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editorial

Lately I was reading an article on how it is often said that it is essential to create a "Knowledge Sharing Culture". Effective collaboration and communication which spans amongst all nurses and midwives will give knowledge management the boost it really needs. In order to enrich our proffessions, current culture change must start at the individual. Every nurse and every midwife has a sphere of influence along with their own individual knowledge, and this is where I believe a knowledge sharing culture can begin.

Creating a Knowledge Sharing Culture

What does it mean to create a Knowledge Sharing Culture?" Well it's about making knowledge sharing the norm. To create a knowledge sharing culture amongst health proffessionals,one needs to encourage nurses and midwives to work together more effectively, to collaborate and to share - ultimately to make organisational knowledge more productive. But we all need to remember a few things:

We are talking about sharing knowledge and information – not just information.

The purpose of knowledge sharing is to help nurses and midwives as a whole to meet their objectives. We are not doing it for its own sake.

Learning to make knowledge productive is as important if not more important than sharing knowledge.

Changing a culture is tough. Not only does it mean change – which has always been tough – it means seeing our work in a different way. It means revealing our hidden prototype like the unspoken acceptance that "knowledge is power".

Motivating Knowledge Sharing

The real answer is to help nurses and midwives see for themselves that knowledge sharing is in their personal interest. The old prototype was "knowledge is power". Today it needs to be explicitly understood that "sharing knowledge is power".

If nurses and midwives understand that sharing their knowledge helps them do their duties more effectively; helps them in their personal development and career progression; rewards them for getting things done (not for blind sharing); and brings more personal recognition, then knowledge sharing will become a reality.

So what are the reasons to share that should motivate people? Here are a few: -

Knowledge is a perishable. Knowledge is increasingly short-lived.If you do not make use of your knowledge then it rapidly loses its value.

By sharing your knowledge, you gain more then you lose. Sharing knowledge is a synergistic process – you get more out than you put in.

To get most things done in any team, including us nurses and midwives, today requires a collaborative effort. If one tries to work alone – one is likely to fail – we need not only the input from other people but their support and buy-in. Being open with each other; sharing with them, helps evryone achieve ones objectives.

Making it Happen

My personal view is that knowledge sharing starts at the individual. After all - if one is a Nuring or Midwifery officer, a manager, a staff or enroled nurse, a student nurse, he/she is still an individual. Each one of us has his or her duties, set of objectives and sphere of influence.

If you believe that knowledge sharing is the way to help you; your department, meet its objectives, then start to practice it within your sphere of influence and encourage others to do the same – "lead by example". The higher up the organisation the more influence you have. And remember, sharing is not just about giving.

Many nurse and midwives have pusued their studies and reached high level of knowledge both in nursing and midwifery studies, let us all start sharing our knowledge and information so that our proffessions will move forward. This journal is giving every opportunity for all those nurses and midwives who would like to publish their studies and other articles especially those related with our work, as nurses and midwives. We should all be proud to share what we have learnt with our colleagues so as to be able to give a better service to our clients.

the editor

messaġġ *from the president*

Paul Pace President

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This is the first issue of our journal for the year 2010. Nurses and midwives have received in their salary the last raise in pay as part of the collective agreement of the civil service which was signed with the government five years ago. This year MUMN will join the other unions and start negotiating another collective agreement which will have an impact on all the civil servants (including nurses and midwives) within the civil service. MUMN will have its own agenda to push forward in the negotiations such as the need to update the on call allowances –something which have never been revised for the last years and the specialization structure which need to be discussed. MUMN will see that all issues in the agreement are beneficial to all nurses and midwives and that the working conditions will not deteriorate but actually improve.

Every union in this country had to take a stand on the electricity and water tariffs and MUMN felt that such tariffs will cause hardships not just to the pensioners and low income workers but also to MUMN members. Politics are part of every union portfolio but politics have to be used for the benefit to MUMN members and to the general population and not to support one party or the other. Unfortunately being a small island with high political content as part of our life style will always give raise to speculations. MUMN have always been consistent and loyal and spoke when injustice was being made. A union is never in government but works with the government when the government wants to meet and discuss in true spirit of dialogue. When such doors are closed or no spirit of dialogue exists, going to the streets to protest is not just a right but it is a democratic right every union has. Why request political parties to take part? – obvious, it is the politician to change the tariffs and a protest is just one of the methods for the population to voice its disagreement. MUMN was part of 11 unions with the participation of 63% of the workforce in Malta. So MUMN was part of the majority of the unions and workers protesting.

MUMN took the official stand on the Primary Health Reform and made its stand official. Documents related to nursing and midwifery have been handed in to the minster as to be part of discussion in order to introduce nursing on the existing depleted document. Also MUMN made it clear that while it will look for the interest of the nurses and midwives involved, it will also be involved to see an improvement in the primary health with no new financial burdens on our patients.

MUMN will be issuing several posters to all wards in all hospitals on the discussions going on with the government. Vacation Leave (letter sent to all members), nursing premium (equal to all) and other issues will be in the posters and its very important that all members inform themselves either by phoning the union or speak to one of the union representatives. Such discussion can lead to industrial actions but MUMN will organize a rally to explain its members the outcome of events.

MUMN is the only shield which nurses and midwives have to protect them from other unions of other professions, from the health division and from central government. MUMN members should not take their working conditions for granted and that even maintaining what we have today is a continuous challenge. But MUMN will be signing not only a new agreement for all nurses and midwives this year but also will see that nurses and midwives will not suffer any consequences due to lack of staff. After all if there is a shortage of nurses and midwives in this country, neither the nurses nor the midwives nor MUMN are too blame.

Paul Pace

messaġġ mis-segretarju ġenerali

Colin Galea Segretarju

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Dawn l-ahhar gimghat l-MUMN kompliet il-hidma taghha sabiex ittejjeb il-kundizzjonijiet tax-xoghol tal-membri taghha.

L-akbar ugih ta' ras jibqa dejjem l-Isptar Mater Dei. In-nuqqas ta' Nurses u tas-soddod qed joholqu stress qawwi li qed iwassal ghal burnout. Il-compliment tan-Nurses fis-swali qieghed dejjem jonqos u l-average illum huwa ta' bejn 3 u 4 Nurses kull sala meta dan suppost ikun ta' 6 Nurses. Sentejn ilhu l-MUMN qablet mad-Divizjoni tas-Sahha li hemm htiega urgenti li jingiebu jahdmu Malta Nurses barannin b'kuntratt definit sabiex tittaffa l-problema tan-nuqqas pero jidher li m'hemmx rieda genwina minn naha tal-Gvern ghaliex is-sitwazzjoni baqghet l-istess. Forsi l-Gvern ghandu problema biex ihallas il-pagi ta' dawn in-Nurses? Ma nafx. Li naf hu zgur li pajjizi ohra li kellhom l-istess problema irnexxielhom jimpurtaw Nurses barannin. Ghaliex ahna differenti?

Barra li n-nuqqas ta' Nurses fil-kompliment qed johloq problemi ta' aktar xoghol fuq in-Nurses prezenti, bil-konsegwenza li qed nitghabbew b'responsabbilitajiet aktar milli suppost, qed johloq ukoll diffikultajiet sabiex niehdu l-vacation leave. Biex imbaghad tkompli titfa l-melh fuq il-ferieta qed ikollna sitwazzjoni fejn in-Nurses qed jinqalghu mis-swali fuq bazi regolari biex imorru d-Dipartiment ta' l-Emergenza sabiex jiehdu hsieb il-pazjenti rikoverati f'dan il-post. Dan igib mieghu frustazzjoni enormi u demotivazzjoni li thalli l-marki taghha fuq sahhet l-istess Nurses. Nurses fi sptarijiet ohra wkoll qed igarrbu n-nuqqas ta' Nurses u problemi sabiex jintlahaq il-compliment u biex jittiehed il-vacation leave.

Issa li s-swali l-godda fl-SVPR imtlew hemm bzonn urgenti li l-Gvern jiddeciedi fejn ser jalloka il-100 kas ta' social cases li ser jinholqu din is-sena. Huwa tard wisq li nibdew nahsbu sabiex nibnu swali ohra godda. Ahna nissugerixxu li jittiehdu tlett swali li hemm vojta fl-Isptar Karen Grech. Isiru fejn isiru hawn ukoll ser inhabbtu wiccna ma l-istess problema li l-Gvern irid isib ta' l-anqas 15 il-Nurse ghal dawn is-swali. Pero l-Isptar Mater Dei ma jistax jibqa' jimla s-soddod tieghu b'dawn il-kazijiet.

L-MUMN prezentat tlett dokumenti lill-Ministru tas-Sahha sabiex jigu nkluzi fil-process tar-riforma fil-Kura Primarja. Tnejn minnhom jitkellmu dwar il-Family Health Nurse u l-Family Health Midwife filwaqt li d-dokument l-iehor fih proposti kif il-Health Centres u l-Bereg ta' llum ghandhom jigu zviluppati. Issa nistennew lill-Ministru sabiex iniedi sensiela ta' laqghat sabiex jigu diskussi dawn it-tlett dokumenti. L-MUMN minn dejjem kienet favur li jkollna Kura Primarja b'sahhitha u effetiva kemm minhabba l-fatt li c-cittadin ser jigi kkurat ahjar kif ukoll jonqos il-piz minn fuq l-Isptar Mater Dei.

Ftit tal-granet ilhu l-International Council of Nurses ippubblikat il-Call for Abstracts ghall-konferenza li ser isir Malta f'Mejju tas-sena d-diehla. Kull min huwa interessat jitsa' jara din is-sejha fuq il-website tal-Union. Ninkoraggixxi li jkollna ammont sostanzjali ta' abstracts ghal din il-konferenza storika li ser isir f'pajjizna fejn madwar 3.500 Nurse minn madwar id-dinja ser ikunu fostna.

Grupp ta' 60 Nurse ser jattendu l-konferenza tal-Commonwealth Nurses Federation li ser issir f'Cipru. Din ser tkun esperjenza siewja peress li ser jigu prezentati papers interessanti u addatati ghall-pajizna. Numru sabih ta' 15 il-Nurse Malti ser jipprezentaw ukoll paper f'din l-istess konferenza. Kien jinhtiegu hafna preparamenti minn naha tal-Union sabiex dan seta' jsehh u nixtieq nirringrazzja lil kull min ta' sehmu sabiex din l-esperjenza ghal dawn in-Nurses tkun ta' success ukoll.

L-MUMN qed tipprepara wkoll il-proposti li ser jigu mressqa ghan-negozjati sabiex jintlahaq Ftehim Kollettiv gdid ghall-haddiema kollha fis-Servizz Pubbliku. Il-Ftehim ezistenti jiskadi fl-ahhar ta' din is-sena u ghalhekk ftit tax-xhur ohra ghandna nigu mitluba mill-Gvern sabiex nibdew nitkellmu fuq wiehed gdid.

Hafna Nurses avvicinawna sabiex isir tibdil fl-istil ta' l-uniformi. Jixtiequ li t-tunic, ghalkemm tibqa' bl-istess kulur, tkun aktar pulita u ma tibqax bl-istil kif inhi llum. Il-Kunsill tal-Union ser jiddiskuti t-talbiet ta' dawn in-Nurses fil-laqgha li jmiss. Peress li l-kulur ser jinzamm l-istess ikun jista' jsir uzu miz-zewg stili differenti skond l-istagun.

Ghallum tkellimna bizzejjed. Nixtieq niehu din l-opportunita sabiex nawgura Ghid Hieni lilek u l-familja tieghek kollha.

Colin Galea

hospitalization's paradoxes

The Danish existentialist philosopher and theologian Søren Kierkegaard wrote: "It is the duty of the human understanding to understand that there are things which it cannot understand, and what those things are. Human understanding has vulgarly occupied itself with nothing but understanding, but if it would only take the trouble to understand itself at the same time it would simply have to posit the paradox". Paradoxes are spoken of in the attempt of harmonizing opposites. The hospital setting is an excellent place whereby opposites dwell side by side.

The greatest paradox that the hospital stands for is that it is primarily a place of life and death. Some be born for this world and others leave it. For certain people hospitalization has a definite time frame whereas for others their time of hospitalization keeps lingering on. Sometimes the intensity of the experience can put one in a big jeopardy as to when s/he can finally be licensed. Hospitals have the capacity to embrace the beautiful and the ugly. They are living witnesses of life's ever present contradictions.

Hospitalization can be a time of jubilation. Healthy babies are delivered; fractured bones mended; dreaded symptoms are diagnosed as benign; and pains are curbed. Hope flourishes and God's goodness becomes visible. On the other hand for quite a number of people hospitalization is a time of remorse. Babies are born dead or deformed; dreaded symptoms are confirmed; breasts are amputated; injuries and wounds are declared as permanent. Hope is shattered. God seems miles away.

For some, hospitalization is a moment of preciseness. The consultant might say to the patient: "As we suspected, you have a hot gall bladder. I can schedule you for surgery tomorrow and you should be home by the beginning of next week". For other people it can be a time of disappointing impreciseness. The consultant might conclude: "We're just not sure what is bringing about all this. By the time being you can go home and we are going to carefully monitor the symptoms. Up to now we do not know what to do more". Some people get answers they look for whereas others get answers that they least expect. Others still remain without an answer. In the hospital the patient experiences the paradox of being both free and bound. S/he is free of life's everyday responsibilities. All appointments and demands are called off. Sympathy not obligations runs the show. Nevertheless illness binds the person. Schedules and services are planned by others. A person's capabilities and energies to fulfill definite purposes, to have good time, may be brutally weakened. Thus, while

Hospitalization's paradoxes

being disengaged from outer responsibilities, the sick patient is inwardly controlled. Moreover, the suggestions for reengagement with life outside the hospital take on a predominantly tentative character.

The hospitalized patient undergoes the paradox of solitude when s/he has various contacts around her/him. Privacy is seldom at the hospital. Having said that the patient ends up doing many things which normally in her/his family would do them with others, such as eating, sleeping, watching TV, going to sleep at night or waking up in the morning. In the midst of these contacts loneliness pervades the patient. Sickness makes strange what once was familiar. The same inhabited body now feels odd. In the past the body was trusted and has been a faithful companion. Now it has become more like a stranger, discharging odd sensations and pain signals, originating unstable moods as well as an upsetting drowsiness. During illness a person is no longer familiar with her/his own body. This proves to be a very distressing paradox.

The patient feels embarrassed because s/he does not feel at ease with her/his feelings. The burden of the disease renders a person emotionally drained. For most of the time the patient is literally assailed by feelings of fear, guilt, anger, and confusion. It is not uncommon if a patient expresses these awful feelings through unbridled sobbing, torturous self-recriminations and dejecting apathy in front of her/his family. In sickness the patient loses both internal and external control. The hospitalized patient faces another subtle paradox. Strictly speaking medical technology has been invented to keep a person's life going. Unfortunately these technological resources tend to be more focused on the disease than towards the person who has the disease. Thus, there seems to be more interest in the livers than the owners of the livers or the heart as a pump rather than the heart as the centre of feelings. Hence the patient is satisfied that s/he is being cured from the disease and distressed because s/he is more than the disease s/he is combating. In his book "The Nature of suffering and the Goals of Medicine", Eric Casel carefully distinguishes between the disease and suffering. "Suffering is experienced by persons, not merely by bodies, and has as its sources in the challenges that threaten the intactness of the person as a complex social and psychological entity". As he rightly points out suffering extends beyond physical pain. Suffering can be understood as anything that jeopardizes the intactness and wholeness of the person. It takes place when anything that a person has emotionally invested is menaced. It happens on various levels at the same time.

Suffering is paradoxical in itself. It is both universal and personal. It surfaces and can be described within the life of a particular person, at a specific time frame. Personal significance of suffering is a basic aspect of personhood. A deep understanding of human suffering has necessarily to consider this subjective interpretation of suffering. The ironic almost tragic paradox is that the disease is carefully monitored whereas personal suffering is mainly overlooked.

Finally hospitals challenge the patient to face the paradox that science works wonders and at times it is so limited. Hospitals are annexes of society's "infinite aspirations and finite limitations". Patients discover that medical technology is very limited. And that these limitations practically mean "medical failures". These failures become arbitrary for the person at that point in time. It is irrelevant if a cure is found later for that disease. In that patient's experience cure is not possible when s/he desperately needs it.

Hospital is the meeting place of paradoxes and life contradictions. It is an entire grey area. It is a place wherein certain earnest prayers are answered whereas others seem to be unanswered. Some say that they are miraculously healed. Others seem to be destined to suffer long agonies and fears. Hospital is the place where the minister of blurred realities, the hospital chaplain, carries out her/his ministry. Hospitalization's paradoxes cannot not make my ministry, together with that of my colleagues, all the more interesting, fascinating, challenging and highly effective.

Fr Mario Attard OFM Cap

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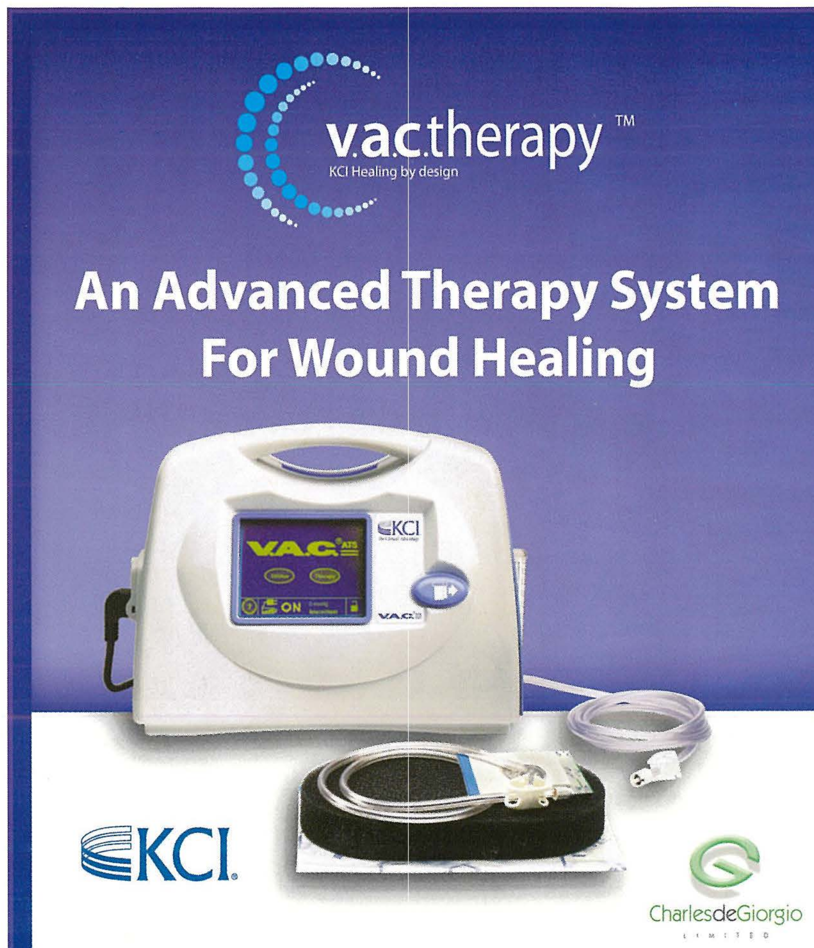

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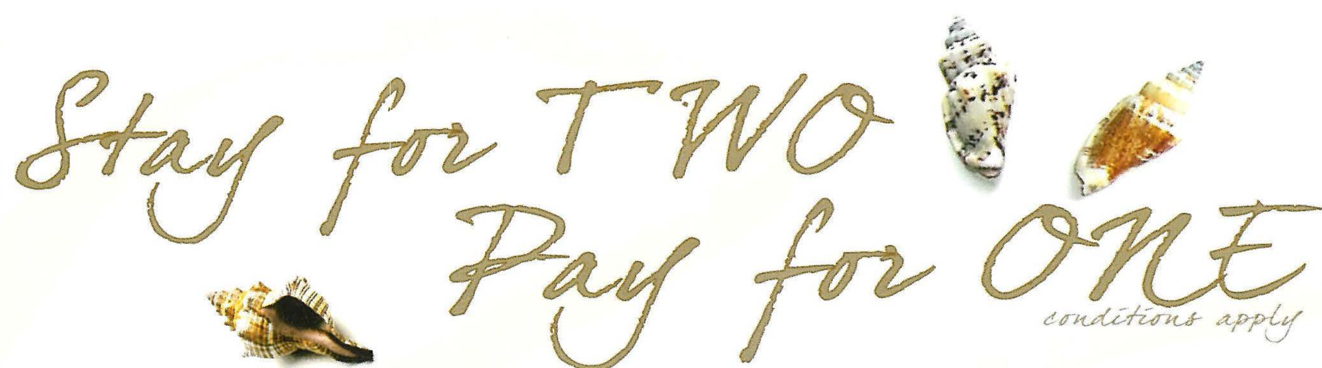

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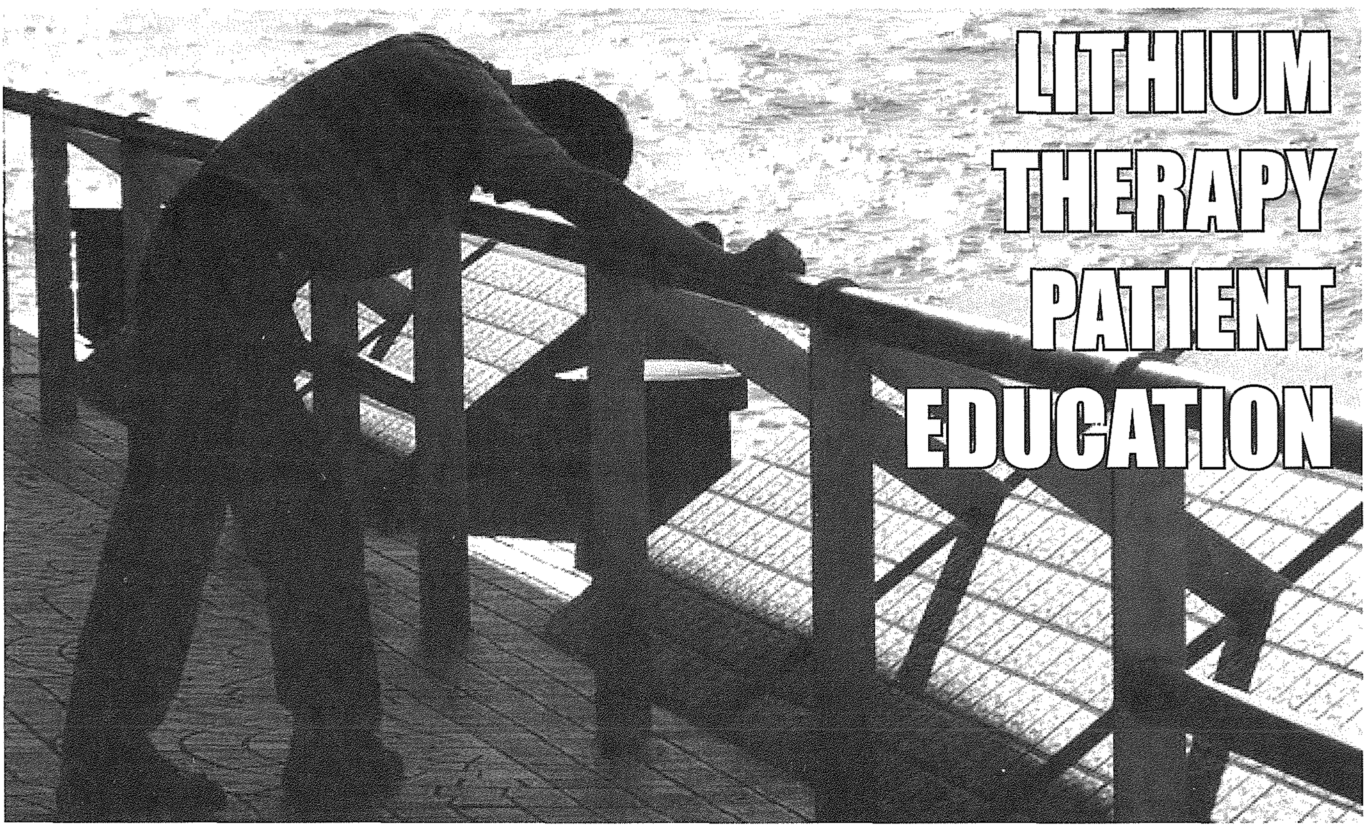


LITHIUM THERAPY PATIENT EDUCATION

INTRODUCTION

Bipolar disorder, also known as manic depression, is not uncommon. About 1-2 % of the population suffers from bipolar disorder at a serious level and about as many again have a less severe form, which nevertheless has an impact on their lives (Angst and Gamma, 2002). Bipolar affective disorder can alternate from periods of depression, combined with other periods of feeling 'well' and then 'too well'. To many it may appear that the mood swings are part of someone's personality and it may take several years to be diagnosed as a serious illness rather than a variation in the witnessed mood changes.

The most dramatic appearance of bipolar is puerperal mania and depression. One of the main difficulties for people who become manic is that they have great difficulty in recognizing that they are ill. They often agree that there is a change, but do not accept that as abnormal. Often when someone is in a severe state of depression, his/her thinking may be so distorted that he/she regards it as a punishment rather than an illness. Manic depression is a condition that runs strongly in families. People having bipolar disorder usually have a relative who either suffers from bipolar or recurrent depression. Genetic association is high because the closer the blood ties to someone with bipolar, the higher risk of developing the illness. The onset of illness is often in teens (Goodwin and Jamison, 1990). Bipolar disorder can be considered a psychotic illness when, either in depression or mania, the person loses touch with reality and experiences delusions or hallucinations. The consequences of the illness can be devastating, and may lead to marital break-ups, unemployment, alcoholism and drug abuse.

When symptoms are mild, sufferers may be still likely to misuse alcohol and drugs (Hunt, 2005). Because of this, the illness tends to be masked and changes in behavior are blamed on the use of drugs and/or alcohol rather than the true underlying illness. Hunt (2005) continued to state that if a person has an episode of mania, he/she has a 90 percent chance to experience a further episode of mania or depression at some point in time in the future.

Symptoms typically begin during adolescence or early adulthood, and continue to recur throughout life. Men and women are equally apt to develop bipolar affective disorder.

PHYSICAL EFFECTS OF MANIA

1. Nutrition/hydration problems
2. Overactive
3. Over-talkative
4. Abundant energy
5. Sleep disturbance
6. Over-involved with others

7. Neglected personal grooming
8. Neglected personal hygiene
9. Loss of weight

Vella, (2006).

DEPRESSION

The characteristics of normal unhappiness, clinical depression and depression in bipolar disorder are very similar so this makes diagnosis difficult. If a health professional feels a strong sense of frustration that he/she cannot connect with someone who is depressed because of that person's slow communication, it is probably retardation that the health care professional is picking up on. One of the most useful psychological symptoms noticeable in making a diagnosis of bipolar is a loss of the ability to experience pleasure or enjoyment. Suicidal thoughts at some level are almost universal in any serious depression.

PHYSICAL EFFECTS OF DEPRESSION

1. Psychomotor retardation
2. Sleep disturbance
3. Constipation
4. Menstrual irregularities
5. Reduced sexual drive
6. Fatigue
7. Agitated if anxious
8. Lethargic and withdrawn
9. Neglected personal hygiene and grooming
10. Weight loss or gain

Vella, (2006)

ASSESSMENT

A detailed initial assessment is essential for effective management of the depressed patient; it is likely this could take more than one consultation. This is usually initiated in a secondary-care setting. However the primary-care team can be important in monitoring treatment and assessing response. Part of the assessment is to help the clinician and patient understand the cause of the depression. This can be seen as predisposing factors (e.g. family history, deprivation), precipitating factors (e.g. loss, life events, physical illness) and maintaining factors (e.g. poor social support, low self esteem) [Jenkins et al, 1992].

Key aspects of assessment may be:
1. Severity
2. Duration
3. Social network
4. View of self
5. Suicidal thoughts
6. Past history
7. Biological systems

DRUG THERAPY

Antidepressants are effective in major depression, if given as a therapeutic dose, and as suggested by Paykel and Priest, (1992) the course of antidepressants can be divided into three phases:

The Acute Phase, where there is usually a delay of three to six weeks before antidepressants become fully effective and changing the treatment may be suggested if patient fails to improve;

The Continuation Phase is when the patients' concordance with such regime is unfortunately poor and provision of education is needed. Relapse is more likely to reoccur in these patients and longer courses of treatment may be needed due to their difficult lifestyle and severe illnesses;

The Prophylactic Phase is when recurrent episodes are present and long term treatment may be considered. Treatment should not be stopped suddenly; the reduction of dosage is spread over four weeks.

There are Indications that the risk of suicides has been reduced when therapeutic doses are used. All antidepressants cause a variety of side-effects (BNF, 1997; MeReC, 1991; Avery, 1997).

Medication is not the only part for management of BPAD. As suggested by Hunt (2005) the treatment of depression in bipolar disorder is more complicated because antidepressant drugs can cause a switch from depression into mania.

LITHIUM THERAPY

Lithium is a drug which is used extensively in everyday psychiatric practice, not only in the treatment and prophylaxis of recurrent bipolar affective disorders but also in treatment of mania (Ferrier et al, 1995). Lithium remains the core of long-term treatment as a mood stabiliser. Although it seems to be an old fashioned treatment, Schou (1998) confirms that "no other treatment has been consistently found to be more effective in preventing recurrence, particularly of mania but also of depression". Lithium is a simple salt and not a synthesized pharmaceutical. The mode of action of Lithium remains to be understood and it is unlikely that it works directly on any neurotransmitter receptor in the brain. Hunt (2005) explains that

the most popular theory is that it affects secondary messenger system beyond the receptor. For a long time Lithium was the only medication available for the treatment of bipolar and mania. Nevertheless, Lithium is still the reference treatment for mania today.

The dose of Lithium for those with BPAD is at least 100 times the intake in a healthy diet. The usual therapeutic dose is 400-1000 mg daily. There is a decrease in the volume of Lithium distribution according to the age, reduction in skeletal muscle mass, and in total body water with an associated increase in body fat. Foster (1992) states that, "Although absorption of Lithium is generally unchanged by ageing, the volume of distribution and renal clearance of Lithium is substantially different in older people".

Lithium toxicity may occur not only at the time of drug initiation, but also in aging patients who have apparently tolerated Lithium well for a number of years. Factors that may predispose to sudden onset toxicity in Lithium maintained patients include addition of new medication (including diuretics) or dehydration. Foster (1992), has suggested that monitoring of intra-erythrocyte (RBC) Lithium levels may help to avoid serious adverse effects.

SYMPTOMS OF LITHIUM TOXICITY

1. Anorexia
2. Vomiting
3. Diarrhea
4. Hand tremors
5. Lethargy
6. Ataxia
7. Vertigo
8. Fever
9. Decreased urine output
10. Decreased blood pressure
11. Irregular pulse
12. Impaired consciousness
13. Seizures
14. Coma
15. Death

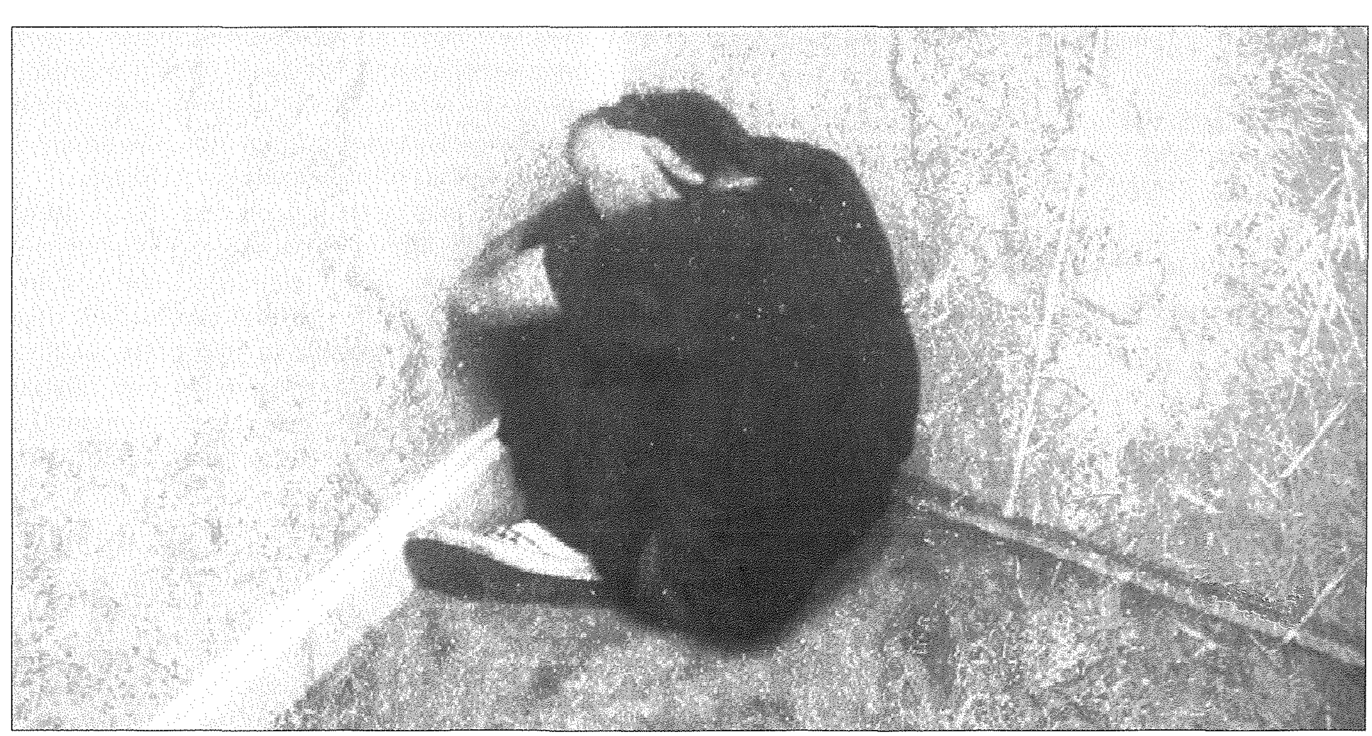
Vella, (2006)

MONITORING

In long term use, therapeutic concentrations have been thought to cause histological and functional changes in the kidney. Lithium salts have a narrow toxic ratio and should not be prescribed unless facilities are available for monitoring plasma levels every three months. It is recommended that the blood test is done at least 12 hours after the last Lithium dose because high readings can occur if the blood tests are taken earlier. NICE, (2006), suggests that thyroid and kidney tests are also needed every six months. The practice nurse has an important role in making sure these tests are carried out. It is essential that patients are adequately informed about:

1. How to take the preparation.
2. What side effects to expect, both in the short or long term and signs of possible toxicity.
3. Why regular blood tests are important.
4. The potential for interaction with other medicines and with undercurrent illnesses.

Such patient information is essential, not only



to minimize the complications and dangers of therapy but also to improve compliance. Ongoing supervision is important. Follow up needs to be tailored to each patient depending especially on the severity and risk assessment. It is more likely that repetitive instructions, followed by feedback, reinforcement and reassurance improves compliance.

Ideally the patient should be reviewed every two weeks. If there is a satisfactory response visits may be lengthened to six to eight weeks.

The mnemonic **screen** may provide a helpful checklist for these reviews.

Assessment of the severity of **s**ymptoms may be facilitated by repeating the questionnaires or the use of mood charts, but most importantly is listening and observing the patient.

Concordance is harder to assess as some patients may say that they are taking the tablets when they are not.

Risk assessment must be repeated, especially in the acute phase of treatment. If the nurse believes that the patient is a suicidal risk, he/she should treat this as a matter of urgency and discuss these concerns with the doctor.

Education can only follow an assessment of the patient's understanding and ability to receive information.

Encouraging the patient is a vital part of caring for people with depression.

Negotiating may well be necessary as patients may be unhappy with their treatment and have not yet discussed this with their GP who prescribed it. It is important to have clear guidelines on how such information is shared within the primary health care team to prevent the nurse being caught between GP and patient.

(Northampton shire guidelines for the Recognition and Management of Depression in Primary care, 1996)

EDUCATING PATIENTS AND RELATIVES

An aspect of care is often highly appreciated by patients is acceptance and patience. It is common to think that a visit to someone in an acute phase of the illness has not been productive but surprisingly often, patients remember and appreciate a health professional's care even if they did not appear to appreciate it at the time. Building this sort of relationship is important if a clinician is to help people with bipolar or mania in the long term. Psychological treatment is aimed at building on this aspect.

The nurse should establish a good nurse/patient relationship. Nursing interventions lead to the development of trust and confidence in the care received. These interventions include sitting with and talking and listening to patients, helping relieve stress, doing 'extra' things and being friendly and offering help. She/he has to plan with the patient several tasks, such as setting up together a schedule of where the patient has to be at specific times. Ensuring a patient to take good care of his/her personal hygiene and giving attention to ensure a well balanced diet and fluid intake. This will help the patient in having regular bowel movements. Encourage activities as this will release excess energy, and in any case educate the patient on how important it is for her/him to have good rest periods.

Suicidal thoughts at some level are almost universal in any serious depression, so suicide is a risk which always needs to be considered. It is a final outcome for about 10-20 percent of people with bipolar disorder. Health professionals may feel reluctant to raise and discuss suicide. Asking in a straightforward but empathic way, emphasizing that this type of thinking is common, is usually the best approach.

All patients should be warned of the dangers of driving and operating machinery while taking antidepressants. Prescriptions for antidepressants should be small in quantity and where appropriate, medication should be supervised by a friend or relative. From my experience during my mental placements in July 2009, I noticed that patients ask for the prescription every time they go for the visit with their consultant. i.e. if they visit him every week they will have a weekly prescription and if they come every month they will have a monthly prescription. In this way the social worker when visiting the patient at home, she can easily notice if the patient is taking his medicine accordingly.

Psychotherapy has been reported to be of good benefit for older adults, including family therapy, and group therapy. Many patients benefit from talking with others with a similar illness. Self help groups can also be invaluable to help both patients and carers to cope more effectively. Professional support and patient information remain an essential part of routine care within the primary health care team.

CONCLUSION

Our attitude towards antidepressants may vary in both patient and clinicians. Indeed in dealing with the pain of others it can confront us with our own

pain. In order to treat our patients more effectively, we need to recognize and deal with our own stigma first. There is potential for nurses to develop shared care of people with depression with their GP colleagues. We need to support these people and tolerate differences within our society. We need to believe that everyone is equally valuable and should be treated with dignity, compassion and respect.

This role incorporates the utilization of different resources, such as liaising with other members of the family and the multidisciplinary team and accessing knowledge for the benefit of the patient. Sherwood (1997), writes that we can play an important part in the "healing outcomes of patients' autonomy, empowerment, security, comfort, relaxation and peace are the goals of caring".

Diane Duca SN
EN-SN Conversion Course

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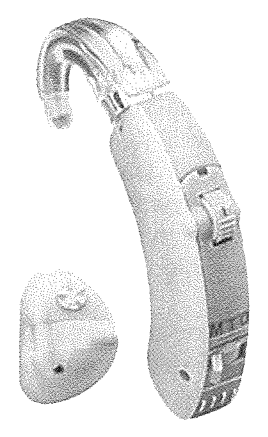

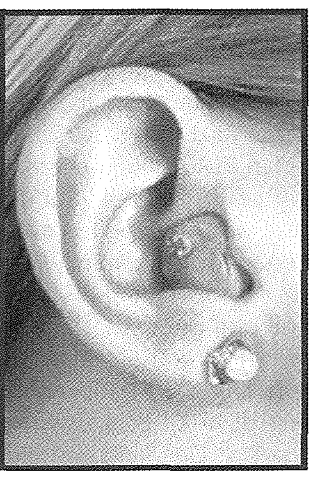

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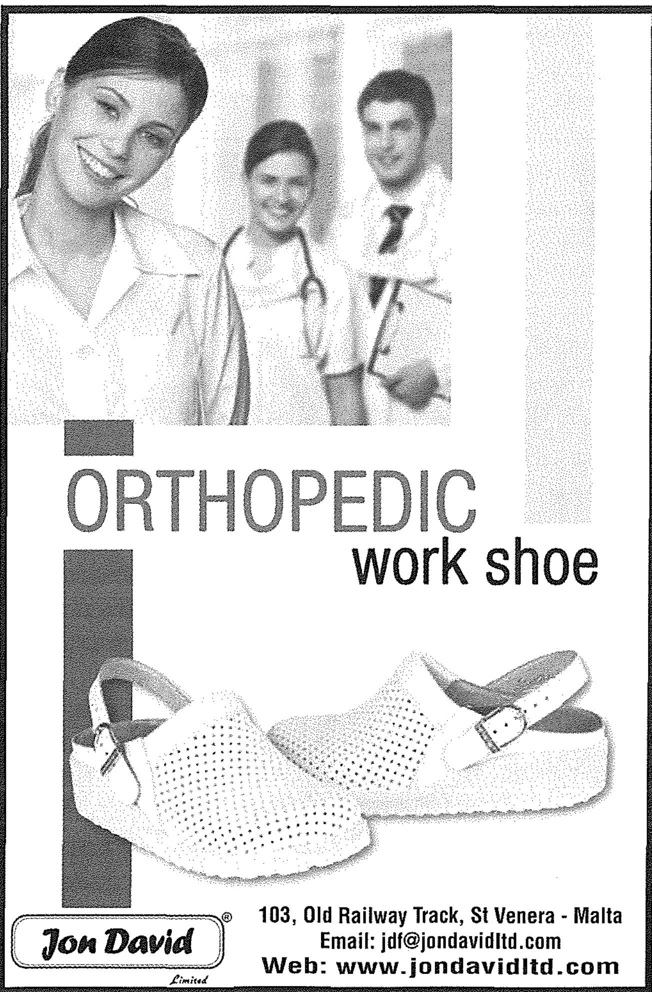
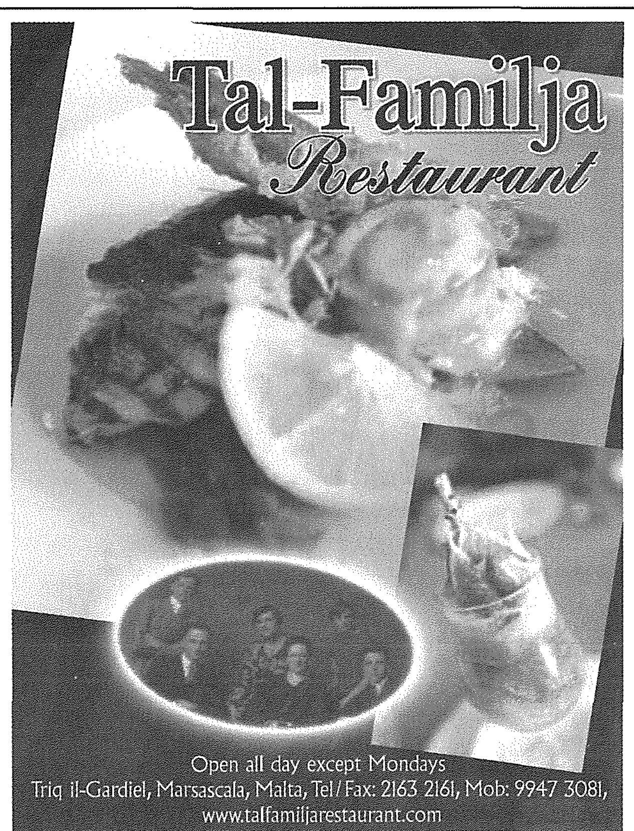


Rapport Anwali ta' Hidma tal-MUMN Group Committee SPBH – 2009

- Nixtieq nibda dan ir-Rapport billi nghid li l-maggoranza assoluta tan-Nurses tal-isptar huma kolla membri fi hdan l MUMN li dejjem appogjaw lill-Kunsill immexxi mill- President is-Sur Pawlu Pace. Dan minkejja l attentati ta' skreditu kontrieh li sehhew bhal daz-zmien sena. Anzi, ta' min wiehed izid, li matul din is-sena il-membri mill-SBPH komplew jisdiedu, bit-tishib ta' membri godda.
- Matul ix-xahar ta' Marzu l-mangement ta' SPBH iddecieda li n-Nursing Officers li qed jahdmu wkoll matul il-lejl jigu mwaqqfa milli jkomplu b'dan ix-xoghol. Dan kien qed jigi propost wara li minn zmien qabel, zewg Deputy Nursing Officers, li ukoll kienu qed jidhlu in charge matul il-lejl, gew imwaqfa wkoll. B' konsegwenza ta' dan, waqt ix- xoghol bil-lejl, in-nurses ta kull sala ikunu qeghdin jitghabbew b'responsabilitajiet amministrattivi minbarra x-xoghol normali taghhom. Ghalhekk wara li giet imsejha laqgha man-nurses involuti, intalbet laqgha mad-Direttur Generali Servizzi fil-prezenza ta' l-Amminstratur Mediku ta' l-isptar fejn intlahaq ftehim sabiex kollox jerga lura ghal kif kien fil-passat, bl inkluzjoni wkoll ta' l-istess zewg Deputy Nursing Officers imsemmija.
- Sa mis-sena 2007 kien ilu mgharuf li is-sala NRU ghandha tigi trasferita ghall-isptar Karen Grech. Minn dak iz-zmien ukoll kien ilu mwieghed li l-istaff complement ghall-din is-sala ghandu jizdied kif suppost. Minkejja l-weghdiet li saru l-istaff compliment baqa' ma zdiedx. Ghalhekk wara diversi tentativi l-MUMN spiccat biex harget direttivi lin-nursing staff tas-sala sabiex ma jammettux aktar minn sitt pazjenti u biex ma jsirux clerical duties fl-assenza tan-Nursing Officer. Xi gimghat wara zdiedu zewg nurses biex bihom u bl-allokazijoni tar-relievers, is-sala setghet tiehu l-ammont totali ta' pazjenti. Issa li suppost it-trasferiment lejn l-isptar Karen Grech huwa imminenti, ll-union qed titlob tahdidiet mal-awtoritajiet dwar garanziji ta' kundizjonijiet ghan-nurses li sakem qed jinkiteb dan ir-rapport dawn it tahdidiet qed jigu rrifjutati sabiex b'hekk l-MUMN ma jibqalhiex triq ghajr li tohrog direttivi godda ghal dan ir-rigward.
- Fid-dawl ta' dawn l attegjamenti li qed jittiehdu minn nahha tal management wiehed bla ma jrid jipprejokkupa ruhu ghall-gejjieni. Il-hsibijiet li tinfetah Palliative Ward fl-isptar Boffa, iz-zieda ta' aktar konsulenti fil qasam tal-onkologija, t-trasferiment tas-servizzi tal-onkologija ghall-isptar MaterDei u x'se jigri mis-sala tad dematologija, li dwarha ftit qed jissemma, huma lkoll fi hsibijietna u nhossu li l-informazzjoni dwarhom m'hiex cara minn naha tal-management. Fid dawl ta'dan kollu, ahna bhala r-rapprezentanti tal-membri taghna jehtieg naraw kontinwament kif in-nurses se jkunu affetwati fil-qadi ta dmirijiethom f'kull stadju ta' l-izvilupp tal-imsemmija pjanijiet. Dan kollu sabiex in- nurses kollha jkunu f' pozizjoni li jghatu servizz ta' kwalita, kif wara kollox huwa mistenni u li jixraq lill-poplu Malti.

Denis Darmanin, Chairman
SPBH Group Committee - MUMN



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New data shows **alli**® plus diet significantly reduces dangerous visceral fat

Presented at the 1st International Congress on Abdominal Obesity in Hong Kong in January 2010

A new study that used state of the art MRI technology reveals that taking **alli**® (orlistat 60 mg) while following a reduced calorie, lower-fat diet can lead to a significant reduction not only in weight but also in dangerous visceral fat.[1] Visceral fat surrounds the vital organs in the abdomen and, in excess, increases the risk of life threatening diseases.[2-7]

The research, carried out over three months at Europe's largest imaging centre, illustrates the changes taking place inside someone's body as they take **alli**. It reveals that overweight adults (BMI ³ 28 kg/m^2) using **alli** in conjunction with a reduced calorie, lower-fat diet not only lost 5 per cent of their body weight, but importantly, 10 per cent of this dangerous visceral fat versus baseline.[1] Results also showed that at week 12 **alli** significantly reduced waist circumference, the best practical marker for visceral fat.[1]

These latest findings, when considered with existing data, suggest that **alli** plus diet not only helps people lose 50 per cent more weight than dieting alone, but also improves health.[8]

Dr Rexford Newbould, GSK study investigator and scientist at the Clinical Imaging Centre in Hammersmith Hospital, UK said: "While it's well-known that overall weight loss of 5-10 per cent is beneficial, what is not so well-known is that the health benefits occur because visceral fat, the fat stored deep within the abdomen, is lost. This new research shows that when people lose weight using orlistat 60 mg in conjunction with diet, they lose visceral fat."

THE REAL BURDEN – VISCERAL FAT

Visceral fat is metabolically active fat which, in excess, can increase the risk of chronic diseases such as type 2 diabetes and heart disease, two of the leading causes of death worldwide.[9] It is these health complications that have the biggest impact on the personal and public burden of the obesity epidemic.

These results show that by losing weight with alli people can not only look better on the outside, they can be healthier on the inside too. We know that most people lose weight to look better on the outside, but losing excess fat on the inside is just as important.

Waistline and cholesterol reductions

Not only has **alli** plus diet been shown to significantly reduce weight compared with dieting alone, but it also reduces waist size. Additional data presented today show that **alli** was significantly more effective than placebo in reducing waist size, with an average loss of 4.5 cm (1.8 inches), over 6 months of treatment.[10] Levels of total and LDL cholesterol were also significantly lower in those people taking **alli** compared with placebo.[11]

Professor Stephan Jacob, Endocrinologist & Diabetologist, Cardiometabolic Institute, Villingen Schwenningen, Germany said: "The size of your waistline is a good way to tell if you have excess visceral fat. People who have too much weight around their middle have a greater risk of developing type 2 diabetes and heart disease than those who carry weight around the hips. Losing weight – and specifically visceral fat – can help reduce the likelihood of serious health problems."

The MRI study follows a recent report launched by leading obesity experts, calling for greater public awareness of visceral fat. It included results from a European survey of over 12,000 people showed that 88 per cent of them do not know what visceral fat is but, after hearing about the associated risks, 61 per cent said they were more motivated to lose weight.[12]

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the attributes of a good nurse

Catherine Sharples,
SRN, BSc(Hons) (Nurs), MSc (Nurs)

'What do you think makes a good nurse?' This is a question I have been asking different people I met over the last few months or so. Answers differed mostly according to where the respondents were coming from.

Patients were almost all quick to say that a good nurse has to be caring and one who knows how to deal kindly with people. However, when confronted by the question: 'What about her knowledge?', they quickly acknowledge that knowledge is important. For teachers, a good nurse needs to be knowledgeable. However, they are quick in adding that how she talks with people especially patients or patients' relatives can make or break these same people who rely on her for care, support and information. Children emphasize the kindly attributes and the smiling face while mothers insist on knowledge and watchfulness. Doctors insist on knowledge and correct, timely decisions. For nursing managers knowledge is important together with strong physical endurance and a certain degree of flexibility regarding her responsibilities.

This was not a scientific study but a simple feeler on what people think is a good nurse. Discussion with colleagues and other nurses highlighted the fact that a nurse may not always be good since she is human. Also, a kind caring nurse may not be knowledgeable. A nurse who is not knowledgeable may even be dangerous, but can a nurse who does not seek to update her knowledge and apply her newly updated knowledge, be called a 'good' nurse?

Lay people seem to take it for granted that all nurses are knowledgeable and that they will use their knowledge in their patients' best interest. On being confronted by the question 'Should she be knowledgeable?' people who say that a good nurse is knowledgeable are quick to agree adding a 'But she has to be caring as well!' Further probing results in an explanation of why a nurse needs to be caring and most of all empathic. Many emphasize the need for the nurse to be an excellent communicator that is a good listener as well as a good speaker.

So how does one become a good nurse? Personality and character traits may help but I believe that everyone can make an effort to improve one's quality delivery of care. The adage 'Do unto others as you would be done by' is a general rule that needs to be kept in mind all the time by every nurse who aspires to be a good one. It is simple enough to ask oneself: 'How would I have liked to be treated had I been in this situation myself?' and try to do that which comes to mind. Many times it will not need astronomic science to meet patients' needs as one would like her own needs to be met in a similar situation. This is perhaps the essence of empathic behaviour. Empathy and a professional conduct should ensure that every nurse is a good nurse.

I have tried to list some attributes of which there are many of what a good nurse should be:

a) highly qualified and trained – always ready to learn
b) excellent in communication – a good listener and a good speaker
c) watchful – attentive to detail
d) emotionally stable – knows how to deal with her own emotions, seeking help if necessary
e) good in making correct decisions – has good presence of mind
f) kind and empathic – sensitive to the needs of others and deals with them sensibly
g) physically strong – to be able to withstand the long hours of stressful work
h) flexible with regard to her responsibility – able to go an extra mile if circumstances call for it
i) active and cheerful – able to focus on the problem at hand with a positive attitude
j) respective of people and rules
k) a patient's advocate – able to speak up in the patients' interests.

Much is expected of the nurse if she is to be seen as being 'good'. However, many of us already have these attributes and use them in our work. We do not make active decisions which to use when. Many of us may actually think: 'Is this all?' It is but the great emphasis here is on being a nurse ALL the time. We may be tired, angry, frustrated or even in pain but the patient or his relatives are certainly not to blame. Moreover, a patient has a right to the best care round the clock and cannot be expected to tolerate suboptimal care because it is nearing the end of a shift or there are many patients to be seen to.

Self-awareness is about being sensitive to our own feelings, achievements and shortcomings in order to be able to address our grievances appropriately where they should be handled and strive towards excellence and consistence in excellence.

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ceremony in honour of those Nu
A special gratitude and appreci
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2. Ms Mary Borg was one of the N
during this ceremony for her ster
3. MUMN Officials met with the Dir
sector.
4. The SVPR Group Committee wor
strived for its members. MUMN P
Rita Briffa, Chairperson of this Gr
Committee.
5. A historic moment for all the Nu
Status from H.E. President of Malt
Permanent Secretary and MUMN
agreement with the Government
6. One of the Nurses is receiving the
7. The Federation of Occupational He
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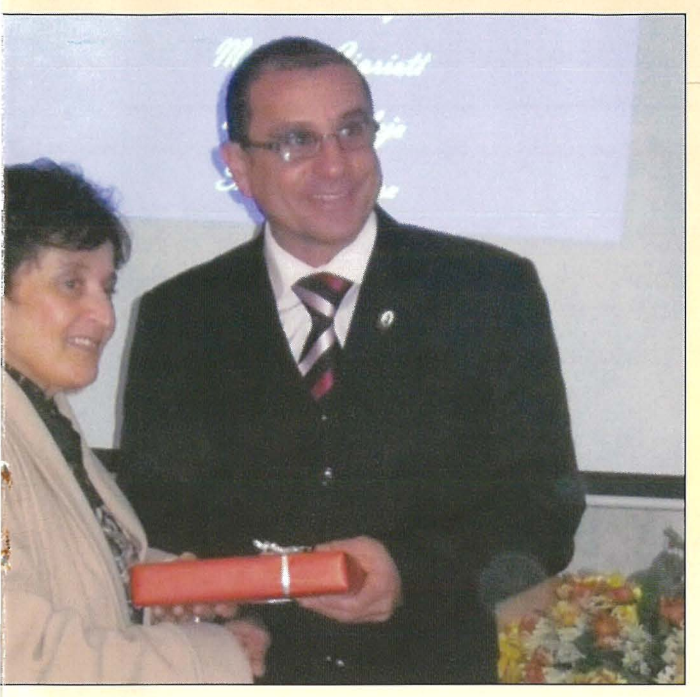
8. The Pensioners Group Committee
to be situated in the Union's pre



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this year's award as being the most Group Committee who
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up Committee together with her colleagues from the same

ses in Malta as they were recognised with the Professional
. Those present were addressed by the Hon. Health Minister,
President. This recognition arrived after MUMN reached an

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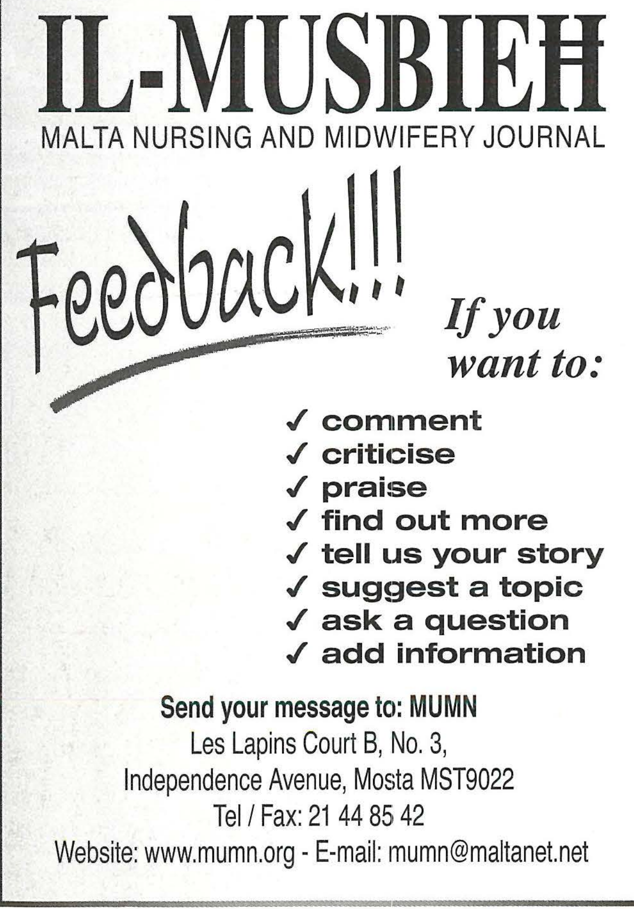

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Coeliac disease and Gluten intolerance

Celiac disease (CD) is a genetically determined condition in which certain grain proteins cause an autoimmune response that damages the lining of the small intestine, causing blunting of the villi and malabsorption of nutrients. Once thought to be a rare condition, CD is now understood to affect as many as 1:266 people worldwide.

Gluten is the general term for the proteins that have been found to be toxic in those with CD - specifically the storage proteins (prolamins) in wheat (gliadin), rye (secalin) and barley (hordein). Many individuals with CD may be only mildly symptomatic or asymptomatic at diagnosis. Or, they may present with various nutrition or malabsorption-related problems such as unintentional weight loss, bloating and gas, ongoing fatigue, lactose intolerance, diarrhoea or constipation, iron deficiency anaemia, folate deficiency, low serum levels of vitamin B12, magnesium and phosphorous. The length of time with active but undiagnosed disease, the extent of gut damage and degree of malabsorption will impact the degree of nutritional compromise. Individuals frequently present with various associated extra-intestinal manifestations of CD such as osteopenia or osteoporosis, infertility, neurological problems and dental enamel abnormalities. Another presentation of CD is dermatitis herpetiformis, a symmetrically distributed blistering and itchy rash appearing primarily on buttocks, elbows and knees. Since the symptoms are common to many other conditions, it is imperative that a doctor makes a preliminary diagnosis through a blood test usually by checking anti-tissue transglutaminase antibodies (tTGA). If blood tests and symptoms suggest celiac disease, a biopsy of the small intestine is performed to confirm the diagnosis.

Currently, the only treatment for CD is a life-long gluten-free diet (GFD). Strict avoidance of wheat, rye, and barley and their derivatives will result in intestinal healing and relief of symptoms for the majority of individuals with CD. Although the diet ultimately brings about greater well-being, it requires a significant amount of effort and commitment, especially in the beginning. Therefore, it is essential that everyone with CD together with family members be referred to a registered dietitian (RD) for nutritional assessment, education and support as soon as possible. Patients who do not follow the GFD or who follow it haphazardly may develop malabsorption-related problems and extraintestinal conditions described above, as well as increasing their risk of small bowel lymphoma.

The GFD is simple in principle, however, completely eliminating all foods and ingredients containing wheat, rye, barley, and most commercial oats can be very challenging. In addition to the obvious sources of gluten like breads, pastas, and most common breakfast cereals, gluten is often found in a wide variety of products such as seasonings, sauces, soy sauce, marinades, salad dressings, soups, prepared meats, candy and flavoured coffee/teas. Individuals with CD not only need to know which foods and ingredients to avoid, but also how to integrate the diet into their day-to-day work and family lives. This includes mastering label reading and becoming familiar with sources of GF foods and basic GF cooking methods. Simply dropping gluten-containing foods from the diet may result in an unbalanced diet lacking in certain nutrients. In addition, specific strategies for eating in restaurants and while travelling away from home, as well as how to prevent cross-contamination of GF foods with gluten-containing foods and ingredients are important.

The GFD is necessary for intestinal healing and recovery for people diagnosed with CD. The nutritional adequacy of the GFD can vary considerably among individuals with CD. Implementing the diet requires significant change and commitment from patients and comprehensive diet education from a skilled dietitian. Periodic follow-up with a registered dietitian, and participation in national support group activities can improve dietary compliance and quality of life for individuals with CD. Although many common foods must be eliminated, the GFD can be both healthful and enjoyable.

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Conflict management refers to the long-term management of intractable conflicts. It is the label for the variety of ways by which people handle grievances, standing up for what they consider to be right and against what they consider to be wrong. Those ways include such diverse phenomena as gossip, ridicule, lynching, terrorism, warfare, feuding, genocide and avoidance.

Conflicts occur when individuals or groups are not obtaining what they need or want and are seeking their own self-interest. Sometimes the individual is not aware of the need and unconsciously starts to act out. Other times, the individual is very aware of what he or she wants and actively works at achieving the goal.

Which forms of conflict management will be used in any given situation can be somewhat predicted and explained by the social structure, or social geometry, of the case.

Types of Managerial Actions that Cause Workplace Conflicts:

Poor Communications : With poor communication, employees experience continuing surprises or are not informed of new decisions, programmes or plans. Sometimes employees are not involved in decision making therefore they do not understand the reasons for the decisions taken. This results in the loss of confidence in the management and they tend to trust the 'rumour mill'.

Amount of resources is insufficient : There could be disagreements about 'who does what', if task allocation is not practised. Conflicts and extra stress can also arise if working with inadequate resources.

'Personal Chemistry' : Two strong personal natures which do not match therefore tend to clash when working together. This worsens when there are conflicting values and actions among managers and employees. One finds that people dislike in others what one dos not like in him or her self.

Leadership Problems : These could include inconsistent, missing, too-strong or uninformed leadership skills. It could be very frustrating if supervisors do not understand the jobs of their subordinates. I t could also be very annoying for employees to see the same continued issues in the work place. Avoiding conflicts and not able to take decisions could also cause a problem.

Conflict Indicators:

- Body language
- Withholding bad news
- Airing disagreements through media
- Desire for power
- Open disagreement
- Disagreements, regardless of issue
- Surprises Strong public statements
- Conflicts in value system
- Increasing lack of respect
- Lack of clear goals
- Lack of candor on budget problems or other sensitive issues

Key Managerial Actions/Structures to Minimize Conflicts

When people work together in groups, there are bound to be occasions when individuals disagree and conflicts arise in the workplace. Whether these disagreements become full-blown feuds or instead fuel creative problem solving is, in large part, up to the person in charge.

One can do a lot to ensure that your employees deal with disagreements in proactive ways by knowing when and how to intervene or when to leave things for that moment. These are some practical tips for dealing with employee spats in the workplace:

- Identify problem and make sure everyone involved knows exactly what the issue is, and why they are arguing. Talk it out until everyone agrees that there is a problem, and understands what the key issues are.
- Allow every person involved to clarify his or her perspectives and opinions about the problem. Make sure everyone has an opportunity to express an opinion. If necessary, establish a time limit and make sure each person sticks to the limit while stating his or her case. It is the manger's responsibility to make sure all participants feel safe and supported.
- Identify the ideal end result, from each party's point of view. It might surprise everyone to discover that their visions are not so far apart after all.
- Figure out what can realistically be done to achieve each individual's goals. If action is taken, how will this affect other projects and objectives? Will the end result be worth the time and energy spent? If the attempt fails, what's the worst that can happen?

Regularly review of job descriptions and involving the employees' input to them. It is important to have a dead line for the job to be finished. It is important to intentionally build a relationship with all subordinates. A regular monthly meeting on a one to one basis is important, so as to inquire about accomplishments, challenges and issues.

The officer in charge should ask for regular written status reports including accomplishments, current issues and needs from the management. Plans are made for the upcoming period. Conduct regular basic training about Interpersonal communications, conflict management and delegation.

Developing procedures for routine tasks and include the employees input. It is important to have employees write procedures when possible and appropriate. These procedures should also be occasionally reviewed and up dated. All staff members should know about these procedures and training should be given to new staff.

Ways of How to Deal With Conflict

There is no best way to deal with conflict. It depends on the current situation. The best solution is to avoid conflict or ignoring it completely. This tactic should be used simply when the conflict is not worth the effort to argue. Although sometimes, this approach tends to worsen the situation.

One can opt to compete, that is to get your way, rather than clarifying and addressing the issue. Competitors usually love accommodators.

By far the best way to deal with conflicts is to compromise – mutual give and take. This is a good tactic when the goal is to get past the issue and move on. Also collaborating and focusing on working together. This approach is used mainly when the goal is to meet as many current needs as possible by using mutual resources. It is also used to cultivate ownership and commitment. This approach sometimes raises new mutual needs.

By far, in my opinion, though, the best way to tackle conflict is by communication. The assumption is that communication is about moving something: about conveying, or sending, or delivering some commodity called 'information'. Communication is the process of creating shared understanding. Communication creates understanding on three levels, each underpinning the one above.

The first and most important reason for communicating is to build relationships with other people. Ignore this fundamental quality of conversation at your peril. If you fail to establish a relaxed relationship, everything else in the conversation will become more difficult. The first task in any conversation is to build a rapport.

Conclusion

Conflict is a natural phenomenon and is not to be always viewed as a disease to be cured and a disorder to be cured. To some extent it may even be necessary and desirable to keep the organization alert or induce it to be more innovative, to open up opportunities for learning and impart flexibility to organizational function.

Facing conflicts and not avoiding them should aid the team for a way forward for a smoother, healthier environment at the work place, thus enhancing new ideas and opportunities.

Astrid Zarb ,Midwifery Officer (Obs 2)

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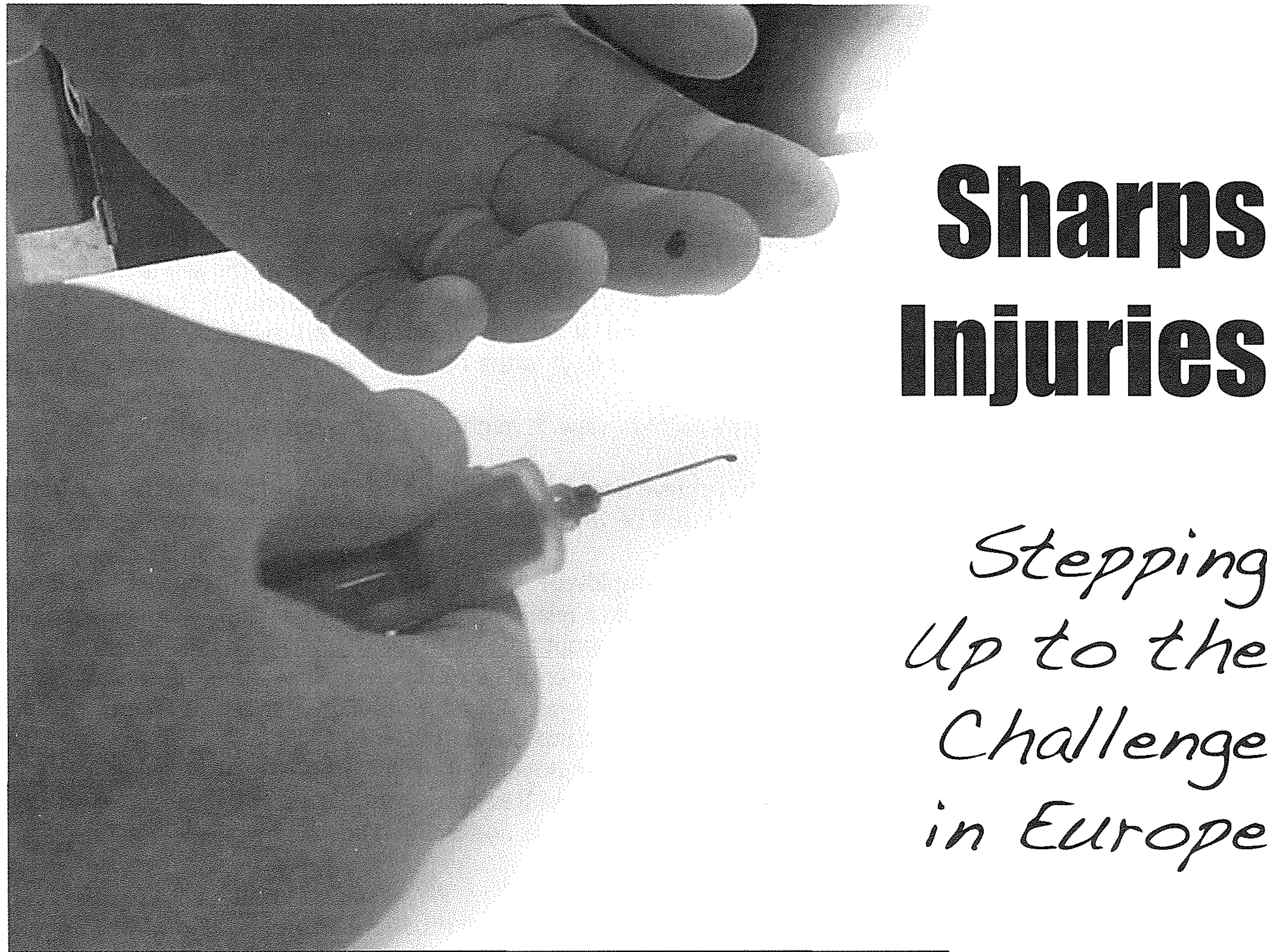


Sharps Injuries

Stepping Up to the Challenge in Europe

Paul De Raeve, *Secretary General of the European Federation of Nurses Associations*

Sharps injuries, and particularly needlestick injuries, bring the risk of potentially life-threatening infections. Every year in Europe approximately 1.2 million needlestick injuries are suffered by healthcare staff. For many years healthcare workers in the USA have benefited from legislation to prevent these injuries. At last it looks like Europe is to step up to the challenge of protecting it's healthcare staff.

Introduction

On a daily basis nurses and other healthcare workers are facing dangerous and potentially life-threatening infections as a result of sharps injuries. By far the most common and significant of these are injuries from used needles (needlestick injuries). There is a huge body of independent evidence that proves that most of these injuries are avoidable if workers are provided with the correct protection, which is readily available in Europe today.

The European Commission has stated that injuries caused by needles and other sharp instruments are one of the most common and serious risks to healthcare workers in Europe and represent a high cost for health systems and society in general. They acknowledge that studies estimate the number of needlestick injuries that occur in Europe at 1.2 million each year.[1]

Needlestick injuries are suffered by nurses, doctors, hospital porters, cleaners, laundry staff, refuse collectors and other workers who are linked with healthcare or who may come into contact with medical waste. More than 30 dangerous blood-borne pathogens are transmitted by contaminated needles, including hepatitis B, hepatitis C and HIV.

Additionally, the emotional impact of a sharps injury can be severe and long lasting, even when a serious infection is not transmitted. Healthcare workers and their families can suffer many months of anguish as they wait to discover whether they have contracted a potentially fatal infection.

Time for Action

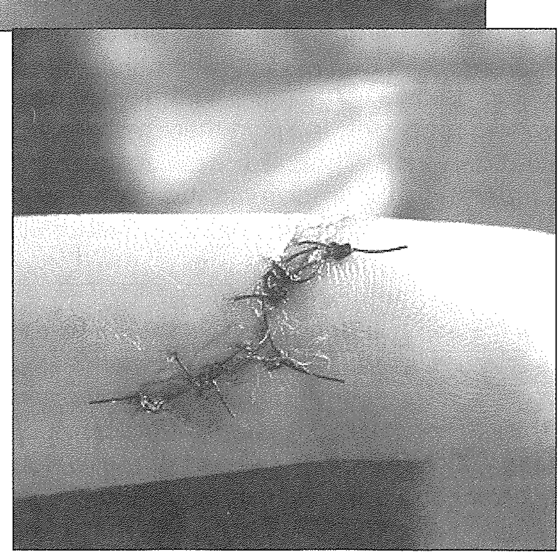
Workers in any other sector would not accept this serious occupational risk. Nurses and other healthcare workers are dedicated to the health and wellbeing of patients. They face many difficult challenges in their daily work and should not have to face potentially life-threatening occupational injuries that are preventable.

On World AIDS Day, in December 2004, I and colleagues from national nurses associations along with more than thirty nurses from nine member states, who had been victims of needlestick injury, visited the European Parliament for a series of meetings with Members of the Parliament and later with the Commission. We turned to the European Parliament for help because it was very clear that we would probably never receive the protection that we deserved via the existing national health and safety legislation, which had in practice proved to be ineffective in this area.

The Parliament heard some very moving stories about life-changing injuries, all of which could have been avoided. Not surprisingly there was a strong response. In July 2006, the European Parliament adopted, by a huge majority, a report and resolution, that requested that the Commission submit a legislative proposal on protecting healthcare workers from blood-borne infections due to needlestick injuries. This eventually led to the European Social Partners, representing healthcare workers and healthcare employers, entering into formal negotiations.

On 17 July 2009 a binding agreement was officially signed by the European Social Partners, the designated EU representatives of healthcare workers (European Public Service Union, EPSU) and healthcare employers (European Hospital and Healthcare Employers' Association, HOSPEEM) on the prevention of sharps injuries in the hospital and healthcare sector. Throughout the negotiations leading to the agreement, medical sharps and particularly needlestick injuries have been formally recognised by all parties as a very serious occupational hazard to workers in the hospital and healthcare sector that needed to be effectively dealt with.

The European Commission later confirmed that at the request of the European social partners and after having examined their representativeness and the legal conformity of the text, it intended to submit a proposal to the Council for implementation of the agreement by a directive. We now await the Council's adoption of the Commission's proposal. However there is not time to waste. Europe's healthcare workers have already waited too long to receive the protection that they deserve.

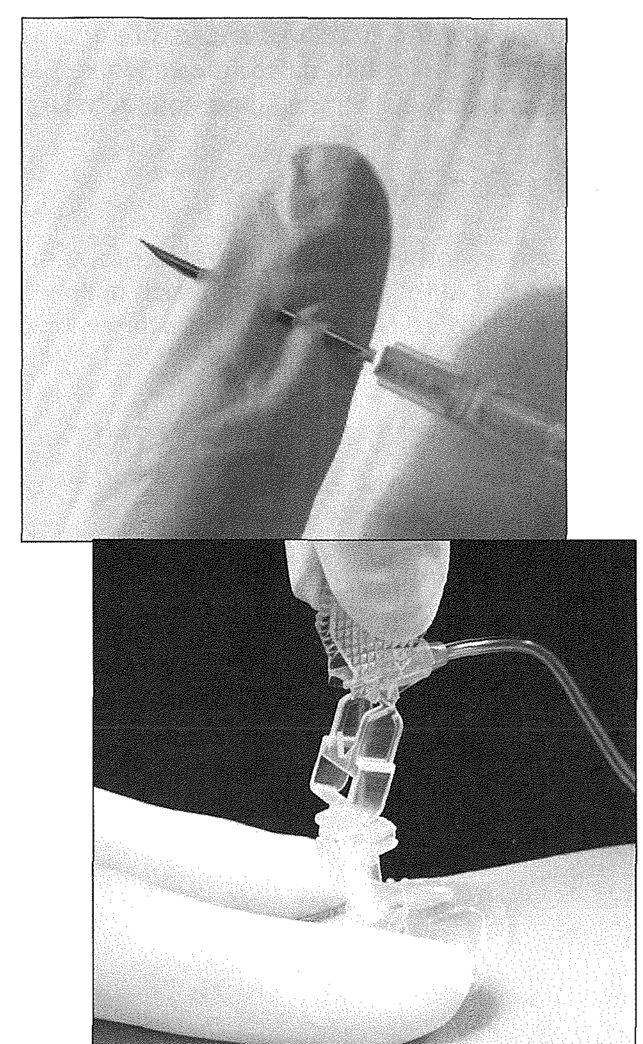


Implementing Effective Prevention Measures

We are all looking to achieve the safest possible working environment in healthcare by preventing

injuries to workers caused by medical sharps, including needlesticks. Protection is required to safeguard all staff in hospitals, laboratories and providing healthcare in alternate settings who may come into contact with used needles and other medical sharps.

Injury from hollow-bore needles is the main route by which healthcare workers acquire blood-borne and potentially fatal diseases occupationally. The bore of the needle acts as a reservoir for blood and other body fluids. The highest risk procedures include blood collection, IV cannulation and percutaneously placed syringes. Surprisingly small amounts of blood can result in potentially life threatening infection.



There is a recognised hierarchy of priorities for sharps injury prevention.

1 The first priority is to eliminate and reduce the use of needles and other sharps wherever possible. In some cases needle-free devices and alternative means of administering medicines are available (such as inhalers, transdermal patches and needleless IV systems).
2 The next priority is to isolate the hazards by protecting otherwise exposed sharps, through the use of medical devices incorporating safety-engineered sharps protection mechanisms, such as shielding and retraction mechanisms. These devices are widely available and independent studies demonstrate their safety and overall cost-effectiveness.
3 Finally, regardless of whether an engineering control is available, safe work practices are always necessary to reduce sharps hazards in the workplace.

A huge range of independent studies conducted in Europe and elsewhere in the world show that a combination of training, safer working practices and the use of medical devices incorporating safety-engineered protection mechanisms can prevent more than 80 per cent of needlestick injuries.[2] Studies have also demonstrated that failure to implement any one of these three elements will result in a significantly reduced impact. Similarly, attempts to implement safety-engineered medical devices only in certain areas or on certain patients is not practicable or effective.

The incidence of hepatitis B virus (HBV), hepatitis C virus (HCV) and human immunodeficiency virus (HIV) is significantly higher in the hospital population than in the general population. Additionally, patients are treated before it is known that they are carrying a serious blood-borne infection, so it is not feasible to reliably segregate patients on the basis of risk and universal sharps injuries prevention measures are therefore, appropriate.

Managers should consult with nurses on the choice and use of safety-engineered devices, identifying how best to carry out training, information and awareness-raising processes. In Spain there are already four regions where sharps prevention measures, including the mandatory use of medical devices incorporating safety-engineered needle protection, is required by law. In supporting the implementation of these measures my colleagues from the Spanish Nursing Council found that it is very important that the nurses that will use the devices are involved in the selection process.

When considering safety-engineered medical devices the following selection criteria should be applied:

- The device must not compromise patient care;
- The device must perform reliably;
- The safety mechanism must be an integral part of the safety device, not a separate accessory;
- The device must be easy to use and require little change of technique on the part of the health professional;
- The activation of the safety mechanism must be convenient and allow the care-giver to maintain appropriate control over the procedure;

- The device must not create other safety hazards or sources of blood exposure;
- A single-handed or automatic activation is preferable;
- The activation of the safety mechanism must manifest itself by means of an audible, tactile or visual sign to the health professional;
- The safety mechanisms should not be easily reversible once activated.

In the Annex to Directive 89/655/EEC, which specifies the minimum requirements for work equipment, it states: 1.8 "Where there is a risk of mechanical contact with moving parts of work equipment which could lead to accidents, those parts must be provided with guards or devices to prevent access to danger zones or to halt movement of dangerous parts before danger zones are reached."

Comprehensive user training is also vital to the introduction of safety-engineered medical devices. Experience has shown that when this is done well, in combination with safer working procedures, the implementation of the safety measures is much more effective.

The employer also has a responsibility to raise awareness amongst workers:

- Highlighting the risks of handling sharps;
- Giving guidance on existing legislation and local policies
- Promoting good practices and safe systems of work regarding the prevention of sharps injuries
- Promoting the importance of recording sharps injuries;
- Raising awareness by developing activities and promotional materials in partnership with representative trade unions and/or workers' representatives;

No Time to Waste

Europe's healthcare workers have waited too long to be adequately protected from life-threatening and life-changing injuries. Our colleagues in the US have enjoyed the benefits of mandatory protection measures to eliminate needlestick injuries since 2001[3], with a major reduction in the number of injuries having been achieved, yet we are still discussing the subject.

The time for debate has passed and we owe it to our collegeas working at the bedside of the patient, who are a vital element of the healthcare system, to act quickly. I encourage all healthcare employers to be proactive in working with their staff to quickly plan the implementation of all of the preventative measures outlined in this article.

The 2004 European Competitiveness Report (SEC(2004)1397) acknowledges the escalating shortage of healthcare workers as a cause for concern throughout Europe. As well as safeguarding the safety of healthcare staff and making this a more attractive profession, these measures have been proven to be cost effective.[4]

We need to work together to quickly make universal protection a reality. There is no time to waste.

The European Federation of Nurses Associations (EFN) consists of nurses associations from all 27 EU Member States, representing more than 1.2 million nurses across Europe.

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MUMN GROUP COMMITTEE IN SVPR - ANNUAL REPORT 2009

The SVPR Group Committee informed our General Secretary about the supply of new shoes. These were accepted by the majority of the nursing staff working in various hospitals. MUMN is waiting for the approval from the Permanent Secretary in the Health Division.

As from this year, all part-time nurses who work only a few hours per week, i.e. less than twenty hours per week were given the opportunity to work on Public Holiday as additional hours.

The Group Committee had to intervene and assist some + 61years nurses who opt to be reemployed. The Management decided that these nurses are to be posted in the Relievers Pool, thus giving the opportunity to the new recruits to be permanently posted in wards.

A problem which arose at the Nursing Administration Office about the custody of a wall safe was discussed with the Management and a common solution found.

In March 2009, a letter was sent to the Director for the Care of the Elderly where MUMN complained about the state and conditions of the Staff Dining Room. Unfortunately for months nothing was done at the Dining Room. Another meeting, this time with the Hospital Planning Manager was held. Following this meeting, there was an increase in the staff compliment of the dining room while most of these staff are attending courses on Food and Hygiene.

Besides, the Management embarked on a project to issue an identity tag to each employee at SVPR with clear indications who was entitled to use the dining room. In fact, photos of all employees are currently being taken. Thus it seems that we can record progress.

One of the most important issues was that of reducing the bed compliment in certain wards. Although with some obstacles and arguments, this project has continued. There are now only few beds over the agreed compliment.

During September and October 2009, several meetings were held with the Residence's Management i.e.
1. Lack of laundry linen - sorted by end of October;
2. Two weeks supply of Control and Narcotic drugs - now the supply is being done on a weekly basis;
3. Out of stock items - Director is investigated these complaints.

The issue of a maintenance officer during the night was raised with Management. Unfortunately the MUMN's complaint about the importance of having this officer during the night was proved when recently a fire broke out in one of the wards during the night.

A new ward at John Paul II block was opened. This was possible following consultations and cooperation between the Group Committee and the Management.

We will be right to say, that this year was a busy one for our Committee but as long as one sees results for the safe environment of staff and residents, we were satisfied.

Rita Briffa, Chairperson
SVPR Group Committee - MUMN

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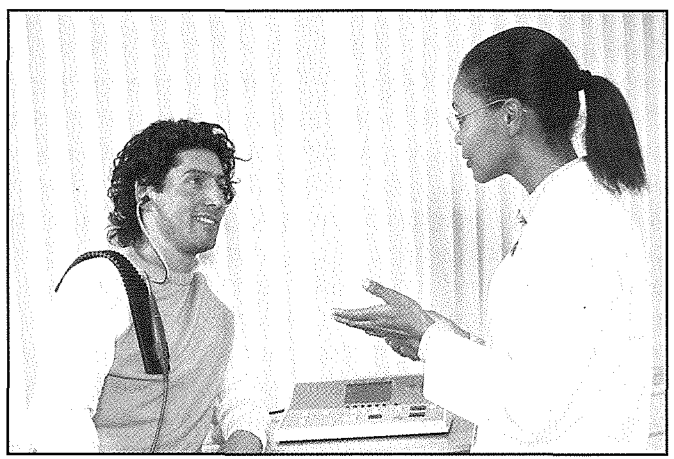
Informed Consent or the doctor knows best?



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The concept of consent to treatment is a relatively new phenomenon. In ancient times, such as the Greek, Roman and Egyptian civilizations, there was no such thing as patient informed consent to medical treatment. However, in this day and age, mankind as a whole is focused on human rights; hence the concept of consent became the subject of case law (CNA Financial Corporation, 2000). Informed consent is the legal embodiment that each individual has the right to make decisions affecting his or her well-being (Merz, n. d.). Law establishes rules that define our rights and obligations and penalties are set for people that violate them (Burkhardt & Nathaniel, 2002). Thus, doctors or other health professionals may be held responsible for damages if the patient is examined or treated without consent (Department of Health, Informed Consent, 1990).

Informed consent is more than simply getting the patient to sign a written consent form. A signature on a form is **evidence** that the patient has given consent but it is **not proof** of a valid consent (Department of Health, 2006). Hence, a valid informed consent requires a process of communication between a patient and doctor, which subsequently will result in the patient's authorization or agreement to undergo a specific medical intervention (American Medical Association, 1998). Nonetheless, a patient has a right to withdraw or withhold consent (International Association for Nursing Ethics, 1999) and to ask for more information before making up his mind (Department of Health, 2001). Informed consent should be based on the moral and legal premise of the patient's autonomy (eMedicineHealth, 2006). It is an arrogant and unaccepted attitude for health professionals to assume that they know best.

INFORMED CONSENT

- ***What is an informed consent and when is it required?***

A **valid** informed consent is one that is given in such a way that the patient can understand what is being said, thus medical jargon should be avoided. It should include an explanation of the nature of the examination or treatment. The doctor should also mention existence of any alternatives and also point out substantial risks. Any medical side effects and any life long consequences should also be revealed (International Association for Nursing Ethics, 1999). Consequently the patient will be in a position to make an informed decision regarding whether or not to consent to the treatment or procedure (University of Virginia, 2001). This communication process is both an ethical obligation and a legal requirement from the doctor (American Medical Association, 1998). It is essential that the patient act under his own free will and not under duress or under a strong influence of another person (Department of Health, 2001). The patient maintains the right to refuse the procedure regardless of the reason. Rationale for non acceptance includes religious beliefs, concerns regarding the risks of the procedure or skepticism regarding possible success of the procedure (University of Virginia, 2001). Dilemmas may arise when the doctor and patient disagree as to the desirability of the proposed treatment, which may result in the courts having to intervene in order to clarify these difficult situations (Harpwood, 1996).

Nonetheless, the person must have the capacity or ability to make the decision. Competency is a legal term used to indicate that a person has the ability to make and be held accountable for his decisions. In order to be competent in decision making, the patient must be able to understand the options available, be able to understand the consequences of choosing each of the options, be able to evaluate the personal cost and benefit of each of the consequences and relate them to his own set of values and priorities (eMedicineHealth, 2006).

Consent may be given verbally or in writing depending on the nature of the treatment or care. **Implied consent** is usually required and assumed for various types of interactions, such as a during blood pressure taking. **Verbal consent** is commonly used for simple procedures, where it entails the doctor gaining verbal permission from the patient to carry out the procedure. However it is recommended that the details should be recorded in the patient's notes. **Written consent** provides documentary evidence that consent has been obtained and provides some evidence that a meeting has occurred between the patient and the individual obtaining consent. However it is of utmost importance to bear in mind that gaining a patient's consent whether it is implied, verbal or

written means no guarantee that the consent was informed or that information provided to the patient was correct (Bartter, 2001).

▪ ***Why is Informed consent necessary?***

The patient has a fundamental legal and ethical right to determine what happens to their own bodies (Department of Health, 2006). Consent which has not been given voluntarily by the patient will not be valid in law. Civil actions can be taken against the health professional that didn't gain informed consent prior to a procedure or treatment; namely for trespassing the person (assault or battery) and negligence. The tort of battery is committed whenever there is any unlawful physical contact imposed by one person upon another without consent. Subsequently this may be accompanied by the tort of assault, which involves putting the plaintiff in fear of an immediate battery. On the other hand, trespass to the patient occurs when the patient is treated against his will and when consent to the proposed treatment is simply not obtained. The latter may occur due to the patient consenting to a different form of treatment to that which was actually given after being misled as to what was to be done, or due to a medical mistake which resulted in the wrong procedure being performed (Harpwood, 1996). Negligence is the omission to do something that a reasonable person, guided by those ordinary consideration which ordinarily regulate human affairs would do, or doing something which a reasonable and prudent person would not do (Burkhardt & Nathaniel, 2002).

▪ ***Who signs the Informed Consent?***

It is essential to bear in mind that **no one else can give consent on behalf of another person** (Department of Health, 2006); therefore consent has to be obtained **solely** from the patient. Gafa (2003) states that the ability to consent to treatment or care is not directly linked with age as long as the patient is capable of understanding the nature of the treatment or care to be given to him. When a patient lacks decision making capacity, irrespective of age or whether he has parents or not; it is mandatory that somebody will be identified as a surrogate to make decisions for the patient. However, the decisions made by the surrogate should reflect the patient's values, including cultural and spiritual perspectives (Burkhardt & Nathaniel, 2002).

There are certain situations where the doctor can act without informed consent, such as in an emergency situation, where immediate treatment is required in order to prevent death or serious health impairment. Hence the doctor will be acting in the best interest of the patient. In these scenarios if it is impossible to obtain the patient's consent or the consent of someone authorized to consent for the patient, then it is presumed that the patient would want the intervention (University of Virginia, 2001). Nonetheless, the ethical principles of **beneficence** and **non-maleficence** are the basis for planning an incompetent patient's care (Bartter, 2001).

Conclusion

Informed consent needs to be obtained every time the doctor or a health professional either touch the patient or perform an invasive procedure (University of Virginia, 2001). The purpose of informed consent is to enable the patient to consider, weigh and balance the advantages and disadvantages of the proposed medical treatment in order so as to make a rational choice either to undergo or refuse. The proper use of this principle prevents or diminishes the probability of errors, negligence, coercion and deception. Furthermore, informed consent encourages the doctor's self-criticism. The rationale for informed consent is to ascertain the patient's autonomy, to promote his right of self-determination, and to protect his status as a self-respecting human being (The International Centre for Health, Law and Ethics, 2003).

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treatment of allergic rhinitis

Allergic rhinitis is an international public health problem. In most western countries, it affects 10 to 25% of the population and its prevalence is constantly increasing. It is characterised by inflammation of the nasal mucosa and a group of symptoms (sneezing, obstruction and a watery nasal discharge) due to an excessive immunological reaction in the presence of an allergen. Owing to its impact on social life and productivity at work, allergic rhinitis gives rise to considerable indirect costs. Furthermore, following work by many researchers, the WHO considers it a major risk factor for asthma owing to the continuity between the nasosinusal and bronchial mucosae.

Allergic Rhinitis is split into two main classifications

1. Hayfever is an acute manifestation which coincides with the presence of allergens in the atmosphere, mainly pollens produced by local flora in May and September. Hayfever is also called Seasonal Allergic Rhinitis. It is easily identifiable, since it occurs at the same period each year, "Hayfever" is the result of an allergy to graminacea pollen. It appears almost everywhere in Europe from April to July and may be severely incapacitating in subjects who must preserve their alertness
2. Perennial Rhinitis persists throughout the year and essentially results from contacts with various different allergens (dust and acarids, animal hair, moulds and occupational allergens). Family histories are often observed.

Whether seasonal or perennial, allergic rhinitis is considered severe if accompanied by at least one of the following symptoms: sleep disturbances and a reduction in social, sporting, professional or school activities.

In all cases, treatment combining preventive and curative measures must be instituted.

Prevention

As always in allergology, reducing the contact with the allergens is the first and more obvious measure to be applied. Washing the nose of the sensitised subject will make it possible to significantly reduce the quantity of allergens in contact with the nasal mucosa and the concentration of local inflammatory mediators.

Other hygiene measures will make it possible to eliminate or reduce the contact with the allergen in question: by using anti-acarid slip covers, by getting rid of pets, by airing living areas and by limiting cofactors that promote the allergy (passive smoking, solvents and other irritants).

Curative treatment

In order to reduce the allergy and its local consequences, one must resort to various combinations of a systemic treatment (essentially antihistamines, or indeed immunotherapy and corticosteroid treatment) and local treatments aimed above all at washing and decongesting the nasal mucosa, while reducing inflammatory phenomena.

Providing the correct advice to a patient suffering from some form of manifestation of allergic rhinitis should therefore be summarized as follows:

1. Identify the allergen involved.
2. Avoid the allergen as much as possible.
3. Cleanse the nasal mucosae as a first step to reducing the impact of allergens on the nasal mucosa. Commercial preparations based on seawater, possibly enriched with trace elements such as Manganese(Mn) are available for this purpose.
4. Refer the patient to another health professional such as the family GP or the Pharmacist so that antihistamines and other remedial medications can be prescribed.

As always, the nursing profession has always been in a position to be essential in the correct management of a patient. Allergic Rhinitis is no exception. The correct advice given to our patients could reduce their reliance on drugs and medications as well as the socioeconomic cost of a condition such as allergic rhinitis.

Reuben Demamuele, B.Pharm, B.Com (Hons).

MUMN 1996 Malta Union of Midwives and Nurses

ICN CONFERENCE AND CNR
2-8 May 2011 Malta

Nurses driving access, quality and health

Call for abstracts

ICN CONFERENCE AND CNR
2-8 May 2011 Malta

Nurses driving access, quality and health

This ICN International Conference will present strong evidence demonstrating how nurses, as key members of the health services team, promote and contribute to quality and accessible health care. The Conference will provide opportunities to disseminate nursing knowledge and leadership across specialities, cultures and countries. The three ICN pillars - Professional practice, Regulation and Socio-economic Welfare - will frame the scientific programme and the dynamic exchange of experiences and expertise.

Featured plenary speakers will bring inspiration and the latest information on the nursing workforce and workplace, ethics/human rights, clinical care and patient safety. Concurrent sessions, symposia and posters will address these issues plus developments in nursing education, pandemics/disasters, care systems and access, technology, regulation and the history of nursing. The Conference will also be the venue for ICN Network meetings and thought provoking main sessions - including a debate on a priority issue for the profession.

To share your ideas and expertise you are invited to submit an abstract for a concurrent session, a symposium or a poster. The abstract submission guidelines and on-line submission system will be available on the Conference website www.icn2011.ch as of 15 March 2010.

The Council of National Representatives, ICN's global governing body, will convene from 2-4 May 2011. Conference participants who are members of ICN member associations will be able to observe global nursing leaders identify the profession's priorities and future directions.

Further information and regular updates on the Conference programme will be posted on the Conference website at www.icn2011.ch

The main objectives of the Conference are:
1. To advance and improve the coverage and quality of health services
2. To demonstrate the nursing contribution to the health of individuals, families and communities
3. To provide opportunities for an in-depth exchange of experience and expertise within and beyond the international nursing community.

ICN Networks
All ICN Networks will hold 90 minute sessions, focusing on their specific areas of interest. Updates on the programme for these sessions will be available on the Conference website and through a series of media announcements. Areas of particular interest include:
- Disaster Response Network
- HIV/AIDS Network
- Leadership for Change Network
- Nurse Practitioner/Advanced Practice Nursing Network
- Nursing Education Network
- Regulation Network
- Remote and Rural Nursing Network
- Research Network
- Socio-economic Welfare Network
- Student Nurse Network
- Telenursing Network

ICN CONFERENCE AND CNR

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Nurses driving access, quality and health

Instructions for the submission of abstracts

The deadline for the receipt of abstracts is midnight (GMT) 15 September 2010.

1. The abstract text must be no more than 2,500 characters (approx. 250 words), including title and authors' information, and highlight the main points the presenter/s wish to communicate. Additional characters will be automatically cut by the system.
2. Abstracts are to be submitted via the Internet at www.icn2011.ch
3. Those whose abstracts are accepted must register for the conference and pay the early registration fee by midnight (GMT) 31 January 2011. Accepted abstracts will be eliminated from the programme and CD-Rom on this date if registration and fee payment have not been received.
4. The abstract can be submitted in ONLY ONE of the following categories:
   Concurrent session: A paper 15 minutes in length.
   Symposium: An 80 minute session with a minimum of three speakers presenting on a single theme from different perspectives. Speakers presenting a symposium must submit a single joint abstract.
   Poster: A visual presentation for display on a poster board.
5. Abstracts can be submitted in English, French or Spanish.
6. Only fully completed presenter profiles and abstract submissions (marked as Final) will be reviewed.
7. A person not a member of an ICN member organisation may only submit an abstract as a joint author/presenter with a person who is member of an ICN member organisation.
8. A maximum of six co-authors may submit a joint abstract.
9. Applicants will be notified by 1 December 2010 if their abstract has been accepted.
10. **All decisions on abstract acceptance are final. Once the decision has been rendered on an abstract, no further correspondence will be undertaken on the selection process.**

Factors that will be considered during selection are:

- Interest to an international audience.
- Relevance to both the Conference theme and one abstract sub-theme.
- Scientific and/or professional merit.
- Contribution to knowledge, practice, policies or programmes of nursing and/or health.
- Clarity of abstract.

Conference website:
www.icn2011.ch

Conference Secretariat:
ICN 2011, c/o MCI Suisse SA, Rue de Lyon 75, P.O. Box 500, 1211 Geneva 13, Switzerland
Tel.: +41 22 33 99 575, **Fax:** +41 22 33 99 651
Email abstracts: icn2011abs@mci-group.com, **Email general requests:** icn@mci-group.com
Web: www.mci-group.com

The International Council of Nurses (ICN) is a federation of 133 national nurses associations representing the millions of nurses worldwide. Operated by nurses and leading nursing internationally, ICN works to ensure quality nursing care for all and sound health policies globally.

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www.icn.ch

The Malta Union of Midwives and Nurses is a union which throughout its existence has strived to support and look after the interests of nurses and midwives alike. The main objective of this union is that it pledges to educate and strive to reduce the risk of every type of illness, assist all patients, use possible means to lessen the discomfort and suffering of all patients and hasten convalescence.

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www.mumn.org

General information

Enjoying yourself in Malta Valletta, Malta's capital and a World Heritage site, is nothing short of an open-air museum. It is a living experience of Baroque architecture, a monument donated by the Knights of St John nearly five centuries ago. Malta's main tourist attractions include the majestic St John's Cathedral, the imposing bastions and Malta's Grand Harbor, often described as the most beautiful in the Mediterranean. Source: www.cityofvalletta.org

Continuing education credits Conference participants will be able to earn international continuing nursing education credits (ICNECs) at this Conference.

Conference fee The early registration fee structure will be announced in June 2010 on the Conference website www.icn2011.ch. The early registration deadline is 31 January 2011.

Exhibition A commercial and professional exhibition will run concurrently with the Conference. Industry, publishers and organisations will showcase their products and services and present the most recent health care information.

Pre-and post conference tours Special pre and post Conference tours will be arranged. Tours will be announced on the website as soon as registration goes "live" in the autumn of 2010.

Professional visits Conference participants will have the opportunity to learn about nursing practice and health care in Malta. The Malta Union of Midwives and Nurses (MUMN) will be making special arrangements for professional visits. Further details will be posted on the Conference website.

Refund/Cancellation Registered participants who are unable to attend the Conference will have their paid fees refunded, less a processing fee of €70, provided written notice of cancellation is received by ICN **before 2 March 2011.** After this date, no fee refund can be expected. Full details concerning changes and cancellations will be published on the ICN 2011 website in autumn 2010.

Transportation to Malta Malta is just a few hours' flying time from most mainland European cities and has very good intercontinental connections (www.visitmalta.com/airport). The following airlines operate to Malta: Air Malta, Alitalia, Bmibaby, EasyJet, Emirates, Finnair, Jat Airways, Libyan Arab Airlines, Lufthansa, Luxair, Norwegian Air, Ryan Air, Scandinavian Airlines, Sevenair, Vueling.

Visas It is advisable that you check about visa and entry requirements before making any travel arrangements. Detailed information can be obtained at www.mfa.gov.mt/ (click on section "Services" - "Travelling to Malta"). We advise you to proceed early with any visa request.

Website update This first announcement and Call for Abstracts contains as much information as is known at the present time. However, the Conference website will be continuously updated with the latest Conference news. Check in at www.icn2011.ch

Working languages The working languages of the Conference are English, Spanish and French. Simultaneous interpretation will be provided for all plenary sessions, as well as a selection of other sessions.

Call for abstracts

To share your ideas, research and expertise on how to provide quality care, improve populations' access to health services or contribute to further advance nursing knowledge and practice, you are invited to submit an abstract. Abstracts must address one of the sub-themes listed below and demonstrate a direct link to the Conference theme of *Nurses Driving Access, Quality and Health.*

Abstract themes:

1. The nursing workforce and workplace
   - What are the priority workforce and workplace issues that affect access to care?
   - What skill mix is required for quality care?
   - What is the impact of positive practice environments?
   - How does the global international labour market affect access, quality and health?
2. Pandemics/disasters
   - What is the impact of climate change on public health?
   - What is the role of nurses in disaster preparedness and relief efforts?
   - How do we screen and deploy disaster nurses effectively?
   - What protective measures are required by relief workers?
3. Ethics/human rights
   - What ethical dilemmas exist in ensuring access, quality and health?
   - What is equity and how is it introduced/maintained in health systems?
   - What measures need to be taken to protect the health rights of vulnerable patient populations?
4. Clinical care, patient safety and quality
   - What innovations in clinical practice support better patient outcomes?
   - What is the link between the practice environment and patient safety?
   - What is quality health care and how is it measured?
5. Nursing education and the learning environment
   - In light of the global shortage of employed nurses, how will a sufficient student pool be attracted to the profession?
   - What are the reasons behind the high student attrition rates and how must they be addressed?
   - Where will we find the faculty necessary to educate future generations of nurses?
   - What innovations do we see in the learning environment?
6. Care systems and access
   - How are care systems evolving to meet changing needs?
   - What happens at the interface between the health and social sectors?
   - How is access measured and achieved?
7. Technology, innovations and informatics
   - How does technology and informatics support access to health services and quality care?
   - What innovations have advanced health care delivery and improved patient outcomes?
   - How does computer technology affect nurses' time spent with patients?
8. Leadership - management
   - What competencies are needed by our nurse managers?
   - Are they different from the abilities of true leaders?
   - Where and how does nursing leadership develop?
9. Regulation and legislation
   - What is the role of professional regulation in ensuring quality care?
   - How can accreditation systems benefit the patient?
   - What will be the impact of national/regional observatories?
   - What impact has recent legislation had on access and quality in the health sector?
10. History
    - How does knowledge of the past help us prepare for the future?
    - What lessons have we learned?
    - What national and global trends do we see in nursing?

Rapport tas-Sena 2009

Thomas Aguis, Segretarju , MDH Group Committee - MUMN

Wara t-trasferiment tal-Isptar San Luqa lejn l-Isptar Mater Dei, il-Group Committee kompla bil-ħidma tiegħu f'dan l-isptar li huwa ikbar. Bħalma taf, il-kumitat kien kompost minn seba' membri. Bejn wieħed u ieħor kienet tintalab laqgħa darba fix-xahar. Numru ta' l-laqgħet ma kienux ikunu formali għax ma kienx ikun hemm quorum. Tant hu hekk li wara xi zmien irrezenjaw zewġ membri u ġew eletti tnejn oħra.

Fost il-ħidma li saret:

1. Irrezistejna l-dħul tal-ODPs fl-Operating Theatre,
2. Irrezistejna t-trasferiment tal-infermiera mill-Obstetric Wards,
3. Intlaħaq ftehim li minn jattendi l-Conversion Course jiġi replaced min-nurses oħra biex ikunu jistgħu jattendu l-kors,
4. Intlaħaq ftehim fuq l-overtime fil-Medicina u l-Kirurġija,
5. Ħriġna direttivi lill-Operating Theatre Nurses li jekk ma jkunx hemm ftehim kulħadd jieħu il-breaks f'ħinhom,
6. Għadna sejrin f'diskussjonijiet dwar il-payroll għax mhux sew li ħadd ma jkun jaf certu dettalji importanti fil-paga tiegħu,
7. Sar arranġament mal-Management dwar cilindri tal-ossiġnu fis-swali li qabel kienu tqal. Sar ftehim li jkun hemm sistema iktar ħafifa u komda biex jinġarru,
8. Tkellimna wkoll li meta senior nurse ikun qed jagħmilha ta' In-Charge, għandu jintbagħat nurse ieħor overtime f'loku,
9. Ġbidna l-attenzjoni tal-Management li l-agreement dwar id-Day Nurses għadu l-istess kif kien u fejn is-sala tkun qed tammetti jista' jiġi bbukkjat nurse overtime,
10. Wara ħafna taħbil il-moħħ xi notice boards bdew jaslulna u qegħdin fil-post,
11. Għadhom għaddejjin diskussjonijiet dwar kif jittieħed il-Time in Lieu miġbur meta maħdum ġo swali oħra,
12. Intlaħaq ftehim li fis-swali tas-Surgical ikun hemm 6 infermiera kuljum,
13. Komplejna u kwazi ftehmna dwar il-Protocol tal-Constant Watches.

DIRETTIVI ORDNATI MILL-UNION:

- **Swali tal-Medicina:**
  - o Li ma nkunux risponsabbli mill-Covering Letters
  - o Li ma naccettawx aktar pazjenti mill-bed compliment u nibagħtu pazjenti oħra għand il-Customer Care
- **Swali tal-Kirurġija, wara ħafna laqgħet fil-prezenza tal-Ministru, ħriġna dawn id-direttivi:**
  - o Biex ninjoraw l-ordnijiet tal-Bed Manager
  - o Biex jintbagħtu l-morda għand il-Customer Care u jiġu ammettiti wara l-11.00 hrs sakemm tintela' s-sala
  - o Biex ma nassistux reviews (day cases) fis-swali bħal removal of sutures, drains u dressings.

Bħalma kulħadd jaf l-Union hija dinamika. Inħeġġeġ aktar membri biex jagħtu l-għajnuna fil-Group Committee għax zgur li sptar bħal Mater Dei jitlob li jkompli jkollu union b'saħħitha bħalma hi l-MUMN.

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