IL-MUSBIEH

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Radiotherapy & Oral Mucositis

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HARTMANN

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editorial

Nurses and midwives struggle with overcrowding each and every day. The reality of trying to provide care for sicker patients, inpatients, and more patients than the department's physical space can handle has created an overcrowding situation that extends well beyond the departments. As nurses and midwives, we work tirelessly to meet the demands placed on us and our profession to care for our patients. How much further can the seams of an overburdened system be stretched? What is being done to address this problem, and how did this challenging situation emerge?

A few years ago, it was forecasted that managed care would result in the need for very few inpatient beds and that emergency departments would only see patients with major trauma and the wards and all the other departments will be for acute cases. These predictions were just one of the reasons that nursing and midwifery were not a sought-after professions. It is a tragedy that we are in a situation that is only expected to get worse, yet we are unable to produce the resource we need the most – nurses and midwives.

The emergency department is viewed as a safe haven by the public, a place to go for care when they are ill or injured. It is becoming increasingly difficult to be able to meet the needs of our patients because of the overcrowding crisis. Overcrowding is not just an emergency department issue; it is a systems issue, and many persons have chosen to use the term "*hospital* overcrowding," which is more reflective of what is truly occurring with an increasing frequency.

Where do we go from here? We need to find, successful, innovative approaches are to be used to lessen the burden of hospital overcrowding on all the hospital departments. We need to work very hard to find these solutions, but unfortunately in our situation things move on very slowly… meetings are called, and again meetings are called to discuss the situation and we end up with a lot of words scribbled on paper and nothing else. We cannot move in any direction, because we are not allowed to do so. We are all in the same boat together, and weather you work in an emergency department, in a ward setting or in an outpatient department setting, the problem of overcrowding is the biggest headache daily. If your department has implemented a strategy that has made a difference, share this information with your peers. We are all in this together; we need to work together to help address the problem.

No matter what some people might say… we, nurses and midwives do all this for our clients. We are afraid, that because of the overcrowding we might not give our clients the care that they really need. And yes we nurses and midwives care for our clients… and yes we want to give the best care that we can give.

the editor

message from the president

Paul Pace President
mumn@maltanet.net

As I am writing this article I am being threatened to be taken to court by the Permanent Secretary since according to him my e-mails are libellous. Life today as President of MUMN is a continuous struggle on the issues the nurses and the midwives are facing.

Just to give you a small idea, presently MUMN has industrial actions in four hospitals and in all eight Health Centres in the Maltese islands. Such disputes ranges from violence on nurses as in the case of Mt. Carmel Hospital, to Nursing Officers ordered to act as couriers or pharmacy administrators in Health Centres, to bloodletting and poor quality of liquid soap in Boffa Hospital, to clamping and nursing officers rosters in Mater Dei Hospital etc etc. SVPR was also in the picture when internal transfers were being issued in that hospital. Some disputes are being resolved, others will not since certain directives will remain in force due to poor management which some hospitals have. Then as MUMN we have a considerable number of disciplinary cases which we face on a daily basis. Some are quite serous in nature since some nurses are even facing dismissal charges.

There was a time, were the Health Division through the Office of the Permanent Secretary, monthly meetings with MUMN used to take place. There was a time that MUMN use to be consulted before any major decision on nurses/ midwives were taken. But that is all gone. One phone call from a member and as MUMN, we would have to figure out how to solve indiscriminating orders on nurses/midwives that MUMN has not even been consulted with the result that industrial actions have to be issued to neutralise the bulldozer type management being used on us nurses and midwives. In Mater Dei Hospital we have reached to a stage that the peasants (that is us nurses) can have our cars clamped or belongings searched whilst the noble class (that is the consultants) will not have such same treatment. But anyway, thank God there is a group of people under the name of MUMN who work and think how to protect the nursing and the midwifery profession.

Let us not be all gloom and doom. Recently we have been informed by human resources that two claims that MUMN has been requesting for some time have been approved. I am referring that the nurses over sixty one who had to renew their employment every three months need not to do that anymore since such contract will be renewed on a yearly basis for such nurses. The second issue is that all degree nurses and midwives from this year will commence in scale 10 immediately and not wait for their appointment. Other good news is that we have presented the sectorial agreement for nurses and midwives and that MUMN is still in negations with the other unions on the civil service agreement. In the civil service agreement, what I can say is that MUMN has major hurdles to be discussed and we are far from our targets set as MUMN. Other issues which MUMN is still trying accomplish is to fill all vacancies of the DNM's in all hospitals and has written several emails on this regard. The midwifery document has been finalised by our midwives and a meeting is shortly coming on the role of the midwife in the community. Another issue is that MUMN has requested a meeting with the Principal Permanent Secretary in the PAHRO Office in Castille since MUMN is proposing amendments in the disciplinary regulations of 1999 regulating the civil sector.

So MUMN is quite very active in all fronts and I did not make any reference of the work MUMN is doing in FORUM where a historic event have taken place where the three confederations which are FORUM, CMTU and GWU all met around a table to discuss the relationship between confederations in Malta. During this year MUMN has received good feedback on its effort to update the email list of its members. Make sure that if you are not receiving any emails from MUMN please to phone on 21448542 or send us an email on administrator@mumn.org so that your email address will join the numerous emails we have in our data base. Such emails are being used so as to update members on the current issues in our profession and to notify all members when industrial disputes have been issued due to lack of meetings which has become the norm in the Health Division. MUMN's membership is also at a record high and that shows that nurses and midwives are feeling more the need to be part of one big family.

I hope you all had a nice holiday with your family since as nurses and midwives, we all deserve it due to our stressful professions. We will meet again in December in the next issue of the musbieh. In the meantime take care of yourself and your family.

Paul Pace President

message *from the general secretary*

Colin Galea
General Secretary
mumn@maltanet.net

Fil-mument l-MUMN hija nvoluta f'negozjati mal-Gvern fit-tliet fora differenti. L-ewwel hemm il-Ftehim Kollettiv għall-ħaddiema kollha fis-Servizz Pubbliku li ilna niddiskutu dwaru minn Marzu tas-sena l-oħra! Għalkemm f'dawn l-aħħar ġimgħat imxejna fid-diskussjonijiet, aħna qed inqisu dan il-Ftehim Kollettiv bħala l-agħar wieħed f'dawn l-aħħar sittax–il sena fejn jidħlu kundizzjonijiet ta' xogħol ġodda kif ukoll bħala żidiet fil-pagi. Kif dejjem għamlet l-MUMN mill-bidunett tat-twaqqif tagħha, qabel jiġi ffirmat dan il-Ftehim, tiġi msejjħa Laqgħa Ġenerali Straordinarja biex tkunu intom il-membri li tapprovaw jew le dan il-Ftehim Kollettiv.

Barra minn hekk wasalna wkoll biex niffinalizzaw il-Ftehim Kollettiv tan-nurses li jaħdmu fl-Isptar Karen Grech. Bdejna wkoll niddiskutu l-Ftehim Settorali tan-*nurses* u l-*midwives* kollha. L-aħħar wieħed li kien sar kien fis-sena 2007. S'issa saru żewġ laqgħat u naħseb li dawn id-diskussjonijiet ittawlu ftit peress li qed niddiskutu kunċetti ġodda. Nispera li sa ħarġa oħra nkunu lestejna tnejn minn dawn it-tlieta biex b'hekk inkunu nistgħu aktar nikkonċentraw fuq il-Ftehim Settorali.

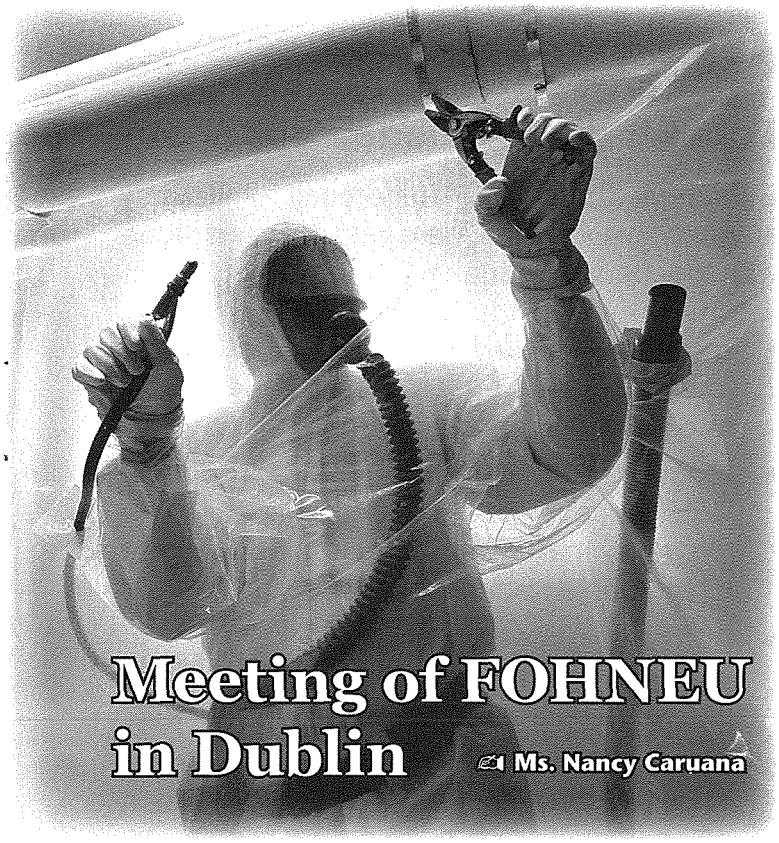
Minn dan ix-xahar erġajna bdejna norganizzaw il-*courses* edukattivi u maniġerjali fl-uffiċċju tal-Union fil-Mosta. Nista' ngħid li dawn il-*courses* qed jintlaqgħu tajjeb ħafna u l-konkorrenza dejjem tkun waħda tajba. Huwa ta' sodisfazzjoni kbir għalina li l-uffiċċju tal-Union jintuża ukoll għal dan il-għan. Kull min huwa interessat sabiex ikun jaf aktar dwar dan jista' jibgħat email fuq mumn@maltanet.net

Matul dan ix-xahar tlajna wkoll niddiskutu numru ta' kundizzjonijiet tax-xogħol fil-Ministeru għal Għawdex. Dawn il-laqgħat kienu pożittivi ħafna u sar progress sinifikanti. Fl-Isptar Mater Dei qed niddiskutu tibdil fir-*roster* ta' *Nursing Officer* u *Deputy Nursing Officer* bil-għan li mingħajr ma ntellfu il-mod ta' kif titmexxa s-sala, dawn in-nurses jitnaqsilhom l-istress li jġib miegħu t-tmexxija tas-swali f'dan l-isptar. Barra minn hekk iltqajna mal-Ministru ta' l-Edukazzjoni sabiex intejbu l-kundizzjonijiet tax-xogħol tan-nurses li jaħdmu fl-iskejjel u li qegħdin impjegati mad-Diviżjoni ta' l-Edukazzjoni.

F'dawn l-aħħar ġimgħat, l-Amministrazzjoni tal-Union iltaqgħet mal-*Group Committee* l-ġdid ta' l-istudenti. Dan il-kumitat għandu ħafna pjanijiet kif l-istudenti fin-*nursing* u l-*midwifery* ikomplu jingħaqdu. Huwa ta' sodisfazzjon għalina li dan il-*Group Committee* reġa' ħa l-ħajja u qiegħed attiv.

Is-sistema ta' komunikazzjoni bl-emails qed tirranka sewwa u numru sostanzjali ta' membri ikkummentaw b'mod pożittiv dwar kif l-MUMN qed tinfurmhom b'mod frekwenti dwar dak li jkun qed iseħħ fuq il-post tax-xogħol tagħhom. Għad baqa' niġbru l-emails ta' numru ta' membri li għadhom ma ntlaħqux u għalhekk inħeġġeġ li dawk il-membri kollha li għadhom ma tawniex l-email tagħhom sabiex jagħmlu dan mill-aktar fis possibli billi jibagħtu email bid-dettalji tagħhom fuq administrator@mumn.org

Colin Galea Segretarju



Meeting of FOHNEU in Dublin

Ms. Nancy Caruana

As a member of the board of FOHNEU (Federation of Occupational Health Nurses within the European Union) I attended the board's 33rd meeting held in Dublin Ireland in May. The meeting was hosted by the Irish Nurses and Midwives Organisation – INMO.

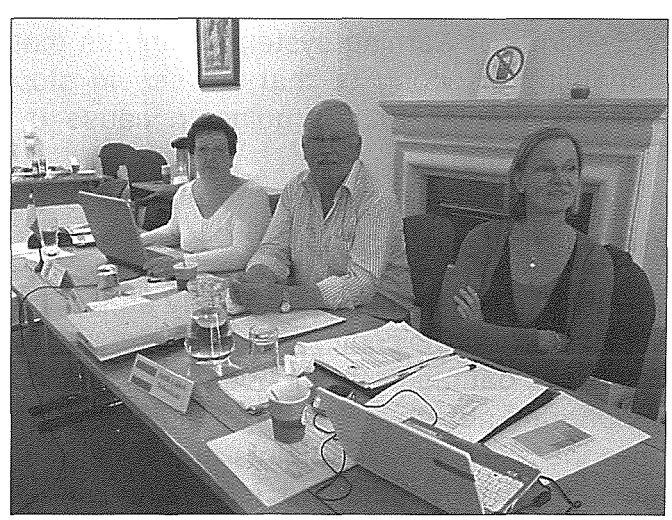
Annette Kennedy INMO Director of Professional Development as well as by Liam Doran INMO General Secretary addressed the meeting. They both spoke about the current austerity policies which the Irish Government has had to implement in face of the Country's financial crisis. All Nurses and Midwives working in Ireland have suffered pay cuts and strict absence management policies have been put in place with adverse effect on health workers increasing mental and physical stress levels.

We were given information regarding the Summit on the EU Directives on needle stick injuries which was about to be held on 1st June at Dublin Castle which was also at the time being organised by INMO..

The meeting was attended by Occupational Health Nurses representing Denmark, Greece, Sweden, The Netherlands, Finland, Ireland, France, Hungary and Malta. National updates from the various countries were discussed. All members split up into different working groups to discuss OHN education, EU lobbying for OHN, FOHNEU finances and the upcoming International Congress.

The 5th International FOHNEU Congress on Occupational Health is being held 19th to 21st September 2012 in Tarragona Spain. The title of the Congress is ***'Embracing the future-Influencing change***. This conference should be of interest to all nurses and midwives and not just the ones directly working in Occupational Health because it will be addressing many issues which are of concern to all health workers. ***Work life Balance, New Emerging Risks, Dealing with an ageing workforce, Psychosocial Risk Management, Shift Work and Health The Nurse's Role in Accident Prevention at the Workplace, Disaster Management at the Workplace*** and many more interesting subjects will be addressed. For more information please visit the FOHNEU website at http://www.fohneu.org/ and the congress website on http://www.fohneutarragona2012.com/.

We are trying to organise a group from Malta as this is a brilliant opportunity to learn more about how to take care of ourselves as health workers and also to take care of the workers in our charge. The Congress is being held at the ***Palacio Ferial y de Congresos de Tarragona***. The dates of the congress were chosen to coincide with the celebrations of Santa Tecla which is described as a burst of joy, music and colour not to be missed. This Congress could easily fit in with an enjoyable family holiday. If you are interested kindly inform MUMN.



Nancy (L) sitting next to the Netherlands OHN reps.

Understanding pain

Everyone has felt pain at one time or another. Pain can be anything from the slight discomfort from sitting too long in the same position to the severe, pulsing pain of a migraine. It can also be a short-term, acute problem, such as a headache, sprain, strain, dental pain and pain during delivery and labor. It might also be a longer-lasting chronic pain, such as arthritis.

The trouble is that many patients that you encounter might not know the best way to manage their pain. A large number of patients are confused by analgesics (pain relievers) and don't know the difference between the main oral pain relievers, paracetamol, aspirin and ibuprofen.

You can play a vital role in helping patients understand more about their pain, so they can get it under control. In some cases, this means they have to use pain relievers. Other times what helps most is being aware of the small lifestyle changes they can make to help avoid problems in the future. Passing on this knowledge not only helps patients, it also demonstrates the difference the community of nurses and midwifes can make to their health and well being.

What is pain?

Pain is described as "an unpleasant physical or emotional feeling that your body produces as a warning sign that it has been damaged".[1] What this means is that pain acts as our body's in-built warning system, telling us that something is wrong or that we should stop doing something that is going to cause us further damage.

How we feel pain?

The main pain sensors in the body are called nociceptors. Nociceptors detect actual or potential damage throughout our body's peripheral nerves.[2] Peripheral nerves run from the skin, muscles, joints and organs to the spinal cord. From there, information about pain is carried to the brain.[3]

Factors that influence our pain

Everyone feels pain differently, but how severely we feel the pain and how we cope with it depends on many factors:[2]

- ***our emotional and psychological state*** – if we feel low then we're usually less able to cope with pain
- ***memories of pain*** – having a bad experience at the dentist as a child, for example, may make dental pain feel more intense as an adult
- ***attitude*** – if we know we have a job to finish then we may be able to work through the pain until it's done
- ***expectations*** – there are some types of pain we may expect to feel worse than others, such as a migraine headache compared with an ordinary headache
- ***beliefs and values*** – for example, some people may believe that it is best to use non-drug treatments to manage their pain
- ***age*** – children may feel pain more intensely than adults
- ***social and cultural differences*** – in some societies complaining about pain is seen as a sign of weakness.

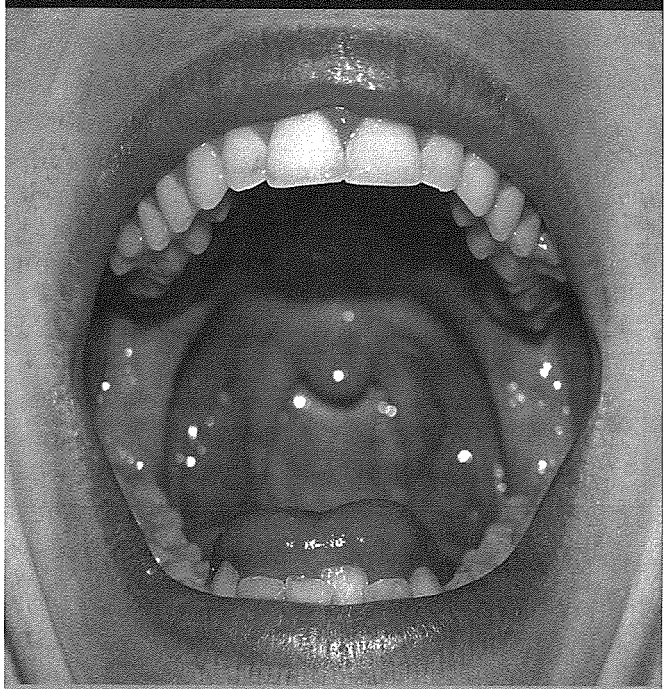
Pain is a problem that each of us feels differently. This may make it hard for you to put yourself in patients' shoes and imagine how they are feeling when they ask for your help. Patients may also be suffering pain at the precise moment they are talking to you, which can make it even harder for them to explain how they feel.

What this means is that it is important to provide self-help tips so patients can take control of their pain in a way that best suits their needs.

References

1. NHS Direct: Medical Glossary: Pain. http://www.nhsdirect.nhs.uk/glossary/index.aspx#P
2. MayoClinic. Health: Pain. http://www.mayoclinic.com/health/pain/PN00017

Radiotherapy & Oral Mucositis



Kristin Sammut Henwood
(Specialist Nurse, ENT)s

There are three main treatment modalities to treating cancer; namely these are: surgery, radiotherapy (RT) and chemotherapy (Priestman, 2007). In recent times, these different modalities are increasingly being used in combination in order to give the patient the best possible chance of increased remission or cure. Nevertheless, this article will focus on radiotherapy, as it has a crucial role in the definitive treatment of head and neck (H&N) cancers (Cady, 2007).

According to Faithfull (2006), nurses often lack knowledge and understanding about the effects of RT and how it impacts on the patients' and their families' lives. Thus, it is essential that healthcare professionals gain awareness of this treatment modality in order to provide effective care and support throughout the cancer journey. A brief overview of RT will be presented hereunder, followed by the possible adverse reaction. Special consideration will be given to Oral Mucositis (OM).

Radiotherapy

According to Faithfull (2006), RT has been used during the last century for treating cancer. This treatment modality consists of the medical use of ionising radiation to destroy cancer cells within the body. This is achieved by two main effects of ionizing radiation on Deoxyribonucleic Acid (DNA) – direct and indirect (Priestman, 2007). Direct action is when ionization occurs directly with the DNA molecule. Additionally, it interacts indirectly when ionisation of a water molecule produces short-lived ion radicals, also associated with DNA damage. If this damage is not repaired, cellular death or loss of its reproductive capacity will ensue (Jham & Freire, 2006; Tadman & Roberts, 2007).

Since DNA content of a cell duplicates during mitosis, cells with a high level of mitotic activity are more radiosensitive. Therefore, malignant cells are susceptible to radiation effects as these cells are in a continuous multiplying process (Faithfull, 2006). Moreover, the desirable effects of RT are further enhanced because cancer cells are generally less effective at repairing themselves than normal cells. Nevertheless, normal cells are also damaged by radiation which can lead to several distressing side-effects. Radiation side-effects vary from site to site and a comprehensive discussion of all possible side-effects is beyond the scope of this article, therefore the H&N region was chosen. Cancers of the oral cavity, larynx and pharynx are increasing in incidence and according to Boyle & Ferlay (2005) account for approximately 5% of cancers across the European Union. Researchers have asserted that side effects of RT to the H&N can be severe (Sutherland & Browman, 2001; Duncan et al., 2005) and can have an overwhelming effect on the patient's quality of life (Tadman & Roberts, 2007).

Adverse Reaction of Radiotherapy

Symptoms caused by RT are generally related to the area which is being irradiated (Faithfull, 2006; Preistman, 2007). There is, however, a common general effect, which is not related to a particular area but is extremely common (Tadman & Roberts, 2007) – fatigue. Faithfull (2006) stated that the aetiology of fatigue is still uncertain but it is assumed to have a cumulative effect that intensifies over the course of treatment (Preistman, 2007).

Adverse reactions to RT are dependent on various circumstances. Namely these are the volume and area being irradiated, the total dose, the fractioning, the age and clinical condition of the patient and the associated treatment (Jham & Freire, 2006). Faithless (2006) stated that many H&N cancer patients are submitted to high doses of RT on large areas including the oral cavity, maxilla, mandible and salivary glands. Adverse reactions may be acute in nature happening during the treatment and are mainly reversible or late complications which are normally irreversible, leading to permanent incapability and worsening the quality of life (Tadman & Roberts, 2007). Common adverse reactions are described in table 1 overleaf.

ADVERSE REACTION	DEFINITION
MUCOSITIS≠+	Oral mucosal irritation, causing severe pain, dysphagia and loss of appetite, which could ultimately lead to malnutrition and weight loss.
XEROSTOMIA	Dry mouth due to lack of saliva, causing mouth pain, loss of appetite, chewing difficulties, halitosis (unpleasant odours exhaled) and dysgeusia (taste alteration).
INFECTION	Infections of the oral cavity most commonly caused by an overgrowth of Candida species.
RADIATION CARIES	Dental cavities that occur as a result of receiving RT, which also makes teeth more susceptible to decalcification.
OSTEORADIONECROSIS	Bone ischemic necrosis especially affecting the mandibles.
SOFT TISSUES NECROSIS	Ulcer located in the radiated tissues, without the presence of residual malignancy.
TISSUE FIBROSIS	Fibrosis is manifested by a loss of pliability and flexibility of the soft tissues, might cause Trismus (inability to open the mouth normally) if fibrosis affects the chewing musculature.
SKIN REACTIONS	These are characterised by erythema (reddening of the skin in the treated area), dry desquamation (red, dry, flaky skin) and moist desquamation (skin peeling, pain, weeping with exudate).
ALOPECIA	Loss of hair in the irradiated area.

Table 1: A compilation of the main adverse reactions experience by H&N cancer patients undergoing RT (Cheng, 2006; Garden, Lewin & Chambers, 2006; Jham & Freire, 2006; Tadman & Roberts, 2007).

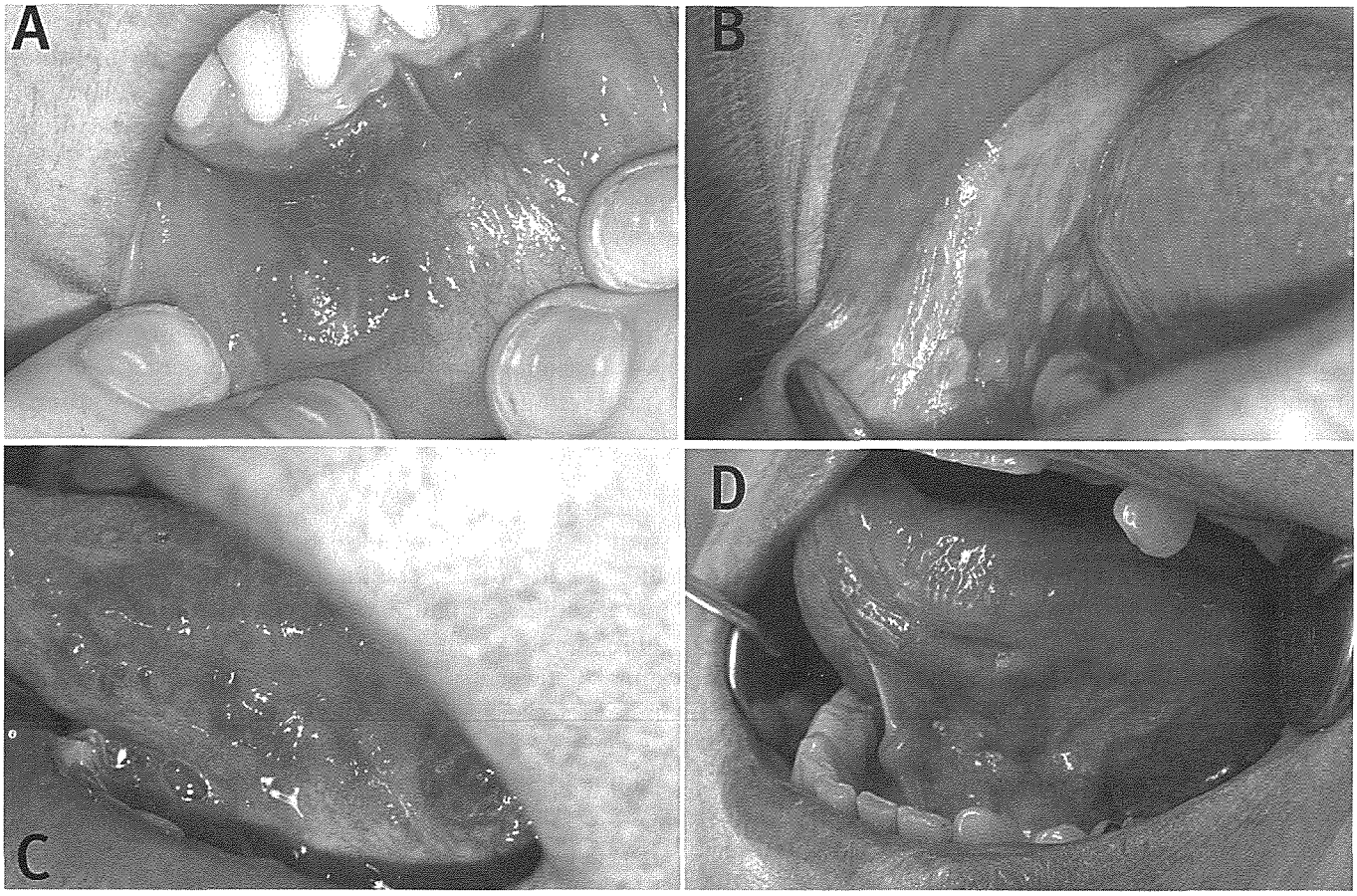
From Table 1, it is evident that numerous oral consequences occur due to RT. Cheng (2006) claims that even though these oral developments are not life-threatening complications; they negatively impact patients' lives. Oral Mucositis (OM) is the most common acute side-effect affecting nearly all patients receiving RT for the H&N (Sutherland & Browman, 2001; Lalla & Peterson, 2006; You, Hsieh & Huang, 2009). Thus a description of OM followed by the preventive and management strategies will be described hereunder.

ORAL MUCOSITIS

The term OM was coined in the late 1980s (Alvarado, Bellm & Giles, 2002) and is defined as inflammation of the oral mucosa associated with chemo or RT. OM has a negative impact on the dimensions generally measured to assess quality of life. Indeed according to Alvarado et al. (2002) OM is a multifaceted clinical problem causing physical, functional, emotional, psychological and social disturbances as it affects the critical functions associated with the oral cavity; including eating, drinking and speaking (Larsson, Hedelin & Athlin, 2003).

The exact nature, duration and severity of the dysfunction associated with OM are dependent on both treatment and host factors, thus vary greatly from one patient to another (Plevova, 1999; Kostler, Hejna, Wenzel & Zielinski, 2001). Numerous patient-related factors have been reported in the literature (Sonis & Fey, 2002; Barasch & Peterson, 2003). These include age, pre-existing periodontal and dental problems, poor oral hygiene, low salivary production, alcohol and tobacco use and nutritional status.

The clinical manifestation range from erythema, severe inflammation to ulceration of the epithelia and bleeding accompanied with intense discomfort and pain. OM along with xerostomia may render patients more susceptible to infections and negatively affect oral intake of fluid and nutrients (Karthaus, Rosenthal & Ganser, 1999). Malnutrition will in turn adversely affect mucosal regeneration (Cheng, 2007). Additionally, these toxicities may also lead to a delay in cancer therapy or modulation of the treatment regimen resulting in unfavourable outcomes of the cancer therapy (Karthaus et al., 1999; Eilers, 2004). Duncan and Grant (2003) stated that this is because



some neoplastic cells will survive or recover during this delayed period. OM is also associated with significant expense due to cost associated with number of visits to healthcare personnel, pain management, nutritional supplements, gastrostomy tube placement or total parenteral nutrition, intravenous hydration, management of secondary infections and hospitalizations (Peterman, Cella, Glandon, Dobrez & Yount, 2001; Lalla & Peterson, 2006).

Thus, OM has emerged as a devastating complication of cancer therapy and the multidisciplinary team, consisting of doctors, nurses, speech therapists, nutritionists and dentists; are in a central position to prevent, recognise and manage OM, aiming to ameliorate its debilitating effects on patients and their families. The following sections will be aimed towards the preventive and management strategies.

STRATEGIES

According to Faithfull (2006) numerous approaches for the prevention and treatment of OM are available. These approaches range from altering the mucosal exposure, changing mucosal epithelial proliferative capabilities, altering the potential for infectious and inflammatory complications together with providing supportive care.

There are endless papers investigating the affects of agents on prevention and management of OM. Some agents that were investigated are mouth-coating agents such as sucralfate (Shih, Miaskowski, Dodd, Stotts & McPhail, 2002); antimicrobial agents including including tobramycin, amphotericin B and flucanazole (Donnelly, Bellm, Epstein, Sonis & Symond, 2003), chlorhexidine (Stockman et al., 2006; Harris, Eilers, Harriman, Cashavelly & Maxwell, 2008) and povidone-iodine (Rahn et al., 1997); natural occurring substances like chamomile (Kostler et al., 2001) and honey; anti-inflammatory agents such as benzydamine hydrochloride (Kim, Chu, Lakshmi & Houde, 1998; Epstein et al., 2001; Berger & Fall-Dickson, 2005; Kazemian, Kamian, Aghili, Hashemi & Haddad, 2009). The use of cytokines, growth factors and laser therapy are recent developments (Duncan & Grant, 2003; Stockman et al., 2006). Albeit, until now, definitive approaches for the prevention or management of RT induced OM have not yet been identified (Karthaus et al., 1999; Kostler et al., 2001; Alvarado et al., 2002; Eilers, 2004; You et al., 2009).

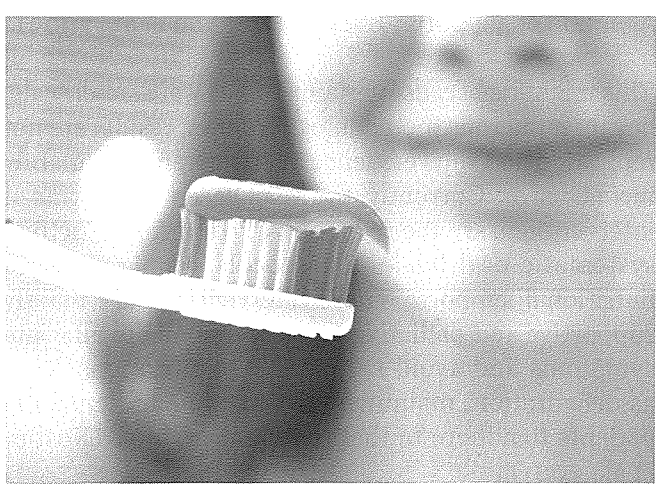
This might be because certain studies were small scale, having numerous methodological flaws, results are not replicated and thus evidence of effectiveness is mainly inconclusive. Currently, the most acceptable forms of interventions are the reduction of patient risk factors, systematic oral hygiene protocols, pain relief and nutritional support. These interventions are mainly supportive and palliative in nature, aimed to alleviate symptoms and avoid secondary complications, such as dehydration, malnutrition, infection and enabling patients to adhere to the treatment protocol (Kostler et al., 2001).

Reduction of Patient Risk Factors & Oral Hygiene Protocols

According to Kostler et al. (2001) poor oral care with concomitant dental and periodontal pathology predisposes patients to a greater risk for oral complications. Additionally, Stockman et al. (2006) pointed out that ill-fitting prostheses, orthodontic appliances, defective restorations and other sources of mucosal and gingival irritation or inflammation have been linked with a higher risk of developing OM and secondary infections.

Thus careful inspection of the oral cavity, periodontal, dental and if necessary, radiographic evolutions prior to the initiation of RT is highly warranted, and should be repeated at regular intervals in the course of the treatment (Kostler et al., 2001; Eilers, 2004). Additionally, all prostheses and orthodontic appliances should be cautiously examined and it is recommended that any restorative dental procedures should be performed at least three weeks before RT (Kostler et al., 2001).

Oral care protocols have a strong potential to decrease problems associated with OM (Eilers, 2004) and thus oral assessment instruments should be used regularly to assess function, pain and the integrity of the oral mucosa. Patients and relatives should also be instructed on how to examine the oral cavity and when to report abnormal findings to healthcare professionals (Larson et al., 1998). Indeed, they should also be able to identify signs of infection. Protocol should be simple, realistic and acceptable for the patients and their families in order to ensure implementation and compliance (Faithfull, 2006). The information should include detailed data regarding toothbrush type, when brushes should be replaced, the need for consistent, regular, and thorough brushing, flossing and the use of mouth rinses (Larson et al., 1998). Dodd et al. (2003) claimed that salt and soda rinses should be used due to its effectiveness and also because patients can easily prepare it at home at a negligible expense.



Denture wearers should be instructed to remove dentures every time oral care is performed, to cleanse them regularly and to use them only whilst eating when mucous membrane breakdown occurs (Eilers, 2004). Patients should also be advised to avoid smoking and consuming alcohol (Wilkes, 1998).
Yet, despite its acknowledged importance in the literature, oral care is often overlooked when nursing workloads are excessive (McGuire, 2003). Indeed, this author also stated that standards of oral care were used inconsistently in patient undergoing cancer treatment and were nonexistent in many institutions.

Pain Relief

The principle symptom of OM is pain, which will significantly affects nutritional intake, mouth care and quality of life (Lalla & Peterson, 2006). Thus management of pain is a primary component of OM management. A gamut of topical analgesics and anaesthetic agents are available, which offer short-term relief. However, most patients with severe OM require systemic analgesics, including opioids for satisfactory pain management (Lalla & Peterson, 2006).

Evaluating a person's pain requires a number of skills in communication. According to Tadman and Roberts (2007) these include listening, verbal and written reporting skills, relationship building and observation. It is an ongoing process that requires a systematic updating and re-assessment of the situation. Various pain assessment tools can be utilized, such as visual analogue scales, numerical rating scales or even patient pain diaries, where apart from encouraging the patients to have an active role in managing their pain, a deeper understanding of how pain impact on quality of life and what interventions were helpful is also gained (Tadman & Roberts, 2007). Other techniques such as relaxation and visual imagery could also improve OM pain (Pan, Morrison, Ness, Fugh-Berman, Leipzig, 2000).

Providing Nutritional Support

OM accompanied with dysphagia, mouth pain, loss of appetite, xerostomia and dysgeusia can significantly affect nutritional intake (Lalla & Peterson, 2002; Cady, 2007). According to Cady (2007) malnutrition is a serious clinical concern for H&N cancer patients, their caregivers and their providers. Additionally, OM and radiation dermatitis, may be exacerbated by poor nutritional state during therapy and may lengthen recovery time because of the effects of malnutrition on wound healing. Thus, nurses working with patient with H&N cancer are in an ideal position to identify those at risk for nutritional-related complications, provide support and education about nutrition during treatment and also influence patients' and families' decisions regarding supportive care (Faithless, 2006; Tadman & Roberts, 2007).

Multiple strategies have been suggested in the literature to prevent morbidity related to malnutrition and weight loss. These include baseline assessment of weight and regular evaluations during treatment, assessment of swallowing ability and hydration status - emphasizing the importance of early detection and prompt intervention (Cady, 2007). Patient and family education is crucial and should incorporate specific dietary guidelines together with nutritional support information. This information should include recommendations to avoid dry, salty, spicy, acidic and hot foods due to the fact that their potential to damage the oral mucosa (Faithfull, 2006). Conversely, liquidized or soft foods may aid to decrease oral discomfort whilst eating and facilitate swallowing (Wilkes, 1998). High risk patients should prompt more aggressive interventions such as the promotion of high calorific diet or the provision of high protein nutritional supplements (Larsson, Hedelin, Johansson, & Athlin, 2005).

Feeding tubes are beneficial in facilitating adequate nutrition and hydration in patients with severe OM (Cady, 2007). Percutaneous endoscopic gastrostomy tubes (PEG) tubes are preferred over nasogastric tubes (NGT) in patients with H&N cancer (Lee et al., 1998, Piquet et al., 2002). Currently, criteria for patient selection regarding prophylactic PEG tube insertion are not standardized and in the local setting, clinical judgment and preference of the caring consultant guides the decision on an individual basis. Usually this intervention is envisaged as the last resort; even though the benefit of prophylactic tube placement at treatment initiation, prior to development of complications is being increasingly recognised in the literature (Scolapio, Spangler, Romano, McLaughlin & Salassa, 2001; Cady, 2007).

Conclusion

A brief overview of RT as a cancer treatment modality was provided, together with the possible adverse reactions associated with RT in H&N cancer patients. Emphasis was given to OM, which from this article, it is obvious that it is more than a sore mouth and well informed and concerned healthcare professionals focused on ameliorating its effects can improve the quality of life of patients experiencing OM. To date, there is no single, effective treatment for the prevention and management of OM and strategies are mainly supportive and palliative in nature.

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Post-Partum Urinary Incontinence

Almost half the number of women giving birth, experience urinary incontinence during pregnancy and/or post-partum[1]. Urinary incontinence was reported by 31% of women with a first-time-pregnancy, who were continent before pregnancy [2]. The incontinence observed during this period tends to regress in 60 to 80% of the cases. However, this might be the result of a light pelvic alteration which could cumulate at each delivery [1]. Prevention and treatment of incontinence normally involves recommendation of pelvic floor muscle training during pregnancy and after birth [3, 4,]. However, it is also important that such persons use good quality continence devices which are adequate for urinary incontinence as well as for absorption of blood, to help improve their quality of life during this period.

Urinary incontinence is the loss of bladder control. Symptoms can range from mild leaking to uncontrollable wetting. Most bladder control problems happen when muscles are too weak or too active. Stress incontinence may happen if the muscles, that keep the bladder closed, are weak. Hence, there may be accidents when one sneezes, laughs or lifts heavy objects. On the other scenario, urge incontinence or overactive bladder, takes place when bladder muscles become too active. One may feel a strong urge to go to the bathroom when she has little urine in the bladder. [5]

Pads and pull-up pants are the main products used for bladder incontinence. Levels of incontinence in different persons may vary in range, from light to medium to heavy. The absorption capacity of product chosen should be based according to patient needs. The more absorbent the product, the less it is discreet. Hence, persons who have light incontinence do not need to use highly absorbent products, which are possibly less discreet and more expensive.

Users' perceptions and desirable features of incontinence products mainly concern security and reliability, odour control, absorption capacity, leakage protection, skin friendliness, wearing comfort, ease in handling, discretion and a good quality/price ratio.

Good quality continence devices are able to provide:

- **A Perfect fit** since they are anatomically shaped to fit closely and safely to the body. Friction from clothes or continence devices is one of causes of groin rash [6].
- **Discretion** having an odour neutralizer, are not bulky, and do not rustle on movement
- **Security & Reliability:** through the use of a system that locks wetness away quickly & safely, through the use of super absorbent gels in the core. This is important when considering that frequent incontinence, constant exposure to moisture, the use of continence devices that do not allow the skin to breathe, and decreased mobility may put a person at a higher risk for Incontinence-Associated-Dermatitis [7].
- **Integrity of device** without tear during use
- **Comfort** through the use of air-permeable materials similar to normal underwear. In contrast to occlusive materials; semi-permeable materials enable the circulation of air and consequently allow heat exchange for a balanced skin climate. Reduction of heat and sweat build-up, enhance skin comfort and support prevention and reduction of skin redness and irritations[6][7].
- **Skin friendliness** through the use of skin-friendly materials which are less likely to cause skin sensitivities. Constant contact with possible allergenic materials may cause Contact Dermatitis (6). Hypoallergenic and dermatologically tested products offer the best possible guarantee of reliably preventing allergic reactions.
- **Anti-bacterial and skin protective effect** by using materials, which are in continuous contact with the skin, that keep a slightly acidic pH [7].
- **Suitability to absorb bleeding** is especially important after birth, in order to cater for heavy vaginal bleeding.

Choosing the right continence device to address a person's needs will lead to the achievement of cost-effectiveness through better use of the products' potentials, thus avoiding excessive consumption and waste. Not all continence devices are indicated for absorption of blood as well as for urinary incontinence. However, these are available on the market, and although not being the cheapest; such devices are not necessarily the most expensive. A summary of the advantages to be achieved when using such good quality products would be: better comfort, substantial savings in laundry costs, less skin problems and a better value for money. The Nurses'/Midwifes' input, in recommending the right continence device to their patients, is of utmost importance, since they are able to understand the necessary features, built into such products, in order to lower health associated risks.

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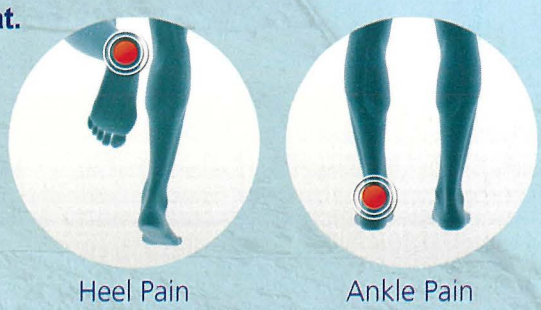

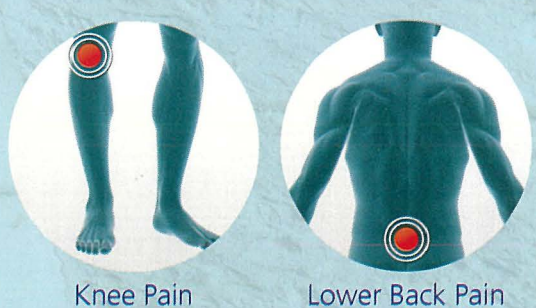

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1 L-MUMN ħadet sehem, permezz tal-FORUM, fil-Protesta organizzata mill-ħaddiema ta' l-Air Malta dwar il-sitwazzjoni xejn feliċi f'din il-kumpanija.

2 Il-kummissjoni elettorali ta' l-MUMN waqt l-għadd tal-voti sabiex ġie ppubblikat ir-riżultat tal-membri eletti biex jiffurmaw Kunsill ġdid għal dawn l-erba' snin li ġejjien.

3 L-MUMN kellha laqgħa maż-żewġ partit politiċi ewlenin f'pajjiżna sabiex tinstab soluzzjoni biex jitnaqqas l-inkonvenjent tal-pazjenti fil-ġurnata ta' l-Elezzjoni Ġenerali. Fir-ritratt tidher il-laqgħa li saret mal-Partit Nazzjonalista.

4 Ftit ġimgħat ilu saret l-attività tas-Sajf ta' l-MUMN fejn numru sabiħ ta' membri attendew għal BBQ fil-MAYA Beach.

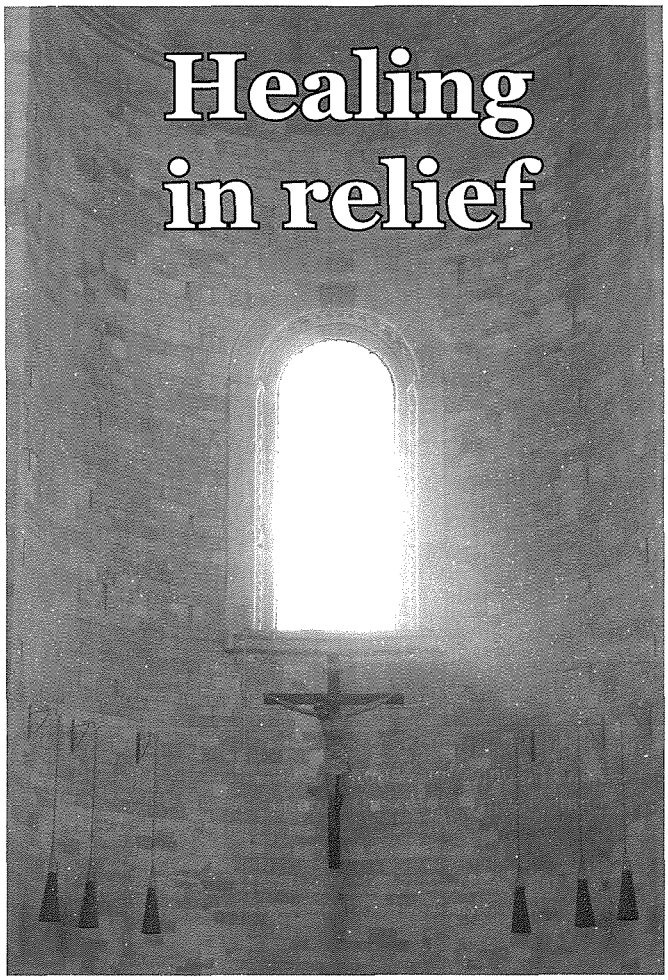
5 L-Uffiċjal (Ms. Nancy Caruana) responsabbli mill-*Occupational Health & Safety* ta' l-MUMN attendiet għall-laqgħa importanti li saret f'Dublin (it-tieni mill-lemin fl-ewwel filiera minn quddiem)

6 Kien ta' sodisfazzjon għall-MUMN li Nurse Ms. Therese Saliba (it-tieni mix-xellug) irċeviet wieħed mill-premijiet prestiġjużi mogħtija mill-Management ta' l-Isptar Monte Carmeli lill-ħaddiema ta' l-isptar u tal-kommunità.

7 Il-Group Committee tal-Pensjonanti mmexxija mis-Sur Paul Bezzina reġa' għal darba oħra organizza ħarġa għall-membri ta' l-istess taqsima.

8 L-Administration ta' l-MUMN flimkien ma' l-Group Committee tal-Pensjonanti fl-Uffiċju Ċentrali tal-Union fil-Mosta.

Healing in relief



Relief is a particular sculptural technique. The term *relief* comes from the Latin verb *levo*, which means to raise. Hence, to create a sculpture in relief means to offer the impression that the sculpted material has been raised above the background plane. The Chapel of *Mater Dei* has recently been witnessing the inspiration of art combined with the power of healing as represented in the two bronze panels which stand on each side of the main altar of the Chapel. Such a remarkable piece of sculpture was designed by Rev. G. Gauci and worked in bronze by the Domus Dei factory in Rome.

Chaplaincy literature has always presented the chapel as that special place where the power of healing is made available all the time, embracing both space and time. In fact, Eric Guthrie, a staff chaplain at Carolina Medical Center Mercy, in Charlotte, NC, wrote an interesting article on the subject entitled *Creating sacred places*. In it he appreciates the uniqueness of the hospital chapel. "The sacred space of a hospital chapel is a sacrifice and an extravagance for God and our hospital congregations. The chapel is largess. It is a gift given out of love and a deeper understanding that the body is more than the sum of its parts – cells, tissues and organs. As a human being has a soul, so also the hospital organism needs a soul. Our souls would languish if there were only walking and no dancing, talking and no singing, speaking and no praying. Stained glass windows and frescos speak to us in a way that ordinary walls do not".

Both panels speak volumes of God's sacrifice and extravagance, spirit and incarnation, walking and dancing, talking and singing, speaking and praying as manifested in the life and ministry of his beloved Son, Jesus Christ, God Incarnate. In both panels one could better understand the saving programme of the Messiah, as Isaiah's last of the four Songs of the Suffering Servant, prophesized 2600 years ago: "Surely he has borne our griefs and carried our sorrows" (Isa 53, 4). With the tabernacle at the centre, hosting Jesus' living and therapeutic presence in the Eucharist, these bronze panels are shinning witnesses of Jesus' healing ministry which is still going on today.

It is wise perhaps to deeply appreciate each panel and describe it with some detail. The first bronze panel to be studied, which lies at the left hand side of the main altar, as you enter from the front door of the Chapel, represents sixteen figures. Starting from its far end and moving towards the tabernacle, we find the following Gospel figures: The paralytic of Capernaum (Matt 9,1-8, Mark 2,1-12, Luke 5,17-26); the man with a withered hand (Matt 12,9-14, Mark 3,1-6, Luke 6,6-11); the deaf man with an impediment in his speech (Mk 7,31-37); the servant of the High Priest in the Garden of Gethsemane (Luke 22,50-51); the two demoniacs in the land of the Gerasenes (Matt 8,28-34); the sick man by the Sheep Gate of Bethesda (John 5,1-15); the healing of the two blind men (Matt 9,27-31); the young boy suffering from epilepsy (Matt 17,14-21, Mark 9,14-29, Luke 9,37-43); the man from Capernaum with an unclean spirit (Mark 1,21-27, Luke 4,31-37); the man cleansed from his leprosy (Matt 8,1-4, Mark 1,40-45); the two blind men from Jericho (Matt 20,29-34); the healing of a dumb demoniac (Matt 9,32-34); the young man blind from his birth (John 9,1-41); a blind and dumb demoniac (Matt 12,22-29, Mark 3,20-30, Luke 11,14-23; 12,10); Peter's mother-in-law (Matt 8,14-15, Mark 1,29-31, Luke 4,38-39); and the healing of the king's official son (John 4,46-54).

On the other bronze panel, commencing from the tabernacle onwards towards its right end, we behold the ensuing nine characters: The daughter of the Canaanite woman (Matt 15,21-28, Mark 7,24-30); the healing of the ten lepers (Luke 17,12-19); a woman with a spirit of infirmity healed on the Sabbath (Luke 13,10-17); the woman suffering from a hemorrhage (Matt 9,20-22, Mark 5,25-34, Luke 8,43-48); the blind man from Bethsaida (Mark 8,22-26); the man

suffering from dropsy (Luke 14,1-6); the servant of the Roman centurion (Matt 8,5-13); a man with an unclean spirit from Gerasa (Mark 5,1-20, Luke 8,26-39) and the blind man, Bartimae'us (Mark 10,46-52, Luke 18,35-43).

Out of these twenty-five healings there are seventeen of them which speak about the physical dimension of the human person. These include the paralytic of Capernaum (Matt 9,1-8, Mark 2,1-12, Luke 5,17-26); the man with a withered hand (Matt 12,9-14, Mark 3,1-6, Lukc 6,6-11); the deaf man with an impediment in his speech (Mk 7,31-37); the servant of the High Priest in the Garden of Gethsemane (Luke 22,50-51); the healing of the two blind men (Matt 9,27-31); the young boy suffering from epilepsy (Matt 17,14-21, Mark 9,14-29, Luke 9,37-43); the man cleansed from his leprosy (Matt 8,1-4, Mark 1,40-45); the two blind men from Jericho (Matt 20,29-34); the young man blind from his birth (John 9,1-41); Peter's mother-in-law (Matt 8,14-15, Mark 1,29-31, Luke 4,38-39); the healing of the king's official son (John 4,46-54); the healing of the ten lepers (Luke 17,12-19); the woman suffering from a hemorrhage (Matt 9,20-22, Mark 5,25-34, Luke 8,43-48); the blind man from Bethsaida (Mark 8,22-26); the man suffering from dropsy (Luke 14,1-6); the servant of the Roman centurion (Matt 8,5-13) and the blind man, Bartimae'us (Mark 10,46-52, Luke 18,35-43). The remaining seven figures show the healing of the human spirit. These incorporate the two demoniacs in the land of the Gerasenes (Matt 8,28-34); the man from Capernaum with an unclean spirit (Mark 1,21-27, Luke 4,31-37); the healing of a dumb demoniac (Matt 9,32-34); a blind and dumb demoniac (Matt 12,22-29, Mark 3,20-30, Luke 11,14-23; 12,10); the daughter of the Canaanite woman (Matt 15,21-28, Mark 7,24-30); a woman with a spirit of infirmity healed on the Sabbath (Luke 13,10-17); and a man with an unclean spirit from Gerasa (Mark 5,1-20, Luke 8,26-39). The only miracle which espouses both the physical and the spiritual domain is that of the sick man by the Sheep Gate of Bethesda (John 5,1-15). The message conveyed by the panels is that healing occurs holistically, embracing the material and the spiritual, the body and the soul of the human person.

The panels also communicate to the beholder the redeeming truth that Christ, the "God [who] is love" (1 John 4. 8. 16), unveils the authentic meaning of suffering. By loving us to the point of handing himself over to be killed for us and our salvation, Christ showed that the trasforming power of suffering is to be found in self-giving love. As the Servant of God, Fr. John Hardon cried out: "Love *wants* to suffer for the Beloved... Love wants to expiate the sins that have so deeply penetrated mankind. Love wants to make up for the lack of love among those who sin. Love wants to relieve the debt of suffering that sinners owe to God. Love wants to give God what sinners are depriving Him of by their sins."

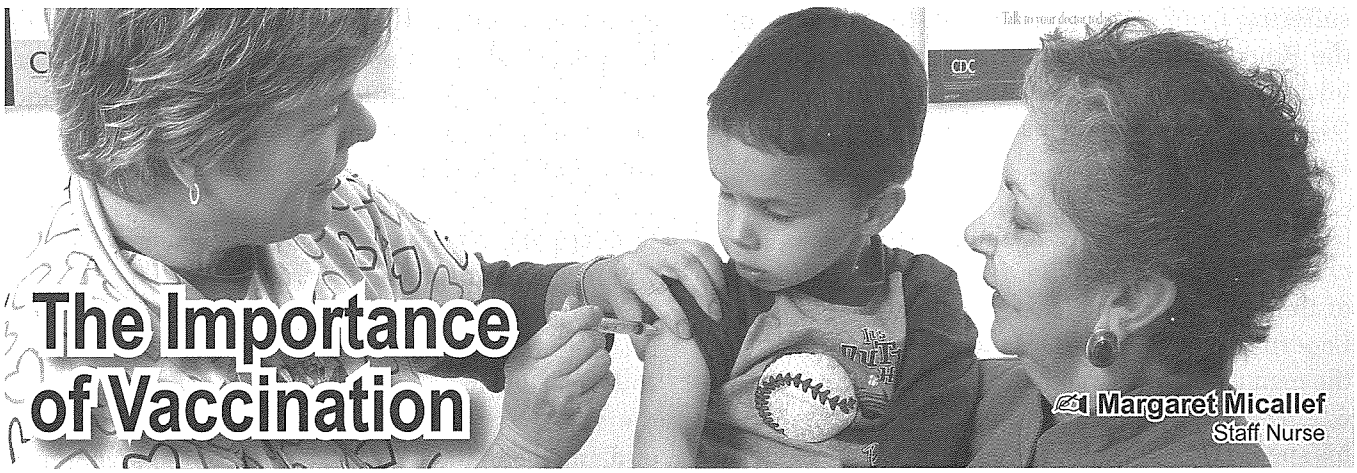
Similarly, this has been the answer given by Blessed John Paul II to question regarding the meaning of suffering, as illustrated in his apostolic letter 'On the Christian meaning of human suffering', *Salvifici Doloris*. "But in order to perceive the true answer to the 'why' of suffering, we must look to the revelation of divine love, the ultimate source of the meaning of everything that exists. Love is also the richest source of the meaning of suffering, which always remains a mystery: we are conscious of the insufficiency and inadequacy of our explanations. Christ causes us to enter into the mystery and to discover the 'why' of suffering, as far as we are capable of grasping the sublimity of divine love. In order to discover the profound meaning of suffering, following the revealed word of God, we must open ourselves wide to the human subject in his manifold potentiality. We must above all accept the light of Revelation not only insofar as it expresses the transcendent order of justice but also insofar as it illuminates this order with Love, as the definitive source of everything that exists. Love is: also the fullest source of the answer to the question of the meaning of suffering. This answer has been given by God to man in the Cross of Jesus Christ" (§ 13).

Everyone suffers. However if you are swimming in troubled waters and happen to be at *Mater Dei Hospital* for any reason, pay a visit to the Chapel and, while contemplating the healing that comes out on your soul and body from these bronze panels, I gently invite you to pray this simple prayer which certainly brightens your heart and mind during this challenging moment in your life:

Behold me, my beloved Jesus, weighed down under the burden of my trials and sufferings. I cast myself at Your feet, that You may renew my strenght and my courage, while I rest here in Your Presece. Permit me to lay down my cross in Your Sacred Heart, for only Your infinite goodness can sustain me; only Your love can help me bear my cross; only Your powerful hand can lighten its weight. O Divine King, Jesus, whose heart is so compassionate to the afflicted, I wish to live in You; suffer and die in You. During my life be to me my model and my support; at the hour of my death, be my hope and my refuge. Amen.

What a healing in relief!

Fr Mario Attard OFM Cap



The Importance of Vaccination

Margaret Micallef
Staff Nurse

Immunisation is the process whereby a person is made immune or resistant to an infection just by administering a vaccine. This can stimulate the body's immune system to protect against subsequent infections. It is a proven tool for controlling and eliminating life threatening infectious diseases.

Sometimes many get confused how the information is brought about vaccinations. First we are assured that thanks to vaccines, some diseases are almost extinct. Vaccination programs have eliminated or significantly reduced many diseases. However these infectious diseases still exist and can once again become common and deadly if vaccination coverage does not continue at high levels. Vaccinations protect against many infectious diseases that routinely killed or harmed many people with serous complications.

Why immunize? We vaccinate to protect, to eradicate which is the best way to put an end to serious effects of certain diseases. If we stop vaccinating we will undo all the progress that has been made over the years. A comeback of epidemic diseases that are under control will face back and illness and death will rise. Immunisation is one of the most cost effective health interventions. Vaccinations should be started at the earliest age recommended but it's never too late.

The Advisory Committee on Immunisation Policies (ACIP) in Malta is the official body that advices the Health Division on all immunisation issues by regularly revising and issuing guidelines and warnings relating to the National Immunisation Schedule.

Maltese Immunisation Background and Legislation

Current Maltese Legislation regarding communicable disease immunisation provides for the free administration of immunisation against diphtheria, tetanus, poliomyelitis, and other diseases as determined by the Superintendent of Health. This legislation also requires that parents have their children immunised with the mandatory diphtheria, tetanus, and poliomyelitis vaccines[1]. In addition there are legal provisions for rubella vaccination of female children aged ten to thirteen years[2], where it was introduced in the national vaccination schedule (free of charge) in 1982 for this age group.

Haemophilus influenzae type b (Hib) was introduced into Malta's immunisation schedule in 1996. It is administered at the same time as the diphtheria, tetanus, pertussis and poliomyelitis vaccines. Presently the Hib is administered as a combined vaccine by the NIS with diphtheria, tetanus and pertussis.

In 1990, the MMR vaccine was introduced and vaccination was extended to all children at 15 months of age. In 1991, a second dose of MMR vaccine was recommended to children aged 11 – 12 years. In 2005, the age for the second dose of MMR was reduced to 8-9 years. A catch-up vaccination programme has simultaneously started for children in between these age groups. As from September 2011, this was even reduced further, at 3- 4years of age, while the first dose was also reduced to 13 months of age.

Hepatitis B vaccination started in 1992, and was first given free of charge to selected high-risk groups, such as health care and hospital laboratory workers. Since 1997-1998, hepatitis B vaccine has been given on a national level to children at the age of 9 years, i.e. those born in 1988 or after. It is also given free of charge to babies born to mothers who are chronic carriers of hepatitis B or to mothers who had acute hepatitis B during pregnancy. Since July 2003, Hepatitis B Is being given to babies aged 1yr 3mnths. Also a catch up vaccination programme has simultaneously started for children in between these age groups. In 2007, the Public Health Act (chapter 465 of the Maltese law) was issued. The legislative aspects of immunization are covered by the Article 27 of the Public Health Act. Since September 2011, the course of Hepatitis B is being started to babies at 12 months of age.

In September 2011, a major step was the introduction of combined vaccination of Diphtheria, Tetanus, whole cell Pertussis, Polio and Haemophilus Influenza Type B (Hib), as part of the free National Immunisation schedule for children.

A National Immunisation schedule is available in Malta and Gozo, and free immunisation service is offered to children in all health centers available in Malta and Gozo.

School health service is also available in both state and church schools in Malta and Gozo.

International vaccination service is also available both in Malta at the National Immunization center in Floriana and in Gozo in Victoria Health Center. These centers cater for:

- Prospective travelers
- Government delegations
- Government departments
- Public Health department
- Hospitals
- Health department (infection control units)
- Local councils

Routine schedule of childhood immunisation in Malta and Gozo till today:

AGE	VACCINE
From 6 weeks	DTaP-Hib-IPV
3 months	DTaP-Hib-IPV
4 months	DTaP-Hib-IPV
12 months	Hep B
13 months	Hep B + MMR
18 months	Hep B+ DTaP-Hib-IPV
3-4 years	MMR
12 years	BCG
16 years	dT-IPV

Other vaccines available but not given under the free national immunization schedule:

- Chicken pox (Varicella)
- Rotavirus
- Pneumococcal
- Meningitis C
- Human Papilloma Virus

Selective immunisation given according to the country the client is visiting at a scheduled time, apart from the routine:

- Hepatitis A
- Typhoid
- Meningitis ACWY
- Yellow fever
- Rabies
- Cholera
- Malaria tablets (prophylaxis)

Seasonal Influenza vaccine is given from September/ October through February accordingly to certain high risk and vulnerable groups. It is especially important that the following groups get vaccinated:

- Health care workers
- Pregnant women
- Children less than 5 especially children younger than 2 years of age
- People age 50 years and older
- People of any age with chronic medical conditions
- People who live in nursing homes and health care facilities

Vaccine Transportation and Storage

Vaccines are stored at a temperature of between +2°c and +8°c. It is important that the cold chain is maintained when handling vaccines from the manufacturer to distribution companies, pharmacy and client in order for the vaccine life and effectiveness. Transportation is done in refrigerated vans and cool boxes protected from light, heat and cold and temperature monitoring. Vaccines must always be stored in temperature monitored pharmaceutical refrigerator and sufficient space allowed in the refrigerator so air can circulate freely. Domestic refrigerators are not suitable.

Administering vaccines: Most vaccines are given by intramuscular or deep subcutaneous injection route. In infants a 23 G (blue) needle is used as the vaccine is being given into the anterolateral aspect of the thigh. For adults same needle is recommended being given in deltoid region. BCG is given intradermally using 25 G (orange) needles.

Contraindications to vaccination: no one should be denied immunisation without serious thought as to the individual and community. Absolute contraindications are, acute illness and fever, immunisation should be postponed after severe local or systemic reactions preceding last dose.

References:

[1]Prevention of Disease Ordinance, 1908. Chapter 36, title III – Immunisation against communicable disease, section 57 of the Laws of Malta.

[2]Legal Notice 50 of 1989. Chapter 36 – Vaccination for rubella regulations, subsidiary legislation 36.31 of the laws of Malta.

Further information:

- Immunization Floriana on 25680222/3
- Gozo Health Center on 22156826
- www.cdc.gov/travel/destination
- www.who.int
- www.ehealth.gov.mt/immunisation
- Link issue 18 of 2010
- The Official Guide to Immunisation 2011 published by the ACIP Committee Malta.

MUMN NEWS MUMN NEWS

from the desk of Paul Pace MUMN President and Colin Galea MUMN General Secretary

TO ALL NURSING STAFF working at Boffa hospital

MUMN had a meeting with the Health Division and an agreement was reached on the following:

1) Scrub suites will be provided by Monday 22nd August to all nurses. Clean uniforms can be picked up for every duty and returned so that a laundry service is now being provided to all nurses.
2) All cleaning detergents including Hand washing Soap will be up to the required standards as that of Mater Dei Hospital by next week.
3) Gloves dispensers, Interfolding paper dispensers, apron dispensers and hand rub dispensers (to be affixed on every bed) will be procured and such procurement has already been initiated.

All directives will be removed with the exception of the Nursing Officers and Deputy Nursing Officers who are not to abandon their respective wards for office duties. MUMN is requesting that additional staff to Boffa Hospital and overtime for nursing staff as to try to maintain the necessary staffing levels.

19th August 2011

Directives to all MUMN members working in Mater Dei Hospital

MUMN has just been informed that when theft occurs on a ward level it is just the nurses, the nursing officer /deputy Nursing Officer who are requested to do an incident report on such theft. Such incident report can be used by the management of Mater Dei Hospital:

1) For disciplinary action requesting even the nurse's dismissal from the government work force using article 20 of the disciplinary procedures of 1999.
2) For criminal charges since such incident report can be handed over to the Police for further actions.
3) For removal of warrant if reported to the Nursing & Midwifery Council.

Such pressures and threats on nurses have caused such hardship and stress that nurses went to buy the stolen machines themselves. MUMN ordered that such machines bought by nurses are to be removed from the ward immediately.

MUMN has also reports that a nurse is facing disciplinary charges for dismissal after being accused of ordering items and such items have expired in the process. Once again such nurse was not even summoned to give his/her version of events but was just faced with dismissal charges. So nurses BEWARE since you could be next.

Therefore the management of Mater Dei cannot be trusted since any incident report can have drastic legal repercussions and MUMN feels that when theft occurs in any particular ward, all staff including doctors, clerks, nursing aids are to do the incident report. MUMN is also prepared that if nurses are issued even an abolishment (written warning through article 18 and 19 through the disciplinary procedures) for not writing the incident report on any ward theft, HGT testing or other nurse practise is to be stopped immediately. It is important to feel that such scenario could happen in any ward and what could happen to one nurse could happen to you.

Therefore MUMN is issuing the following directives with immediate effect to ALL MUMN MEMBERS:

1) No written incident reports on items stolen from your ward are to be written even when such reports are requested from the nursing management.
2) No machine or equipment is to be purchased as a replacement by the nurse.
3) To be prepared for further directives by

MUMN when MUMN feels that nurses are being targeted for dismissal or other disciplinary actions.

It is important that nurses in all grades and are members of MUMN to adhere to such directives. The minute such directives are not followed; MUMN could then not be in a position to stop legal proceedings. Show such directives to nurses not members of MUMN as to be aware the consequences that could happen to anyone.

25th August 2011

Instructions to all Nurses working in SVPR

MUMN have been receiving numerous phone calls from its members on the internal transfers being presently done within SVPR.

MUMN is instructing all nurses - members of MUMN - to ignore such transfers until proper meetings with MUMN officials take place. Such instructions are with immediate effect.

27th August 2011

Directives TO ALL Nursing Officers and Deputy Nursing Officers and Nursing Staff working at the Health Centres

MUMN is issuing directives since the Health Department did not offer proper transportation service for the top up system of laundry, drugs, DDA, medical and general disposables needed at the Health Centre.

MUMN is issuing directives that as from the 10th September, Nursing Officers, Deputy Nursing Officers and Nurses are not to leave their Health Centre for procurement and supplies purposes. Also such errands are not to be delegated to our Nursing Aids working in the Health Centres. MUMN would like to rest assure everyone that all Nurses working in the Health Centre (including the nursing management) will not be held accountable to any out of stock items which will result due to MUMN directive. No DDA is to be ordered unless a proper policy agreed with MUMN on the DDA disposal of expiry drugs is issued.

MUMN would like to remind everyone that the nursing management in the Health Centres should have the same services and treated equally in respect as the nurse's management working in Hospitals.

6th September 2011

Open Letter

Mr. Edward Borg,
CEO

Mt. Carmel Hospital

Dear Mr. Borg,

If one is to check all the emails on FW1/MW1, a book could easily be written. Unfortunately such emails have always fell on deaf ears, with senior management at Mt. Carmel Hospital and the Heath Division ignoring such emails or considering that other priorities are more important. In fact when Mt. Carmel Hospital is in the news, it is due to new community service/ feasts/worker of the year award. Mt. Carmel Hospital was NEVER on the news due to long, pending, important issues such as patient and nurse's health and safety were finally resolved. In fact when series incidents occur at MCH, the tendency is to blame either budget restraints, or mepa or some nurses/nurse who can be used as a scape goat. The same can be said for the electrical generator.

MUMN will not sit on a table to discuss any issues when nurses are in danger of getting hurt or even possible get killed. That will not be on MUMN's conscience. Nurses in Mt. Carmel Hospital especially in the acute wards are constantly in Danger of violence but for the Health Division, that is the least concern since MCH is third division and no innovations have occurred these last years to make MCH wards a safer place for both other patients and the nurses. Blaming nurses, justifying violence and shifting other issues into the matter is the method adopted by the management of Mt. Carmel Hospital with the friendly neighbour the Heath Division totally agreeing with its line of reasoning. After the grave series violence of last year in FW1 were nurses were beaten and the ward set on fire, no disciplinary action nor upgrades have taken place in such a ward. No

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wonder Mt. Carmel Hospital has a stigma since it is not considered even a priority by even the Health Division itself. In the meantime, people like myself, the Minister, Dr. Saliba and yourself, are sleeping comfortable in our beds while nurses are being jeopardised due to lack of proper ward facilities.

I will not write a long email since on FW1/ MW1 as I have just said, a book has already been written and promises fall short very very quickly.

MUMN is issuing directives with IMMEDIATE EFFECT for all nurses working in FW1:

For the safety of the Nurses and Patients in FW1, Ms. _____is to be nursed ONLY in the single room – door closed- during the day and night. MUMN will only consider to allow the patient to be nursed in the single room area ONLY during the day, when the ward is rendered safe – by having all four windows which lead to the inner yard, sound proof so that no communication and objects can be passed to other patients in the inner yard, and that such windows are violence proof so that such patient cannot break and access herself to the inner yard. The door between the single room area to the clinics is to be changed to a heavy sturdy door which can withstand any violence. Only when such changes have taken place will such patient be allowed to be nursed in the single room area ONLY during the day. The minute anyone (Consultant/Doctor, Hospital management or even a nurse) allows Ms. _____ out of the single room area, all nurses –without any prior notice after this email – are to leave the ward and to attend at the SNO office IMMEDIATELY. The person who defies such directive will have assumed the responsibilities of the patients inside the ward with all the legal repercussions. Such patient can be sent on leave from the Single room area and when admitted has to be placed immediately in such an area.

I would like to note that the single room area had TV facilities but due to budget constraints, no access to TV channels is now available. Once again since all money was taken up by the feasts, patients have no access even to local channels. PITY for such patients.

MUMN is issuing directives with IMMEDIATE EFFECT for all nurses working in MW1:

Two incidence have already occurred by patient _____ in MW1 where even nurses were injured. With the type of patients being nursed in MW1, such patients and the nurses are in great physical danger. Therefore MUMN is issuing a directive that if anyone (Consultant/ doctor, Hospital Management etc.) are to transfer such patient to MW1, –without any prior notice after this email – all nurses are to leave the ward and to attend at the SNO office IMMEDIATELY. The person who defies such directive will have to assume the responsibilities of the abandon ward and all legal repercussions.

Also MUMN is aware that in FW1, not all air conditions are working due to technical faults and high electricity tariffs. High Electricity tariffs are not the nurse's fault so MUMN cannot understand why air conditions are being disconnected for such a reason and leaving the nurses and the patients in a furnance. On the 15th September 2011, at 9.00 a.m., I as President Of MUMN will attend to FW1 and if not all the air conditions are not working properly, all nurses will walk out of the ward and taken to the SNO office. Saving money on electricity on the nurses and patienst expense is unbelievable to this union.

9th September 2011

PRESS RELEASE
MUMN issues directives to Nurses due to lack of health and safety in the wards at Mt. Carmel Hospital

The lack in proper ward facilities at Mt. Carmel Hospital is an encouraging factor for serious incidents to take place where unfortunately patients and nurses are being exposed to violence. Teenage patients who are highly violent are being placed in the same wards with patients who have a criminal record and this is purely a time bomb for acts of violence to take place. The nursing profession can consider itself 'lucky' that only one nurse was injured after two serious incidents occurred in Mt. Carmel Hospital this month.

MUMN has issued several press releases on the lack of basic facilities in this hospital such as an electric generator, the lack of facilities in the ward for female patients with violet tendencies, and the several lack of nursing staff compliment in all wards. The current situation is that level one nursing, that is one patient to one nurse, which is ordered by the doctor for special patients, is not even being provided since there are no nurses to provide such treatment.

The management of Mt. Carmel Hospital appeared more inclined to the organisations and funding of feasts, worker of the year award and other such festivities than in the actual health and safety of the wards where both nurses and patients spend so much time during the day. Unfortunately the stigma which Mt. Carmel Hospital is said to have among the Maltese nation is also within the Health Division due to lack of investment much needed in these wards. Recently MUMN has been informed that certain wards which have exceeded their financial budget due to the high electricity tariffs had certain air conditioning units disconnected so nurses and patients were left in the furnace of summer in their wards.

On this regard nurses who have to attend to such violent patients, in wards which are not purposely built for such patients, are being issued directives by MUMN as a means of protection and will reduce the risk to injury to both other patients and nurses. It is the nursing profession and not the medical profession who are after all is exposed to such violence. The Health Division is inclined more to issue defensive press releases than to try to make Mt. Carmel Hospital wards safer for all. If the upgrading in these wards will not materialise in the coming weeks further directives will have to be issued as to wake up the Health Division from its siesta.

10th September 2011

Directives to all Nursing/ Midwifery Staff working at Mater Dei Hospital

MUMN has been receiving several reports that clamping without any prior notice is being done against nurses/ midwives. Also the searches when leaving hospital on our belongings is only being targeted to nurses and midwives. MUMN will not tolerate these discrimination against us especially in the light a fine of 34 euro is being issued immediately on clamping, otherwise your car will remain clamped and nurses/ midwives remain without transportation. That is the THANK YOU after a hard day work.

In the light of such events, let us all stand

and be counted that we are not second class professionals as someone tries to pass that impression.

MUMN is issuing a directive with immediate effect that all nurses and midwives are to refuse any searches on their belongings. Also all identification badges are to be put inside our pockets and are not to be shown to anyone.

12th September 2011

PRESS RELEASE
Ministry for Gozo keeps on studying while Gozitan citizens needing chemotherapy keep suffering

Although two months have elapsed from MUMN's appeal to relieve the pain and suffering for the Gozitan citizens who are travelling to Boffa Hospital to receive chemotherapy, the Ministry of Gozo press statement issued on 5th September 2011 declared that the Ministry is still studying on such a service.

Such press statement gives a clear message that the Ministry will keep on studying for many years to come. This shows the purely lack of commitment in such a humanitarian service to the Gozitans who have to suffer the heat in summer or the cold winter weather when all this can be avoided. In fact the Maltese Government is recently more inclined to help the people of Libya then actually helping the Gozitans who wish to have such an important treatment in Gozo General Hospital.

The message from the Ministry of Gozo is clear. The lack to respond to MUMN's appeal and from the press statement issued, not from the Ministry of Gozo but from the Health Division, the chemotherapy being requested by MUMN to be available in Gozo General Hospital (GGH) would never be provided in GGH under the present administration. The Minster of Gozo's lack of action on such a matter gave a clear message to all the Gozitans that instead of overcoming all obstacles to introduce chemotherapy in Gozo General Hospital, the Minister was more inclined how to avoid the appeal issued by MUMN to start providing such service.

To this very day, even though MUMN published the letter sent to the Minster of Gozo and a copy to the Prime Minister, no reply was sent to MUMN on such an important issue.

Through arrangements with MUMN, this year Gozo General Hospital would soon be supplied by a group of nurses and that shows the commitment of MUMN as to help the Ministry of Gozo to introduce such new service. In fact MUMN has requested that in the next three years at least twelve nurses are to be transferred to Gozo General Hospital as to strengthen the existing service and introduce new service for the Gozitan patients.

MUMN would like to thank various NGO's who issued support through public statements on this issue and the numerous emails and blogs in support of MUMN to persist on its campaign until chemotherapy is initiated in Gozo General Hospital.

MUMN will keep on reminding the people of Gozo and promises that will increase its activities even during the campaign of the General Election as to remind the Gozitans that the Ministry of Gozo failed on such an important health issue. MUMN will keep on striving for the people of Gozo since its priority are not to any political party but to the welfare and the well being of the Maltese people being Gozitans or Maltese.

17th September 2011

PRESS STATEMENT
The Situation of the Health Sector in Malta vis-a-vie the Mediterranean Scenario

MUMN is issuing this press statement to inform the public and the Maltese Government that the health sector in Malta is not in a position to support any influx of patients from any country to Mater Dei Hospital. The Government of Malta has to keep in mind the welfare of the nation and does not resort to decisions just to please the international community.

With a health sector as in Malta

1) Where Maltese patients are left on a stretcher since no beds are available in Mater Dei Hospital.

2) Where patients are being nursed in hospital corridors where no toilet and hand washing facilities exist.
3) Where the state of the art hospital is even not sufficient to the Maltese population.
4) Where there is a great shortage of nurses in all government hospitals.
5) Where patients dignity and privacy is not being observed due to overcrowding.
6) Where the country has huge waiting lists in both operational and investigative procedures.
7) Where no adequate community nursing care exists in the country.
8) Where there are insufficient beds in Intensive Care, in medical wards and surgical wards.
9) Where there are huge waiting lists of out of stock lists of drugs and vital disposable equipment.
10) Where there is only one acute general hospital for the whole population.

It would be highly inappropriate to offer health care services when such problems already exist in our small country. MUMN believes that bigger countries with bigger health care facilities are to address such problems. In fact countries such as The United States of America have huge hospital ships which can take up more than 900 patients and are even better equipped than Mater Dei Hospital. The Maltese population and the nurses, are already doing huge sacrifices due to short falls which occurred when planning of Mater Dei hospital occurred. In the two years which Mater Dei Hospital has been operating, three corridor areas which should have never taken in patients have been opened. Patients are being nursed in such areas against all principles of aseptic techniques, against all principles of infection control, against all principles of nursing practices and where the dignity and the privacy of the patients in such areas does not exists.

The government used to boast that Mater Dei hospital will be a show case on how modern hospitals should be run but we are all aware today that was a funny statement with serious implications to the Maltese citizens. MUMN will not allow that additional beds to be placed in the existing Mater Dei/ SVPR wards which even today such wards have no adequate nursing staffing levels. MUMN has not been consulted in any way on the Government intentions or the contingency plans (if they exist) which are to be implemented in case of a huge influx of patients arriving at our shores. In the meantime MUMN is noticing that areas within Mater Dei Hospital which are not equipped to hold patients are being cleared with loads of rumors running in Mater Dei Hospital. That is not the approach the government is to adopt since then the nurses will not be used as "the sacrifice lamb" in a political saga.

MUMN will support nurses who will refuse to nurse patients in corridors making nursing an impossible task similar to third world countries. This statement is being issued in the light that certain Maltese politicians tend to see foreign affairs as being more important for their own personal interest and therefore would not be capable to expose the huge limitations which the health sector in Malta is passing through at the detriment of all Maltese who need such an essential service.

20th September 2011

Conference 2012

COMMONWEALTH NURSES FEDERATION

Inaugural Commonwealth Nurses Conference

Call for Abstracts

Our health: our common wealth

Saturday 10 and Sunday 11 March 2012, The Commonwealth Club, London UK

Conference theme

This inaugural conference will be based around key themes and will provide an opportunity for nurses and midwives to showcase and share their contribution to improving the health and wellbeing of citizens of the Commonwealth. The conference is being held on the eve of Commonwealth Week 12–18 March 2012; so come and join the celebrations and fun on Commonwealth Day Monday 12 March 2012 and the other Commonwealth Week events.

Abstracts should address the key themes which are:

- meeting the health MDGs
- the regulation of nursing and midwifery
- using information technology to improve care
- the health effects of climate change
- developing a healthy workforce and healthy systems of work
- innovation and excellence in clinical practice

Abstract submission

Email your abstracts (of no more than 300 words) to the Commonwealth Nurses Federation at cnf@commonwealthnurses.org by 31 October 2011.

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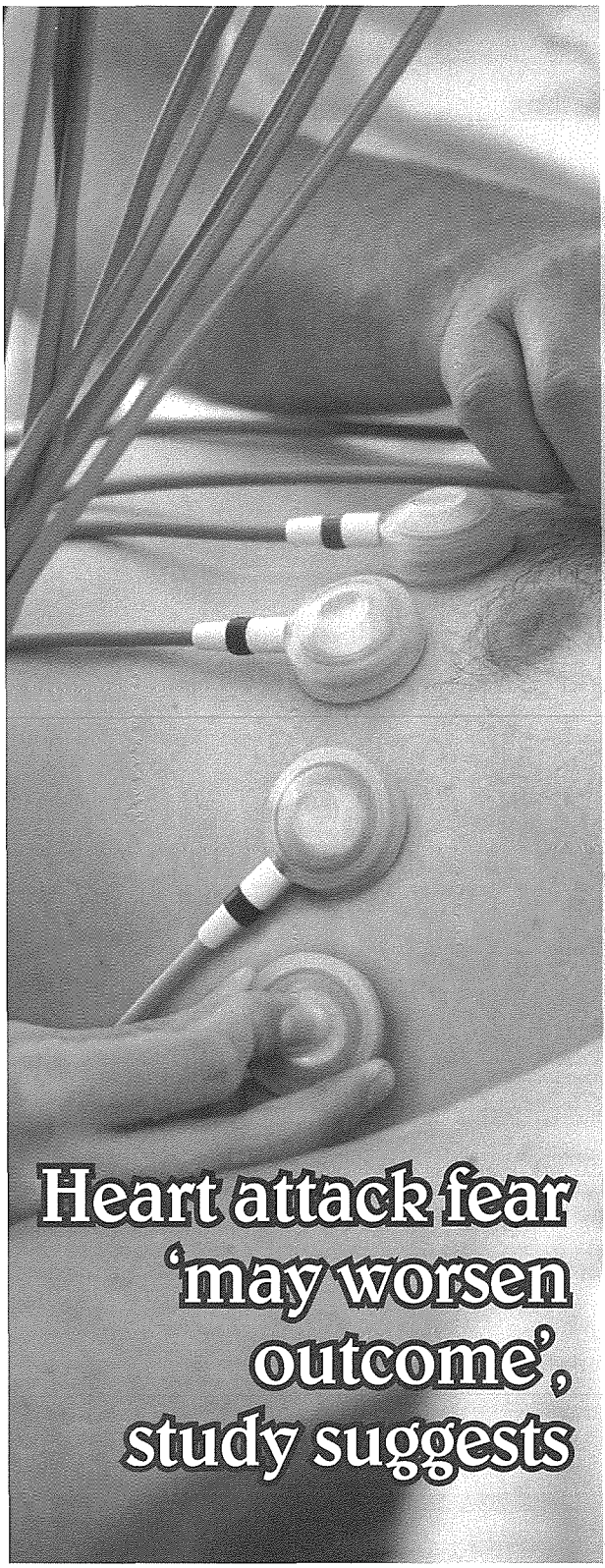

Heart attack fear 'may worsen outcome', study suggests

Some patients express a fear of dying during a heart attack

People with an intense fear of dying during a heart attack could suffer a worse outcome, research suggests.

London-led researchers asked 208 patients to rate their levels of fear following a severe cardiac event.

People who reported they were most distressed during an attack had higher levels of chemical markers - linked to inflammation - in their blood.

Writing in the European Heart Journal, the authors say heightened inflammation may lead to poorer long-term health.

"Large inflammatory responses are known to be damaging to the heart, and to increase the risk of longer-term cardiac problems such as having another heart attack, " said British Heart Foundation professor of psychology, Andrew Steptoe.

The research, led by a team at Imperial College, found that patients who reported an intense fear of dying had raised levels of TNF alpha - a marker that has been linked to inflammatory processes in the body.

They also measured heart rate variability and the stress hormone cortisol, three weeks after the event.

Professor Steptoe, who worked on the study, said: "Fear of dying is not just an emotional response, but is linked into the biological changes that go on during acute cardiac events.

"This is an observational study, so we do not know whether helping people overcome their fears would improve the clinical outlook."

Dr Mike Knapton, associate medical director at the British Heart Foundation, said: "This study suggests that people who are most distressed during a heart attack have higher levels of particular chemical markers in their blood, which are associated with greater inflammation in the body.

"Inflammation has previously been linked with an increased risk of heart attack but we don't yet fully understand why.

"What we need to know now is whether we can allay people's fears at the time of a heart attack and whether this actually translates into better outcomes in the long term."

Source: http://www.bbc.co.uk/news/health-13619022

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