+356) 2124 2884, www.sahha.gov.mt

From our diary
Mid-djarna...



1 & **2** SEMINAR GĦALL-ATTIVISTI TA' L-MUMN
Din is-sena wkoll il-Kunsill tal-MUMN organizza seminar għall-attivisti kollha tal-Union bit-tema – 'Liema huma l-problemi li qed isibu n-Nurses u l-Midwives fix-xogħol tagħhom?'. F'dan is-seminar kienu mistiednin il-Ministru tal-Politika Soċjali u l-Kelliem Ewlieni Laburista fuq l-istess settur. Peress li l-Ministru kien indispost ġie mistieden id-Direttur Ġenerali Servizzi mid-Diviżjoni tas-Saħħa.

3 Għal darba oħra l-*Pensioners Group Committee* tal-Union organizza attività oħra għall-membri tiegħu. Din id-darba kien imiss li nżuru l-ġżira sabiħa ta' Għawdex. Prosit lil dan il-*Group Committee* immexxi tajjeb minn Paul Bezzina.

4 Il-preparamenti u x-xogħol involuti sabiex 'Il-Musbieħ' jasal fi djarkom huwa intensiv u sostanzjali. F'dan ir-ritratt qed naraw l-aħħar fażi tiegħu fejn numru ta' membri qed joffru l-ħin tagħhom sabiex jippakkjaw dan il-ġurnal biex b'hekk wara jieħduh il-posta. Grazzi mill-qalb lil kull min huwa nvolut f'dan il-ħidma fejjieda.

Meningitis in Children

Dr **Joseph Mizzi** MD MRCP MRCPCH

Meningitis is a rare but serious disease. There are about ten reported cases every year in Maltese children. Every effort should be made to procect our children from meningitis because it can result in permanent neurological problems, such as hearing loss and seizures, and even death in about 5% of cases.

There are two lines of defence; firstly, children can be protected by immunisation; secondly, parents should learn how to recognize the signs of meningitis so that the ill child is brought immediately to medical attention. Early treatment results in a better outcome, usually with full recovery.

VACCINES

Meningits can be caused by viruses and bacteria. Viral meningitis is more common, but it is usually not serious. Many cases of viral meningitis manifest flu-like symptoms and often remain undiagnosed. Previously polio and mumps were significant causes of meningitis. These diseases have been practically eradicated by routine immunisation.

Bacterial meningitis is less common, but it is a more serious infection. There are three bacteria that commonly cause meningitis in infants and children after the first month of life. As late as the 1990's, *Haemophilus influenzae B* (Hib) was a common cause of meningitis. However since the introduction of the Hib vaccine, given at 2, 3 and 4 months of age, this form of meningitis has become exceedingly rare.

Streptococcus pneumoniae, or pneumococcus, is a common cause of middle ear infection and pneumonia. It can also cause meningitis (approximately one child every two years in Malta). The rate of pneumococcal disease in children was reduced dramatically with the introduction of the conjugate pneumococcal vaccine in the USA in the year 2000. The World Health Organization recommends that the pneumococcal vaccine should be included in the national immunization programme of all countries as a matter of priority. Indeed, it is currently under consideration for inclusion into the Maltese schedule. The pneumococcal vaccine is administered at 2 and 4 months of age, with a booster dose given in the second year of life. Children under five years of age who were not previously immunized can also recieve the vaccine.

Neisseria meningitides, or meningococcus, is the leading cause of bacterial meningitis. It can also cause septicaemia (blood infection) which has a worse outcome than meningitis. There are several strains of meningococcus, including group A, B, C, W135 and Y. Group B is the most common form of meningococcus disease in our country. A vaccine for meningooccus B is undergoing clinical trials, and hopefully it will become available in the coming years.

A polysaccharide vaccine is available that covers the other serotypes (ACWY). It provides short-term protection when travelling to countries where these forms of meningitis are present (e.g. Sub-Saharan Africa).

Meningococcus type C, although rare, is sometimes seen in young Maltese children and can result in death. It was far more common in other countries such as the UK before a vaccine against meningococcus C was included in their national schedule. This conjugated vaccine offers long-lasting protection against meningococcus C. It is given in two shots in infancy, with a booster dose at one year. Children over one year of age who were not previously immunized only need to receive one dose.

EARLY RECOGNITION

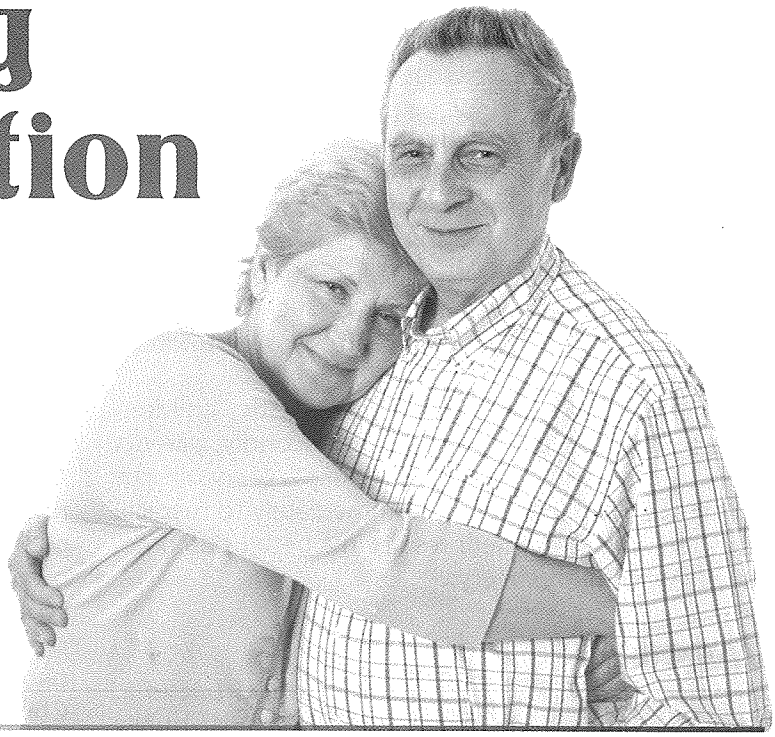
The symptoms of bacterial meningitis and septicaemia can develop rapidly, often within a few hours. The signs of meningitis are fever, severe headache, neck stiffness, vomiting, dislike of bright light and drowsiness. Infants and young children may not manifest the typical signs of meningitis. An infant may simply feed poorly, dislike being handled or become very lethargic. A shrill cry or unusual moaning should alert parents to the possibility of meningitis. Seizures (abnormal jerking movements and loss of consciousness) are rarely associated with meningitis and, in fact, most seizures in young children are simply the result of a high fever ('febrile fit').

A rash is an important sign to look for when a child is unwell with fever. It may start as tiny spots that looks like small pin pricks; may spread quickly and develop into large dark red blotches. These spots do not blanch – in other words, they don't fade if a transparent glass is pressed against the skin.

Parents should seek immediate medical advice in the following circumstances.

1. Infant less than 3 months with fever irrespective of the general condition.
2. Infant less than 1 year of age with fever if the child looks unwell.
3. Older child with fever and signs of meningitis (as above).
4. Child of any age with fever and a non-blanching rash.
5. If the general condition deteriorates even if the child had already been examined before.

Promoting rehabilitation of older people



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Loreto Ward, SVPR

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CHANGES ASSOCIATED WITH AGEING

As a person grows older, several organ systems experience an age-related decline in function. Some of these changes have little effect upon the daily performance of most old people (e.g. wrinkling and reduction in height). Other age related changes that can occur in the elderly such as arthritis, osteoporosis, dementia, visual and hearing loss or loss of muscle mass may result in frailty and weakness (Tideiksaar 1989).

CURRENT PLACE OF WORK

Currently St. Vincent de Paul Residence (SVPR) accommodates females and males with a bed complement of over 1050 beds, thus being by far, the largest institution for the elderly in Malta. Apart from delivering residential accommodation for the elderly, this nursing home aims at providing medical, nursing, social and spiritual needs of all residents. A high percentage of the elderly suffer from one or more chronic physical and/or psychological conditions. Their dependency level varies according to the disease and disability. Rehabilitation plays an important part in the delivery of care.

Doctors, nurses, nursing aides and care workers provide care on a 24-hour basis. Services of physiotherapists, occupational therapists, speech therapists and podologists are available from Monday to Friday at a stipulated time whereas social workers, a continence care specialist and an infection control nurse are also available on request. Moreover, pharmacy is daily accessible till 2.30pm from Mondays to Saturdays. Spiritual directors are on duty on a 24-hour basis.

Residents are usually admitted to a ward following a short stay in the Admission and Assessment Ward or from other wards in SVPR after requesting an internal transfer. However this is not always the norm as recently clients are being admitted directly to a ward either from Zammit Clapp Hospital, St. Lukes Hospital, Jean Antide Ward at Mount Carmel Hospital or admitted directly to the ward from their own home. Assessment by the Multidisciplinary Team (MDT) is carried out either at the Admission and Assessing ward or on the ward depending on the admission process.

REHABILITATION

> ***All nursing homes must provide rehabilitative services to every resident. 'The process of optimising opportunities for health, participation and security in order to enhance quality of life as people age'***
> *(WHO 2002).*

The process of rehabilitation aims at restoring optimum function following impairment due to illness or injury. Mair (1972) stated that rehabilitation is the restoration of an individual to his or her fullest physical, mental and social capabilities. Anyone with losses in their neuro-sensory or physical function can benefit from rehabilitative programs. However one should also take into account the needs and wishes of the person and the people nearest to them.

Rehabilitation may not always achieve the restoration of ability lost through diseases of old age, but at least it aims to help the patient to make the best use of those abilities which remain (Squlres 1996).

Although residents in nursing homes have a decline in functional capacity, dependency, passivity and apathy can be avoided or postponed by ensuring a safe and an encouraging environment around them. (Downton1993).

The recognition of rehabilitation of the older person can be enhanced by the provision of further education and training for nurses and other healthcare personnel.

ASSESSMENT

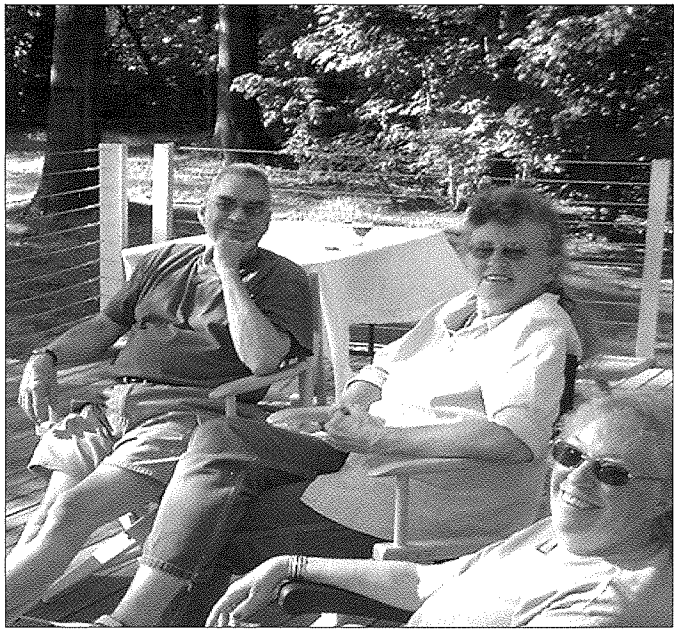
Geriatric assessment is a multidisciplinary approach that involves various combinations of geriatricians, nurses, physiotherapists, occupational therapists, speech therapists, social workers, pharmacists and other healthcare professionals.

During assessment of an elderly patient the team will help in identifying problems, resources, strengths and needs of services. Assessment forms a vital part in the development of patient - nurse relationship. During assessment it is advisable that a spouse / family member or friend to be present. In certain cases, the patient may find a full assessment an exhausting experience. In such circumstances the assessment can be completed over a couple of days. It is essential for the assessor to be supportive, understanding and sensitive to each patient's needs (Garrett 1987).

PHYSICAL EXAMINATION

During the examination the team can begin to identify the main problems. Following certain illnesses and disabilities the older person may present with a number of problems. The team then should be able to prioritise and alternative methods of action are discussed. Decision on what action to adopt can be taken by the MDT. A time frame is set up and reassessment is carried out from time to time so as to evaluate the progress.

In the course of rehabilitation the patient is encouraged to do more and more for himself, even if this means that he goes at a much slower pace than when everything is done for him. We should be familiar with each resident's fear and discomforts. Staff



shortage combined with increased workload will cause stress on staff and this will probably be perceived by the resident. Staff fatigue and personal worries can easily trigger irritability, which residents could interpret as threatening.

ENVIRONMENT

The environment should be assessed. Any factor that may hinder or enhance in the rehabilitation process should be identified. Action should be taken to ratify.

Environmental factors are important in maintaining the independence of elderly people. In general, it seems that environmental factors contribute to between a third and a half of falls resulting in injury (Morfitt 1983 cited by Downton 1993). Considering that most old people in nursing homes are physically and/ or mentally frail, and the environment in these homes is supposed to be 'safe', many objects with which they come into contact are in fact poorly designed, and seem in fact to increase risk of falls and injuries (Downton 1993).

Most falls in the elderly are caused by complex interactions of intrinsic and extrinsic factors. Approximately, one half of falls in the elderly can be mainly attributed to extrinsic causes such as poor lighting, slippery floors or furnishings that are too low or too high. The rest are caused by intrinsic factors such as gait, balance and sensory impairment, cognitive decline, depression, incontinence, polypharmacies or a number of chronic conditions such as drop attacks or hypothyroidism (Steinweg 1997).

Tideiksaar (1998) refers to slipping and tripping over obstacles, poor lighting, loose carpets, slippery floors, ill-fitting shoes, untied shoelaces and long

pants as factors which can cause falls. Furniture and aids such as chairs, commodes, armchairs, tables and walking aids may be hazardous as well (Steinweg 1997). In addition, Tobis *et al* (1985) hold that poor lighting exacerbates the visual changes associated with ageing.

In view of the multiplicity of extrinsic factors found as contributing to falls, environmental modifications can be a major therapeutic tool in fall prevention especially in residents with irreversible medical problems. Environmental fall management includes the assessment of the environment, adequate space, correction of potential fall hazards and the careful selection of devices together with professional advice from multidisciplinary team members, will help in rehabilitation process (Tideiksaar 1989).

Ironically, falls in nursing homes are probably a sign that there is a positive approach to rehabilitation (Chetcuti 1997). If the number of falls is low, it could be the result of overprotection or little activity.

Wards should be adequately equipped so those patients can do as much for themselves as possible. Height adjustable beds help patients to get in and out of bed unaided. Wards should be designed and clearly marked so that patients can find their way about to lavatories, dining room etc. The day and date should be indicated in bold letters and in a prominent area. Besides, daily newspapers, television and radio encourage interest in current affairs to our elderly. When caring with demented patients the staff should continually impart basic information about orientation. Families and friends can also assist in the rehabilitation process. They should be informed about all therapy being given and should be encouraged to be part of the rehabilitation team.

FACTORS WHICH MAY HINDER REHABILITATION IN ELDERLY

Residents may be suffering from multiple pathology and these may hinder potential rehabilitation. Polypharmacy may also inhibit rehabilitation. Besides, there are a number of elderly as well as caring personnel who may be sceptical and have very low expectations of rehabilitation. Moreover, in certain conditions such as patients suffering from depression, dementia and personality behaviour, rehabilitation may be hindered. *Healthcare personnel need to do things with the elderly residents, not do things for them.*

Each person is unique, irrespective of age. It is important how healthcare personnel address elderly patients. All residents must be treated with dignity and respect. Furthermore, emphatising what the person is going through is of utmost significance.

Healthcare personnel who help residents out of chairs when they are just about able to get up themselves, or wheel the patient to the dining room rather let them spend quarter of an hour getting there, are blocking rehabilitation out of misguided motives of kindness or efficiency. Nurses should work towards providing support to help older person achieve independence not restraining them.

ATTITUDES OF STAFF

The unique function of the nurse is to assist the individual, sick or well, in the performance of those activities contributing to health or its recovery that he would perform unaided if he had the necessary strength, skill or knowledge and to do this in such a way as to help him gain independence as soon as possible (Henderson 1966).

Hence, all healthcare personnel can do a great deal to help the older person feel at home and give support to residents who feel anxious or uncertain. This is more characterised when elderly residents are admitted into a new ward as this may be an enormous experience for them. They must be promptly welcomed so as to minimise their sense of loss or sadness.

Our primary goal as health carers is to enable our elderly residents to participate in activities of daily living mainly in self-care, productivity and leisure.

This can be achieved by enabling our residents to do things that will enhance their ability to participate or by modifying the environment to better support participation. Residents must be perceived from a holistic point of view.

Furthermore, all healthcare personnel must be reflective practitioners. Bailey (1995) comments that: "reflective practice requires practitioners to review their nursing actions and interventions critically". Reflection is intensely personal. Jarvis (1992) describes that "reflective practice is more than just thoughtful practice; it is the process of turning thoughtful practice into a potential learning situation". The experiences we encounter on the ward leave us with many new thoughts and feelings.

***Each resident* must** be actively involved in the therapeutic process since each person has an instinctive need to use time purposefully. This can help individuals gain health and well-being by using their biological capacities and capabilities.

Leave for short spells at home is recommended. Having some money to spend is almost as important as wearing clothes. Having money at hand perhaps to buy a packet of biscuits will give the patient a feel of independence and choice and not a sense of helplessness. A kitchenette on the ward, in the occupational therapy department or at the 'Activity Centre' can be used to encourage patients to assist or cook a favourite meal for themselves.

Outing to places of interests during which activities are performed will stimulate lively discussions between patients and staff, apart from bringing back memories. This will also help to sustain interest and mobility. Social activities organised by the 'Entertainment Section' of SVPR such as 'Tombola' and Barbeques and activities at the Activity Centre such as sing-songs and different indoor games are well worthwhile for the liveliness and lifting of morale. Mixing of sexes during these outings can be beneficial.

'Keep Fit' activities, in addition to individual physiotherapy, can be fun and promote physical activity.

CONCLUSION

Advances in public health science and medical technology have extended the lives of those with chronic illnesses. Care may be offered continuously by a variety of professionals in a coordinated manner, sensitive to diversity respecting the physical, psychological, social and spiritual concerns of each patient (Kyba 1999).

Elderly residents in each ward of SVPR should be given excellent care. Promotion of rehabilitation is indispensable. However, this depends on a healthcare team with strong interpersonal skills, clinical knowledge,

technical competence and respect for individuals. Moreover, good care should be informed, backed by scientific evidence, values and personal and professional expertise. Systematic and clinical knowledge are important, but so are compassion, communication skills including good listening techniques and experience. Moreover, nurses and healthcare personnel must be tolerant, and non judgmental.

As members of a caring team of an ever-growing number of ageing patients, all healthcarers play an important part in dealing with the problems associated with ageing. The need to treat clients holistically and to regard each resident as an individual with respect, dignity, patience and excellent caring attitudes, plays a major role in every profession.

Geriatric nursing is an ongoing process of updating education and knowledge, through research, seminars and sharing of experience with other healthcare personnel, whatever their profession. Besides, geriatric nursing is an entity on its own and in need of further educational development. It is vital that more importance is given to geriatric nursing by developing appropriate courses in this area.

Moreover, communicating efficiently and effectively with other disciplines is of utmost importance. Promoting rehabilitation of older people is not an easy task. Thus, this major goal can only be achieved by realising the importance of working within a multidisciplinary team anticipating and aiming the best to all elderly residents. By involving residents and relatives in the promotion of rehabilitation and allow them to express their wishes, reciprocal respect, trust and satisfaction is generated.

In addition, in order to succeed in the rehabilitation of the elderly resident, all healthcare personnel directly involved in the delivery of care and most of all, the resident, must be willing to incur a degree of calculated risk to retain independence and enhance quality of life.

It is imperative to keep in mind that when working with elderly persons, all healthcare professionals must aim to add life to years and not years to life.

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L-Ikel Għal Waqt l-Isports

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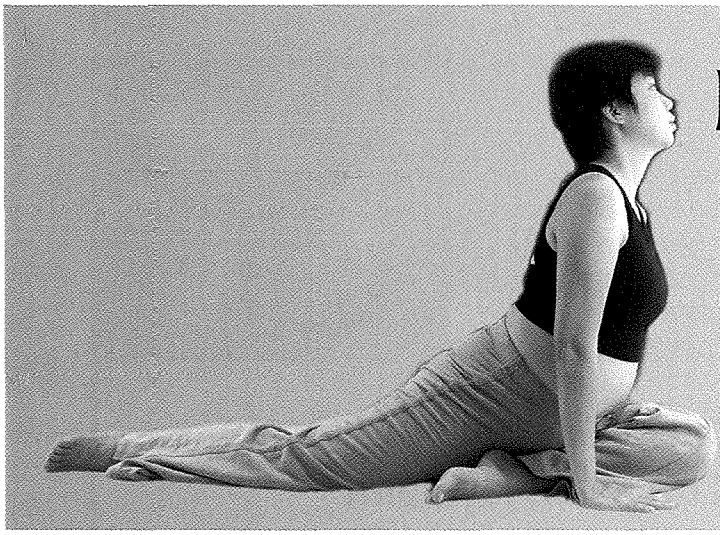
Dak li nieklu meta nagħmlu xi tip ta' sport, jiddetermina kemm aħna nkunu kapaċi nagħmlu u kemm nagħmlu suċċess f'dak l-isport. Bħala nutritionist li kelli kuntatt kemm 'il darba ma' nies li jipprattikaw xi sport, naf li ħafna sportivi ma jiġux mgħallma kif għandhom jieklu sabiex iżidu l-istamina tagħhom u għalhekk jiffunzjonaw aħjar.

Meta wieħed ikun jittrenja regolari, irid jipprepara ruħu mill-bidu biex imur aħjar. L-ewwel ħaġa li irridu nifhmu hija li l-karboidrati, bħall-ħaxix u l-frott jagħtu enerġija li naħluha bil-mod fuq tul ta' ħin u l-proteini jagħtu enerġija li tinħela malajr fi ftit ħin. Mela meta wieħed qed jittrenja, qabel xi event jew training, irid jieħu ammont ta' karboidrati biex jakkwista enerġija biex ikollu stamina biex jissaporti s-sessjoni kollha tat-training jew event. Għal din jista' jieħu frott, għaġin jew xi karboidrati oħra. Irid joħodhom madwar nofs siegħa u siegħa qabel jibda biex waqt l-eżerċizzju ikollu biżżejjed stamina u jixrib ammont mhux ħażin ta' ilma. Imbagħad waqt l-eżerċizzju irid jixrob ilma jew sports drink li jkun bażi ta' zokkor biex ma jixxuttax mill-ilma u jiġi deidrat fil-waqt li z-zokkor ikompli jagħtih enerġija biex ikompli l-eżerċizzju. Wara l-*event*, wieħed irid jieħu xi tip ta' proteini biex imbagħad iġib lura l-enerġija malajr u jpatti għall-enerġija li jkun uża. Min ikun se jagħmel xi sprint, irid jieħu proteini xi 45 minuta qabel l-isprint, biex ikollu ħafna enerġija x'juża fi ftit ħin.

Importanti ħafna li wieħed jixrob sew waqt it-training u l-isport. Min ma jagħmilx dan, jispiċċa deidrat u jista' jbatgħti minn uġigħ fil-muskoli u anke jispiċċa bla saħħa jew iħossu ħażin. Ikollu wkoll aktar ċans ta' aċċidenti, li jiġbed xi muskolu, bugħawwiġijiet u problemi oħra relatati ma nuqqas ta' preparazzjoni għall-isport. Min jiekol ikel li mhux addattat jista' jagħmel ħafna ħsara lilu nnifsu u jkun f'periklu ta' attakki tal-qalb, ħsara fil-muskoli u ħsara oħra li jistgħu iħalluh f'pożizzjoni li ma jkunx jista' jagħmel aktar sport. Għalhekk huwa mportanti ħafna li kull minn jittrenja professjonalment jew bis-serjeta jieħu parir minn għand nuttrizzjonista li jiggwidah dar kif u x'għandu jiekol biex jagħmel aktar suċċess fl-isport.

FLORENCE NIGHTINGALE MUMN BENEVOLENT FUND

Il-Florence Nightingale MUMN Benevolent Fund (FNBF) Group Committee organizza ċerimonja speċjali għal dawk in-Nurses u Midwives li rtiraw mix-xogħol fis-sena li għaddiet sabiex jiġi apprezzat ix-xogħol li huma wettqu kemm mal-pazjenti kif ukoll mal-kollegi tagħhom. Din iċ-ċerimonja bdiet b'quddiesa ta' ringrazzjament, u wara li l-President tal-Union qal żewġ kelmiet ta' l-okkażjoni, ingħataw Momentos komemorattivi lil dawk kollha li rtiraw mix-xogħol u huma membri fl-FNBF. Fir-ritratti jidhru l-konċelebbrazzjoni tal-quddies, l-ogħti taḷ-Momentos, u ritratt ta' dawk li rċevew il-Momento flimkien mal-President Paul Pace, Viċi-Presidenta Maria Cutajar, iċ-*Chairperson* tas-Social & Cultural Executive, Lora Pullicino kif ukoll il-Group Committees tal-FNBF li huwa magħmul minn George Fenech Chairman, Charles Grima Segretarju, Frans Agius Kaxxier u Carmen Abdilla, Josef Trapani u Marvic Azzopardi bħala Membri.



Post-Natal Depression: The darker side of motherhood

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INTRODUCTION

Having a baby is one of the most important and happiest events in a woman's life which requires an enormous life adjustment. Jones & Venis (2001) emphasize that despite this happiness and emotional wellbeing, the mother is vulnerable for depression. Green, Kitzinger & Coupland (1990), state that due to the changes taking place, memories of childbirth and the people involved may have a positive or negative effect; which ultimately may lead to short or long term emotional and psychological repercussions. Hence, for a woman childbirth represents a time for great vulnerability to become mentally ill (Eberhard-Gran, Eskild, Tambs, Samuelsen, Opjordsmoen 2002 & Dennis, Janssen, Singer 2004). Up to 80% of new mothers experience some kind of mood disturbances in the postpartum period. The woman may feel upset, alone, afraid and unloving towards her baby. Moreover she will feel guilty for having these feelings (eMedicine Health, 2006).

In Section 1, Postnatal Depression is examined in detail, together with its causes, signs and symptoms. Prevalence rates and psychological characteristics of Maltese women are also discussed. In Section 2, Postnatal Depression is discussed in relation to midwifery care. Finally in Section 3, literature about the women's experiences of postnatal depression is reviewed.

SECTION 1 - GENERAL INFORMATION

Postnatal Depression

Psychiatric disorders after childbirth are usually classified in three categories, postpartum blues, postnatal depression and puerperal psychosis. Postpartum women are at an increased risk for depression (Eberhard-Gran et al 2002). Postpartum depression has been used as an umbrella term for many postpartum emotional symptoms (Henderson & Jones, 1997). However Beck (1998) states that it is important to differentiate postpartum depression from postpartum anxiety disorders and panic disorders. The women may develop a disabling form of mood disorder called postpartum depression. This affects about 10% of childbearing women (Miller 2002, eMedicineHealth 2006) and may start from 24 hours post delivery to several months postpartum (Epperson 1999).

Postpartum depression is a non-psychotic depression episode that commences or extends into the postpartum period (Cox, Murray & Chapman 1993). As with depression presenting itself at other instances, postnatal depression can be mild, moderate or severe (Davies, Howells & Jenkins 2003). Early detection of postpartum depression by the midwife and other health professionals is of outmost importance (Hanna, Jarman, Savage & Layton 2004, Jones & Venis, 2001). Postpartum depression is a traumatic event that can even have lasting effects on the woman's confidence in herself as a mother. Moreover it affects the quality of life of the mother, whilst threatening the psychological and healthy functions of the mother, infant and entire family (Keng, 2005).

Causes of postnatal depression

The etiology of postnatal depression remains unclear. However, Townsend (2000) states that women who experience moderate to severe symptoms, probably possesses a vulnerability to depression. On the other hand, giving birth is a period of time where major changes are happening to the woman such as physical changes and emotional changes. Thus, the adjustment to these changes can contribute to depression (Jones & Venis 2001, Henderson & Jones 1997). Moreover, hormone imbalance is thought to play a role (eMedicine Health 2006). Other risk factors include mental illness before pregnancy, conflict in the marriage, loss of employment, mental illness including postpartum depression in the family,

poor social support from family and friends, stress or negative life events occurring during pregnancy, traumatic birth experience, separation from baby, a difficult baby and also a history of severe premenstrual syndrome (eMedicine Health, 2006). Nonetheless, the new mother is on call, 24 hours, 7 days a week (Borg, 2004).

Signs and symptoms of postnatal depression

Symptoms of postnatal depression include difficulty in sleeping, early morning wakening, loss of appetite and weight, difficulty in thinking, concentrating or making decisions, feelings of guilt, inadequacy and worthlessness, loss of energy, anxiety, decreased interest in sex and also feelings of rejection (Miller 2002, eMedicine Health 2006, Davies et al, 2003). Moreover, in cases of severe depression the mother may also have thoughts of death or suicide (Epperson 1999, Dennis et al, 2004).

Prevalence rate of Postnatal Depression in Malta

From the literature reviewed, the author found a local study that was carried out by Felice, Saliba, Grech and Cox (2004), which aimed to find out the prevalence rates and psychological characteristics regarding depression in pregnancy and postpartum in Maltese women. Pregnant women (n=239) were randomly chosen and interviewed during the booking visit and again at 36 weeks' gestation by a telephone interview. At 8 - 10 weeks' postpartum another interview was carried out at the participants' home. Twenty cases were found to be depressed; a prevalence of depression of 8.7%. However, only 9 cases were 'true' postpartum depression, the remaining 11 cases were previously diagnosed as depressed during pregnancy and remained the same during the postpartum period. The results indicate that prevalence rate of postnatal depression in Malta is low. This can be due to the strong supportive system found in the Maltese culture, which includes emotional and instrumental support. Moreover, postnatal depression was associated with problems with the in-laws, marital conflict, poor emotional support and dissatisfaction with social contact.

Similarly, Miller (2002) states that cultures with low prevalence rates are characterised by strong social support for the new mother and that prevalence rates of postpartum depression is 'significantly' different amongst cultures.

SECTION 2 - MIDWIFERY CARE AND POSTNATAL DEPRESSION

The midwife's role

Motherhood needs physiological, psychological and social role adjustment. Perinatal mental health is becoming more prominent and it's an important matter for the midwife and other health professionals (Currid, 2004). The midwife is one of the professionals that are in close contact with pregnant women and mothers. Moreover, the midwife is involved in labour and delivery and in the first few days after birth. Hence the midwife can play a potentially critical role in identifying and helping women that are facing these difficulties (Ball, 1987). Sweet (2002) classifies the midwife as that health professional who may screen and educate about postnatal depression. Moreover, Mauthner (1997) states that midwives have a responsibility to help women at risk of, or are experiencing postnatal depression. The midwife can teach the family about the signs of postnatal depression and identify those women that are at risk. Thus, if need be the midwife can refer the women to the appropriate specialists. However to be able to do this, the midwife should have enough knowledge on postnatal depression, in order to be able to identify and refer those women that are at risk. Hence staff education on this issue is deemed as a 'prerequisite' (Borg Xuereb, 1999).

The midwife needs to be sensitive to the woman's needs. Women with postnatal depression normally think that they are going insane, have a fragile self esteem and worry that if they express these thoughts with a midwife or other health care professional, they will be 'locked up' or that someone will have a right to take their baby away from them (Epperson, 1999). The most vital elements to help new mothers to prevent postpartum depression are education, support and practical help. Besides providing physical needs for the new mother, the midwife and other health care professionals should be aware and on the alert to the psychological needs.

Identifying postnatal depression

When postnatal depression occurs for the first time, the woman and her partner may fail to identify it as a disorder and attribute its symptoms as a 'normal' procedure after having a baby (Jones et al, 2001). As a result, depressed new mothers usually do not seek help and therefore don't receive the required psychiatric help (Veltema, Perreard, Bousquet & Manzano 1998). On the other hand, women with a previous episode of Postnatal Depression are at an increased risk to experience future episodes of depression (Dennis et al 2004 & Epperson 1999). Epperson (1999), states that complications of labour have not been consistently shown to predict the occurrence of postnatal depression. However, Koo, Lynch & Cooper (2003) states that women having an emergency delivery are twice as likely at risk for developing Postnatal Depression. Thus the responsible midwife should meticulously assess the woman and identify those with certain risk factors, so that proper referral can then be made (Dennis et al 2004). Moreover, her approach

should be one of warmth and acceptance. The midwife should be honest and empathetic (Ugarizza, 2000). Many fears and worries can easily be solved or prevent by the alert and responsible staff.

Screening for postnatal depression

The main aim in screening is to prevent depression and/or prevent the situation from becoming worse. Providing early treatment interventions are the first step in dealing with this problem (Beck 1998, Jones et al 2001). It is of utmost importance to keep in mind that each mother and each depression vary, so individual care and planning is required. Comprehensive care from the midwife needs to be provided to the mothers and infants; hence it is essential that screening for psychosocial difficulties is carried out in depth.

Various instruments used to measure postpartum depression have been derived from conceptualizations of postpartum depression as a major depression occurring after birth with symptoms like any other depression experienced outside the postnatal period (Ugarizza 2000, Henderson et al 1997). Screening should be performed repeatedly by the midwife during the perinatal period (Davies et al, 2003). On the contrary, Dennis (2005) stated that any psychosocial or psychological interventions will not decrease the number of women who develop Postnatal Depression.

One such instrument is the Edinburgh Postnatal Depression Scale (EPDS) which is used internationally in the perinatal period (Buist et al, 2002). It is a simple, easy, quick, self report questionnaire (see appendix A). Other screening tools include Beck's Depression Inventory (see appendix B), Postpartum Depression Prediction Inventory and Postnatal Depression Screening Scale.

The art of communicating with the woman

Farrer (1990) states that by attending to the comments of the woman and also assessing her attitude to the staff, to the baby and to her family, the midwife will be in a better position to anticipate those factors that may be causing psychological stress. The midwife needs to ascertain how the mother is feeling and particularly note the expression of anxieties, tearfulness or unhappiness (Henderson et al, 1997).

As a result of this, the midwife will have a greater insight into the underlying problem. The midwife needs to encourage the nervous or insecure mother to care and handle her baby whilst reminding her that the midwife is there to assist her and to teach her various skills. It is crucial that the midwife talks and listen to the mother. It has been suggested that if the mother is allowed and encouraged to talk about her birth experience and feelings with the midwife, this can be therapeutic and helpful to the mother (Mauthner 1997). The midwife should have the ability to promote a helping relationship between the woman and herself, to communicate effectively, to provide the mother with empathic support and be able to listen at times of need. **Listening to the mother entails more than hearing the words of the other person** (Henderson et al, 1997).

Education

An aspect of psychological care can be carried out by educating the mother about the various postpartum moods and affective disorders. Only through education can the mother feel free to openly discuss her discomfort (Ugarizza, 2000). Nonetheless, Borg (2004) emphasized that this can be done by teaching the women to adapt themselves to evolve the day around the baby's demands.

Empowerment

In psychological care, another important factor of considerable value is empowerment. Barker, Stevenson & Leamy (2000) developed an empowering interactions framework which focused on the belief that people with mental health problems need to feel in control of their lives as much as possible. Therefore, collaboration is the key, participation is the way and self determination is the ultimate goal (Barker et al, 2000).

Awareness

Buultjens & Liamputtong (Article In press) state that stigma is usually attached to those women who are unhappy after childbirth, are not coping with the demands of motherhood and don't bond with their baby straight away. Due to this, postnatal depression can be a **shocking** and **isolating** experience for women. It is also a complex illness with varying degrees, reasons for onset and medical treatment. Hence, by making the community aware of postnatal depression, fewer women will suffer in silence

Support

The responsible midwife must keep in mind that all women, irrelevant of social class, race or education level are at risk for mental health illnesses during the perinatal period. The woman and her family should be provided with a sensitive, humane and a caring environment to that this will help them to feel strengthened and supported whilst being treated (Currid 2004, British Columbia Reproductive Care Program 2003). The midwife needs to notice and highlight the strengths and protective factors of the woman and also that of her baby and family. Sandall (1996) states that were there was **continuation of midwifery care**, the mother might be more ready to talk to the midwife about her feelings. Moreover, the midwife will be in a better position to note any changes in the mother's mood and behaviour. A

collaborative team approach which includes the midwife and other health professionals is needed in order to offer the woman and her family the help and support required as early on as possible (British Columbia Reproductive Care Program 2003).

Social Support and Medical treatment

Support from the midwife is transient and only part of the wider social support system which is a vital aspect when providing psychological care to the parents. The midwife can help the family to identify and utilize these sources. As in any counselling process; including the significant others and family members will be helpful. Giving information about newborn care, social assistance, homemaking and other supportive services may also be helpful (Jones & Venis, 2001).

When treating mental illness the midwife and other health professionals view the mother in the context of the complexity in her life. A Bio-Psychosocial-Spiritual Framework aids in early identification, assessment and treatment of the woman with a mental illness during the perinatal period.

Medical treatment such as antidepressants and anti-anxiety medications is case specific and based on a risk benefit ratio. Antidepressants tablets such as fluoxetine (eg. Prozac) are commonly prescribed for postnatal depression (Miller, 2002).

SECTION 3 - WOMEN'S EXPERIENCES OF POSTNATAL DEPRESSION

Hanley & Long (2006) conducted a study that examined the experiences of Welsh mothers that were diagnosed with postnatal depression. It also investigated whether postnatal depression is socially determined. Participants (n=10), primagravida or multigravida, were selected from 30 women diagnosed with postnatal depression. Data collection was carried out by qualitative interview using a semi structured questionnaire. Maternal age ranged from 17 – 33 years. The results highlighted that the mothers (n=8) had barely any knowledge of the effects of postnatal depression before becoming pregnant. Moreover, they were unwilling to reveal or share their feelings. Most of the participants were from lower social economic group hence this pertained that the mother returned to work which resulted in little quality time for their family and their babies. Support network was absent and the mothers relied on social services and voluntary support groups. Although the findings are not representative of the whole population due to a small sample, this study raises the issue of whether postnatal depression validate its medical definition or whether it is socially constructed.

Similarly, Buultjens & Liamputtong (Article in Press) carried out a study that examined the women's experiences of depression after childbirth. Participants (n=10), included women that had been diagnosed and admitted to a hospital mother and baby unit in Australia. Data collection was carried out by qualitative methodology using an in depth interview. The findings indicate that most of the women believed having a baby was an exciting, happy time. Although they acknowledged that it would be a difficult transition they were unsure as to what level. Many of the women were not ready to the 'extent' to which their lives would change. Contrary to Hanley et al (2006), the primagravid mothers came from high socio-economic backgrounds. These participants tended to perceive motherhood as having 'less' or 'no reward' when associated with their employment status. When experiencing emotional problems, it was noted that these women felt isolated because they had no one to turn. Moreover, they were not informed that help was available. On the other hand, those that knew about this help had a tendency to avoid it, as they were embarrassed of the way they were feeling. It seems that none of the women were informed about postnatal depression.

Due to the small sample of mothers interviewed the findings cannot be generalised. However the in depth data collected generated useful and rich information. Maternity carers should provide the mother with required assistance should the need arises. Moreover, if the mothers experience this 'overwhelming emotional reaction' health professionals must not assume that it's occurring due to individual inadequacy.

Mauthner (1997) conducted a study which was carried out in England, to explore and understand the women's experiences and accounts of postnatal depression. Participants (n=40), included primaparous and multiparous mothers. Data collection was carried out by a qualitative approach, by using s semi structured, in depth interview which lasted over three and a half hours. Nearly half of the participants (n=18) experienced postnatal depression. However, these women were reluctant to reveal their feelings and difficulties to their partners, family, friends and health professionals.

The results highlighted that the majority of women were disappointed with the help they received from health professionals. One of the reasons was that these health professionals failed to notice that the mother was having difficulties. These findings indicate that it is vital that the midwife and other health professionals are aware and have enough knowledge on postnatal depression. Thus, then they will be in a better position to recognize, provide or suggest means were appropriate support can be given.

From the three studies reviewed (Hanley & Long 2006, Buultjens & Liamputtong - Article In Press, Mauthner 1997), **it seems that women are disappointed with the help received and are not being given enough information about postnatal depression. On the other hand, women are reluctant to share their feelings.**

Implications for practice

The author believes that to prevent and screen the mother for postnatal depression, community visits should continue **at least** till 4 weeks' postpartum. Locally, the community visits are over by the 10th day. It will be beneficial if the community visits are extended or other extra visits are carried out around the 4th and 6th week post delivery. During these visits the midwife can examine the mother and perform EPDS (Edinburgh Postnatal Depression Scale). Then during the 6 week postnatal visit another EPDS can be performed. Hence whilst the mother is still receiving perinatal care, she is being screened throughout. Locally, at present, counselling sessions for postpartum depression are carried out by a psychiatrist. These could be carried out by a midwife. A midwife must be able to give the necessary supervision, care and advice to women during pregnancy, labour and the postpartum period. Moreover, she has an important task in health counselling and education, not only for the women, but also within the family and the community (International Confederation of Midwives, 2005).

Conclusion

When evaluating the outcomes of postnatal care, it makes no sense to care for the person's physical needs only; it is essential to take into account mental health needs. As future midwives, together with the skilled qualified midwife, we must treat these mothers as individuals, focusing on their emotional, physical, psychological and social well being. Nonetheless, Borg Xuereb (1999) stated that education must be dedicated to developing skills and standards of care in midwifery; hence it will be reaching the needs of the childbearing mothers and their changing needs Therefore it is important that the midwife professionally assesses, plans and if need be implements and evaluates the care plan for the susceptible or affected mother. Awareness among the health care providers is of utmost importance so that postpartum psychiatric disorders can be identified early and treated efficiently; aiming to reduce unnecessary prolonged suffering.

The midwife should provide individualized care in order to assist the mother in her coping process, offer her psychological support which includes counselling and advice and moreover encourage empowerment to boost self esteem. Through this the mother will receive **high quality maternity care** that **ensures her physiological, psychological** and **social well being.**

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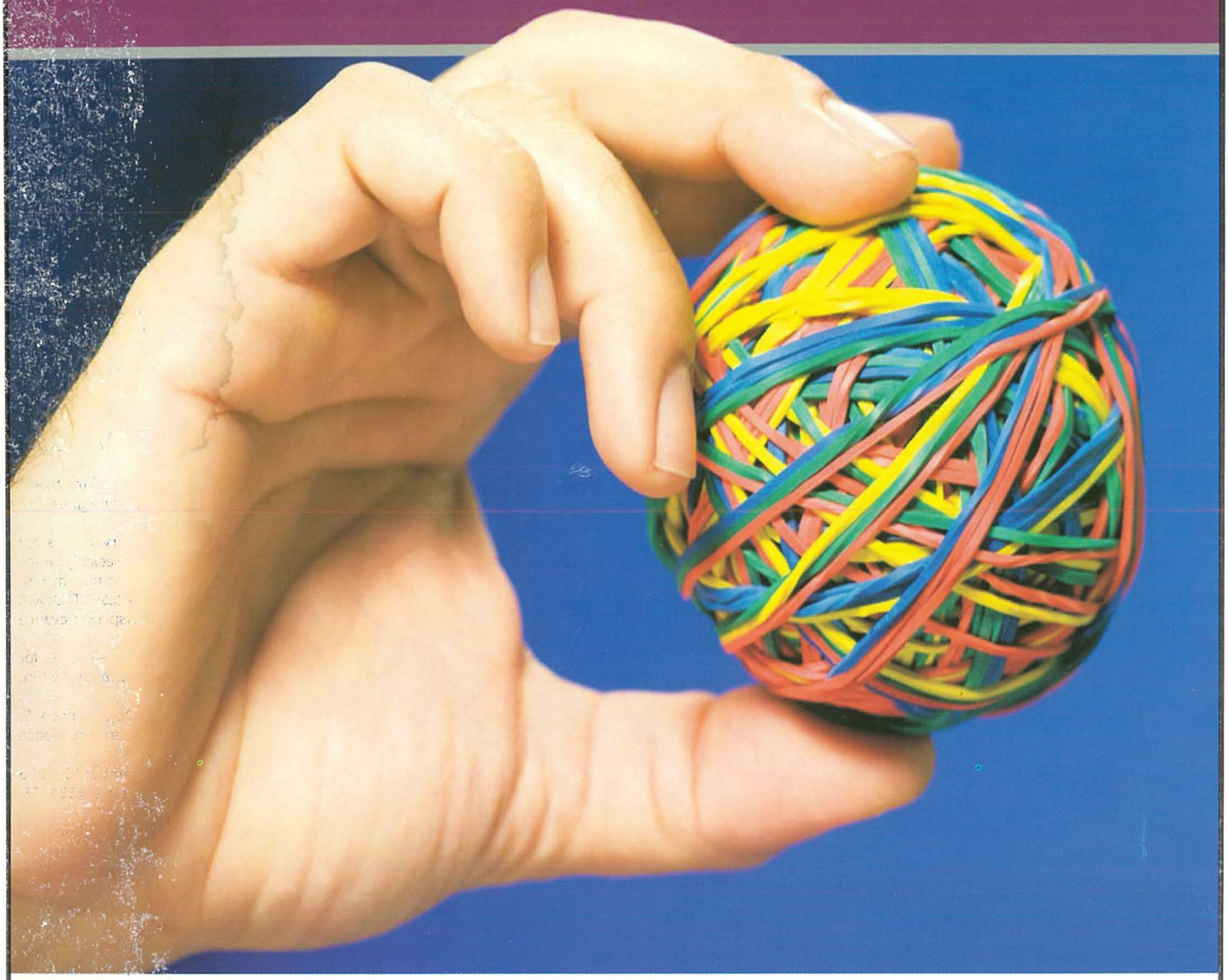

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