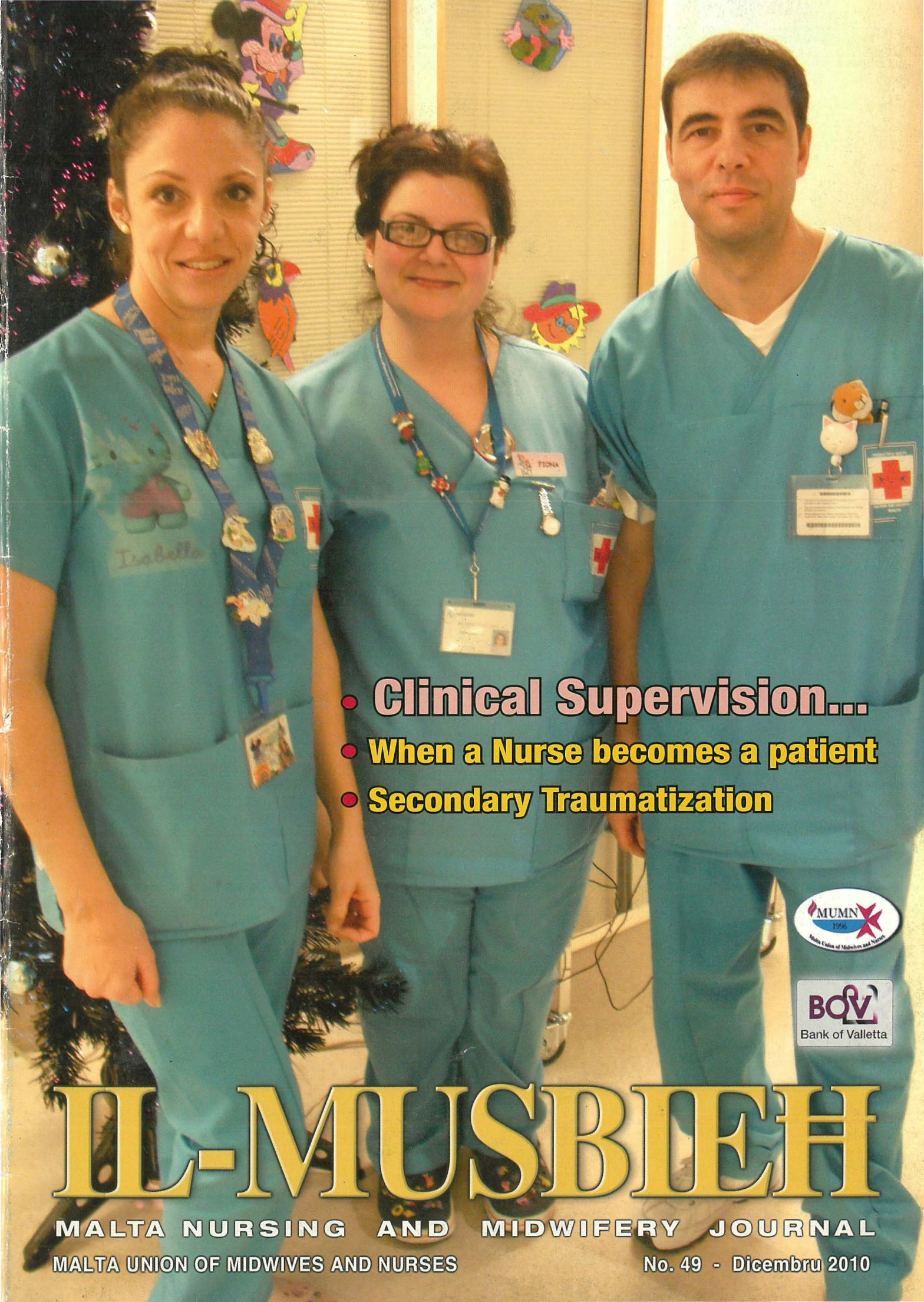

- Clinical Supervision...
- When a Nurse becomes a patient
- Secondary Traumatization

IL-MUSBIEH

MALTA NURSING AND MIDWIFERY JOURNAL

MALTA UNION OF MIDWIVES AND NURSES

No. 49 - Dicembru 2010

HARTMANN

Molimed

Prodotti maħluqin għall-inkontinenza ħafifa, magħmulin b`teknoloġija avvanzata u maħsuba biex ikunu kemm komdi u ma jidhrux

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IL-MUSBIEĦ

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F'Din il-Ħarġa

Editorial 4

Message from the President 5

Kelmtejn mis-Segretarju Ġenerali 6

When a nurse becomes a patient 7

Secondary Traumatization 13

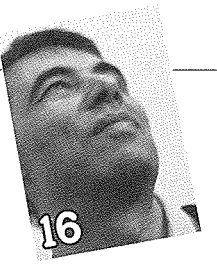
Joseph Agius 16

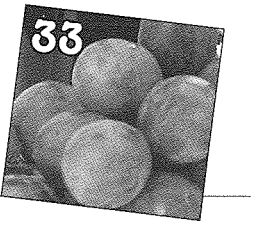
From our diary... 21

Clinical Supervision... 23

The FNBF joins in "Il-Musbieħ" 28

Itjeb u aħjar 33





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

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

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editorial

Dear Colleague,

Every year, I struggle with ambivalence about the Christmas season. My concern is that many a time messages we deliver during this season doesn't match the messages we get during the rest of the year.

I believe in relating with nurses and midwives and our clients well every day: providing resources so they can do a good job, and giving timely recognition for special efforts and outcomes. This will reflect on the care our clients will receive.

Any sincere Christmas message must extend beyond this festive period. All year we need to feel good about what we do, what we're paid, whom we work with, where we park, where and what we eat, where the nursing office is located, what's done about our safety, and what's invested in us to update our practice. We may not have all these things all the time, but most of them have to be there most days if we're to feel good about our profession and ourselves.

I'm also concerned about the message we give others during the Christmas period. Too many of us without thinking engage in talks about low wages, high hours, and low staff. The public doesn't have the knowledge, time, energy, or interest to resolve these internal problems. Our message to the public should make them, and us, feel good.

Christmas is rich in value for all of us. It gives us a perfect opportunity to do personal and professional public relations. Extend your hand to your nurse colleagues and other health care practitioners for the tough work they do every day. Thank the gift givers for the mug, the breakfast, the flowers. If the message is sincere, then go ahead and laugh, sing, or dance. If it's an empty gesture... don't let it bother you. Move on... and don't look back.

The message I would like to deliver to all of you for this Christmas on behalf of all the editorial board is that all of us should do our utmost to get the best and give all our best. Let's make it a special Christmas for us nurses and midwives, for our families and for all our clients.

the editor

message *from the president*

Paul Pace President
mumn@maltanet.net

Another year is over and what a year it was. The shortage of nurses and the consequence of such shortage was one of the major issues which MUMN was heavily involved through various industrial disputes. The outcome of the last industrial action sparkled a discussion which put nurse's shortage on top of the national agenda in the country. Certain changes took place after the industrial actions such as the courier pharmacy service in SVPR, the changing of the DDA policy, adequate relieve pool in Mater Dei hospital and the record intake of university students for the nurse's courses. But discussions are still under way and there are still pending issues which have not been addressed such as the issue of level one in Mt. Carmel hospital and that such hospital (Mt. Carmel) expects to have nurses working in pitch dark whenever there is an electrical power failure.

MUMN is heavily involved in the new collective agreement since the present collective agreement will expire by the end of this year. As MUMN, I can guarantee to all our members, that if any major changes in our working conditions are in the final document, MUMN will call a general meeting prior signing and approving such a document so as to have the proper feedback from its members.

Next year, the first challenging event would be definitely the hosting of the International Council of Nursing Conference which will be held from the 5th May 2011 till the 7th May 2011 at the Mediterranean Conference Centre Valletta. Prior such a conference that is from the 2nd May 2011 till the 4th May 2011, the nurses associations from 134 countries will be meeting at the Hilton Hotel on various nursing issues which have a global effect within the nursing sphere. All Maltese nurses and Maltese student nurses will have the opportunity to meet thousands of nurses experiencing the profession within different cultures from different continents. The conference consists of multi concurrent sessions which will compromise various nurses' specialties' including those specialties which are not available in our local hospitals. It is a golden opportunity to establish links and extending our knowledge especially those who are interested in continuous lifelong learning.

Next year also MUMN will be thriving in establishing a career progression salary scale. At the current system, any nurse who wants to achieve a better salary scale has to leave bed side nursing and has to apply for a management post. This is causing great distress and concern since the managements post are too few for too many. It is time where nurses who achieved special skills or who possess a high level of expertise through experience can achieve a better salary scale without the need to go into management. This would be an innovative aspect in nursing but has become an important factor which our nursing profession needs in Malta. It would definitely one of our missions to achieve in the name of all the nurses and midwives in Malta.

Christmas is back. There are those who during this year lost one of their dear ones and it won't be much of a Christmas. I would like to thank those numerous nurses and midwives who have sent their condolence for my father's death. There are other nurses who like me have lost one of their parents and can only look back at the wonderful time one had with his or her parents. My message for this Christmas is too enjoy the family, nourish the moments together and remember our loved ones who have passed away. With all the difficulties and all the problems in life we should never forget that the family is our most precious asset and we should never take anyone for granted. In the name of MUMN executive council, I wish you all a happy Christmas and a prosperous year.

messaġġ mis-segretarju ġenerali

Colin Galea Segretarju
mumn@maltanet.net

Sena oħra għaddiet. Matul din is-sena l-MUMN resqet quddiem l-awtoritajiet dawk ir-rappreżentazzjonijiet li kienu qed ixeklu l-ħidma tagħna fuq il-postijiet tax-xogħol kif ukoll laħqet ftehim fuq diversi postijiet tax-xogħol li permezz tagħhom iż-żewġ professjonijiet ser ikomplu jimxu l-quddiem.

L-ewwel akkwist li nixtieq insemmi huwa dak tal-*Partimers*. Illum il-*Partimers*, għall-ewwel darba fl-istorja ta' pajjiżna, huma regolarizzati mill-Kummissjoni għas-Servizz Pubbliku. Dan ir-rikonoxximent ifisser li l-*Partimers* mhux ser jibqgħu imwaħħlin fl-ewwel u l-unika skala li kienu jidħlu fiha. Illum il-*Partimers* qed igawdu mill-istess *career progression* bħal l-kollegi tagħhom il-*Fulltimers*. Biex wasalna s'hawn, dan il-proċess ħa aktar minn tlett snin però fl-aħħar wasalna u wasalna fejn xtaqna. Barra minn hekk dawk il-*Partimers* kollha li llum huma regolarizzati bl-*appointment* ser ukoll igawdu mill-proċess tal-*Bridging* sa mid-data tal-Ftehim li għamlet l-MUMN f'Ottubru 2007.

L-MUMN laħqet ukoll Ftehim mad-Diviżjoni tas-Saħħa sabiex is-servizz tal-*ward clerks*, fl-Isptar Mater Dei, jibqa' għaddej sa tard wara nofsinhar speċjalment f'dawk is-swali li *discharges* u l-*admissions* iseħħu wara nofsinhar u qed tinħela *Nurse* jew *Midwife* sabiex tagħmel ix-xogħol ta' *ward clerk*.

Barra minn hekk il-*portering system* ser tissaħħah tant li n-*Nurses* u l-*Midwives* mhux ser ikomplu jmorru jiġbru DDA's huma mill-ispiżerija. Dan jgħodd għall-Isptarijiet Mater Dei u Monte Carmeli kif ukoll għar-Residenza San Vincenz de Paule.

Fiċ-ċentri tas-saħħa, għall-ewwel darba fl-istorja kemm ilhom miftuħħin dawn iċ-ċentri, ġie introdott l-*overtime* b'sistemi ġusti għal kulhadd. Nifhem li għad hemm bżonn ċertu *fine tuning* però l-prinċipju ġie akkwistat u bdejna. L-istess nista' ngħid għal *food allowance*. Illum in-*Nurses* li jaħdmu f'dawn iċ-ċentri qed jirċievu l-istess ammont ta' *food allowance* li jirċievu n-*Nurses* li jaħdmu fl-Isptar Mater Dei. Akkwist ieħor huwa li ċ-ċentri tas-saħħa li kienu magħluqa nhar ta' Ħadd ser jibdew jagħtu servizz anki f'din il-ġurnata liema servizz ser ikun dak li l-professjoni tan-*nursing* tippermetti u dan għas-sodisfazzjon ta' kulħadd.

Il-Union bdiet tinnegozja Ftehim Kollettiv gdid għan-*Nurses* li jahdmu fl-Isptar Karen Grech (ZCH). S'issa saru żewġ laqgħat produttivi ħafna u għalkemm jeżistu xi divergenzi, jien konvint li b'rieda tajba minn kulħadd għandna naslu biex niffirmaw dan il-Ftehim Kollettiv ġdid.

Barra minn hekk in-negozjati tal-Ftehim Kollettiv ġdid għall-ħaddiema kollha fis-Servizz Pubbliku issa ħa spinta tajba però għad baqa' biex tiġi diskussa l-akbar uġigħ ta' ras li hija l-parti finanzjarja. Nisperaw li dan il-proċess ma jieħux ħafna fit-tul biex b'hekk in-*Nurses* u l-*Midwives*, fost l-oħrajn, jibdew igawdu minn dan il-Ftehim il-ġdid.

Kien ta' sodisfazzjon għal din il-Union li f'Għawdex ġiet ippubblikata s-sejħa għall-applikazzjoni sabiex jimtlew il-vakanzi fil-grad ta' *Nursing Officers*. L-MUMN hija nfurmata li l-proċess sabiex toħroġ sejħa sabiex jimtlew il-vakanzi fil-grad ta' *Deputy Nursing Officer* huwa miexi wkoll.

F'dawn l-aħħar ġimgħat l-MUMN innutat li l-Ftehim li din il-Union għamlet sabiex in-*Nurses* u l-*Midwives* gradwati jirċievu s-salarju tagħhom fuq skala 10 qed jinkiser b'mod sfaċċat. Din il-Union diġa' kellha laqgħat mal-awtoritajiet konċernati u jidher li din is-sitwazzjoni ser terġa tiġi għan-normal. Fin-nuqqas ta' dan l-MUMN tiehu dawk il-miżuri neċessarji sabiex tħares lil dawn il-professjonisti kif ukoll tiddefendi l-Ftehim li għamlet għaxar snin ilu.

Innutajna b'dispjaċir li żewġ *Nurses* nisa kollegi tagħna li jaħdmu fl-Isptar Monte Carmeli ġew aggrediti b'mod serju minn żewġ pazjenti f'żewġ okkażjonijiet fl-istess ġurnata. L-MUMN ikkundanat mingħajr riservi dan l-aġir u pprotestat bil-qawwa kollha ma' l-awtoritajiet minħabba proċedura ħażina li ġiet addotata kif ukoll għan-nuqqas ta' *policies* li jirregolaw sitwazzjonijiet bħal dawn.

Din il-*Union* hija preokkupata wkoll għal ċertu sitwazzjonijiet li qed iseħħu fir-Residenza San Vincenz de Paule fejn aktar minn okkażjoni waħda kien hemm swali li matul il-lejl ma kienx hemm Nurses biex jieħdu ħsieb ir-residenti. Barra li din il-prattika hija perikoluża għar-residenti, qed toħloq stress enormi fuq in-*Nurses* li jkunu qed jaħdmu fis-swali oħra viċin dik is-sala li ma jkollhiex *Nurse*. Din is-sitwazzjoni trid tiġi ndirizzata minnufih għaliex hija riżultat ta' nuqqas ta' Nurses f'din ir-residenza.

Nixtieq infakkar li l-applikazzjonijiet sabiex nattendu għall-Konferenza ta' l-ICN fetħu u nistgħu napplikaw minn fuq il-*website* tal-ICN. Il-*website* tal-Union għandha wkoll *link* għal dawn l-applikazzjonijiet. Tħallux għall-aħħar għaliex il-prezz jogħla b'mod konsiderevoli wara l-31 ta' Jannar 2011.

Illum ser nieqaf hawn għax ħadt ftit spazju mhux ħażin! Nixtieq nieħu l-opportunità sabiex nawgura lilkom u l-familji tagħkom Milied Hieni u Sena Ġdida mimlija Saħħa, Risq u Hena.

Galea

When a nurse becomes a patient

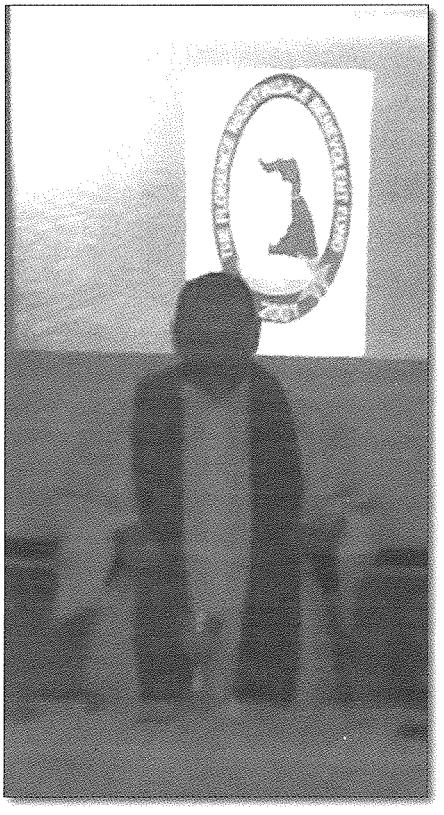
Nursing means caring.
Being a patient implies its reception.
How does it feel like to cross the border?

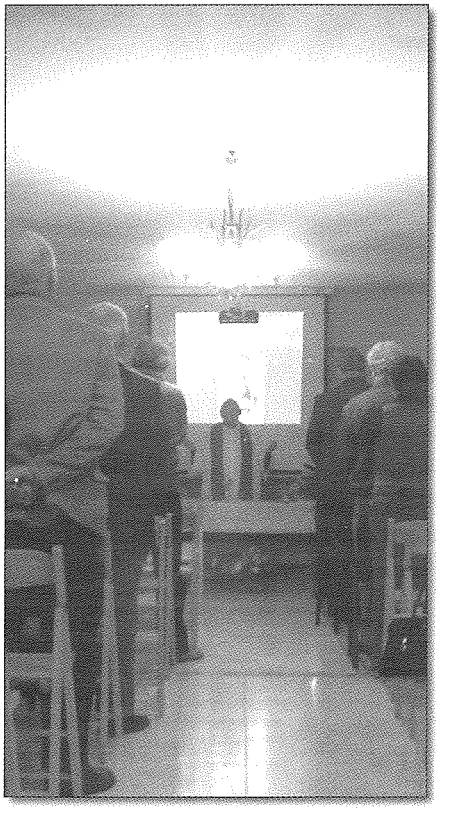
The nurse's main concern is the patient. S/he cares for the sick and injured in the hospital to restore health and alleviate suffering. The nurse cares for patients around the clock. S/he helps them become more independent to recover faster. The nurse works with the doctor to cure the patient and coordinates the multidisciplinary care team to meet the patients' needs. In his/her protective role, the nurse ensures a safe and healthy environment for patients. S/he is an excellent health promoter by promoting health and illnesses' prevention. As the patients' advocator, the nurse is with people during the most crucial times of their lives, primarily when they are born, injured or ill and when they die.

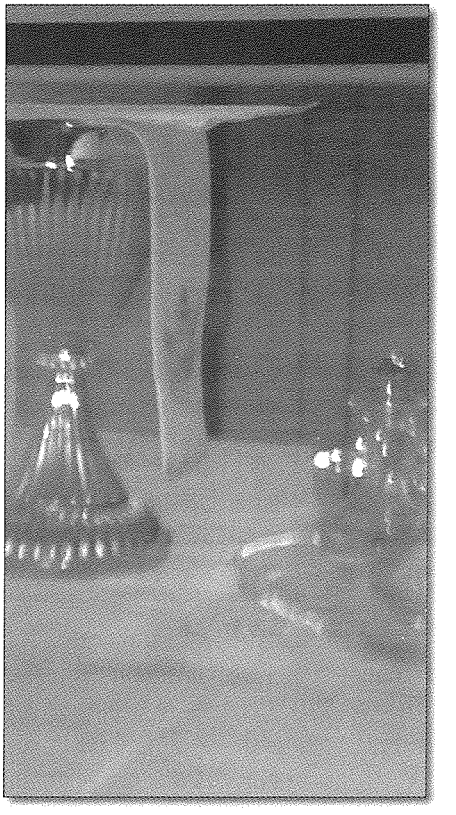
It is shocking when a nurse becomes a patient. The nurse is now cared for, becomes dependent and ends up being a passive receiver in his/her treatment. His/her vulnerability calls for other health professionals to protect his/her rights. From a teacher of health promotion the nurse becomes its student. Moreover, as a patient, the nurse might need frequent spiritual and emotional support.

When a nurse becomes a patient s/he starts realising the blessing to be supported and the duty to translate that support in responsible care.

Fr Mario Attard OFM Cap
FNBF Spiritual Director







Surgical Drapes and Gowns; Safeguarding An Essential Barrier

In surgical operations, medical staff as well as patients; must be reliably protected irrespective of the type of procedure. The "First – Do No Harm" approach, attributed to Hippocrates 460-370 BC, is still to be followed. A quotation from the N.I.C.E. guidelines states that 'Surgical attire is intended to function as a barrier between the surgical field and potential sources of microorganisms in the environment, skin of the patient or the staff involved in the operation. It also performs an additional function of protecting the operator from exposure to blood or body fluids' Asepsis is defined as a practice to reduce or eliminate contaminants from entering the operative field in surgery to prevent infection. Background history includes Hippocrates 460BC who realised the importance of absolute cleanliness; Ignaz Semmelweiss 1846 who identified surgeons hands as the route of spread of puerperal fever; Sir Joseph Lister 1865 who introduced hand and wound antisepsis with the use of carbolic acid; Ernst von Bergmann 1886 who invented the steam sterilization of surgical instruments, introducing an aseptic technique.

Surgical Site Infections are infections that occur in a wound, created by an invasive surgical procedure. A prevalence survey in 2006 estimated that approx. 8% of patients in UK hospitals have a healthcare-associated infection. Surgical Site Infections accounted for 14% of these infections and nearly 5% of patients who had undergone surgery were found to have developed an SSI. SSIs are associated with considerable morbidity and it has been reported that over 1/3 of post-operative deaths are related to SSI. SSI can double the length of patient stay in hospital and thereby increase health care costs (1). Medical literature estimates that 1/3 of SSI's are preventable.

How Barrier Materials Help to Prevent Surgical Site Infections: During surgery, the natural germ barrier of the skin is damaged by incision, which is considered to be invasive. As a result, germs may penetrate the wound through direct transfer. Since, the main sources of infection are micro-organisms on the skin of the patient and the surgical team, it is very important to create an effective germ barrier between the surgical field and potential sources of bacteria, whilst also safely isolate the incision field in order to prevent the risk of infection.

nfection Prevention by "Safe" Surgical Barrier Materials According to EN 13795

In June 1993, the Medical Devices Directive 93/42 EEC was transposed into national legislation in all EU and EFTA states. It took the European Committee for Standardization (CEN), 10 years to develop and finalise a series of standards concerning surgical drapes, gowns, and clean air suits; known as the EN 13795 in June 2006. These standards ensure that the use of such attire effectively protects both patient and healthcare professionals from the risk of exposure to infection. The EN13795 consists of 3 parts as follows:

• Part I General Requirements describes the fundamental properties of surgical drapes, operating theatre clothing and clean air suits. Single-use and reusable products are subject to the same safety standards.

• Part II Test Methods describes the tests with which the various properties of the material are tested. Test methods are normed and fixed in order to make products comparable.

• Part III Limiting Values defines the limiting values which a product has to achieve. Infection risk may vary depending on the duration and the amount of liquids involved, therefore 2 performance levels were fixed:

- High Performance: Longer procedures involving high volume of liquids
- Standard Performance: Short duration procedures involving low volume of liquids

Characteristics to be evaluated in surgical gowns and drapes include: Resistance to microbial penetration (dry and wet conditions), Cleanliness (microbial and particulate matter), Linting (prior and after twisting and compressing), Resistance to liquid penetration, Bursting strength (resistance of a fabric to puncture under dry and wet conditions), Tensile strength (ability of a product to withstand fabric tearing under dry and wet conditions). In the case of drapes, Liquid control and Adhesion for fixation (for the purpose of wound isolation) are also evaluated.

Lessons learned from the past: A study (2) in 1996 concerning analysis of surgical drapes and gowns taken from hospitals in Germany showed considerable shortcomings in quality. This was confirmed in an investigation carried-out in hospitals in England, Wales and France (3) in 2000. This study revealed that improvement is needed in the area of wound isolation by means of adhesives in surgical drapes. Wrinkles, similar to a tunnel formation were noticed beneath the adhesive tapes. Results obtained for one manufacturer revealed that varying performance was found at different areas of products. Products from this same manufacturer gave a relatively low hydrostatic pressure resistance as well as microbial penetration in the front area of the surgical gowns in "HP Quality". High performance surgical gowns from 2 manufacturers showed a very low hydrostatic pressure as well as microbial penetration on the forearms with the seam (3).

Conclusion: On account of innovative material properties, the contamination risk can be reduced decisively. Standardised and homogeneous quality must be demanded for surgical drapes and gowns and the user must select his supplier with great care.

References:(1) Surgical site infection-Prevention and treatment of surgical site infection. National Collaborating Centre for Women's and Children's Health Clinical Guideline October 2008 (2) Werner HP, Feltgen M: "Quality of surgical drapes and gowns" Hyg Med 1998; 23, Suppl.1:1–36 (3) H. P. Werner; M. Feltgen; O. Schmitt:"Quality of surgical drapes and gowns". Journal of Medical Hygene (2001) Vol 26.

"Despite the demand of low priced dressing materials, which, it must be said, are rarely dependable or of high quality, I refuse to abandon my principle of delivering the best there is to offer, time after time."
Paul Hartmann,1885

Tanya Carabott, P.Q.Dip.HSc (Mgmt)

An End to the Discomfort of Dry Skin

Atopic dermatitis is a disorder found on the face, chest and the folds of the elbows and knees. Characterised by intense cutaneous dryness, red patches may appear, which may be oozing, and itching. Atopic dermatitis is the result of an inherited predisposition to allergies, particularly affecting children from the age of 2 months and then takes the form of flare-ups and remissions. After the age of 5, flare-ups frequently disappear but the skin remains dry and sensitive. In certain cases, atopic dermatitis may continue into adulthood. Atopic dermatitis is thought to have multiplied two or three-fold over the past 20 years: almost 10% of children under the age of 10 are said to be affected.

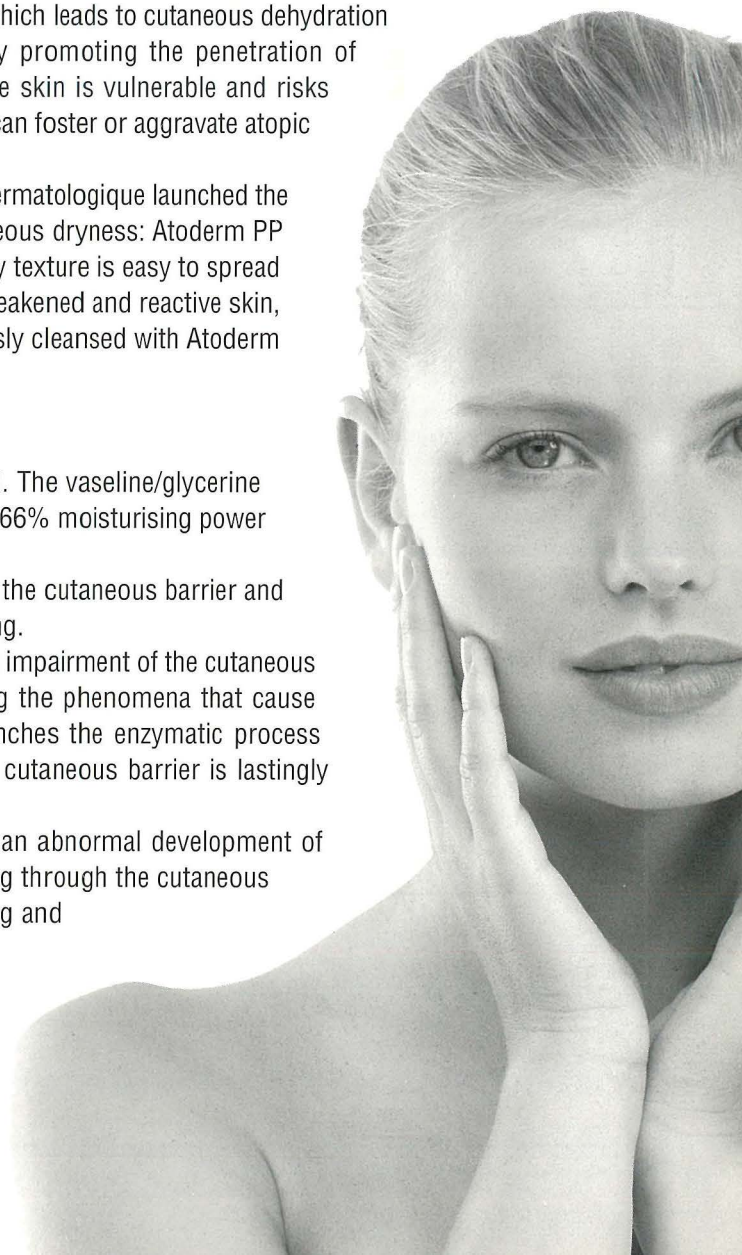
Atopic skin suffers from an impairment of the cutaneous barrier resulting in a lack of lipids, especially ceramides, in the intercellular cement. The skin becomes much too permeable; water is less well retained in the surface layers and thus evaporates in excessive amounts, which leads to cutaneous dehydration and skin dryness. The cutaneous barrier is impaired, thereby promoting the penetration of allergens into the skin and maintaining the skin's reactivity. The skin is vulnerable and risks being colonised, also by pathogenic bacteria whose proliferation can foster or aggravate atopic dermatitis.

A major player in dermo-cosmetics, BIODERMA Laboratoire Dermatologique launched the 1st anti-recurrence emollient balm for severe and recurrent cutaneous dryness: Atoderm PP ANTI-RÉCIDIVE, an everyday emollient balm. Its' rich and creamy texture is easy to spread and does not leave a greasy film on the skin. Ideal for very dry, weakened and reactive skin, it is recommended to apply it once or twice a day to skin previously cleansed with Atoderm Gel Moussant or Atoderm Oil Rich Soap.

BIODERMA's 4 Keys to Success:

1. HYDRATION - Very dry, weakened skin needs to be hydrated. The vaseline/glycerine duo guarantees immediate hydration after just 1 application. +66% moisturising power after 2 hours; + 42% after 8 hours.
2. RELIEF - Scratching to relieve the itching sensation weakens the cutaneous barrier and aggravates the situation. Zanthalene soothes and stops itching.
3. THE RECONSTRUCTION OF THE CUTANEOUS BARRIER - The impairment of the cutaneous barrier plays an important role in triggering and maintaining the phenomena that cause intense and reactive cutaneous dryness. Vitamin PP re-launches the enzymatic process responsible for manufacturing the intercellular cement. The cutaneous barrier is lastingly reconstructed.
4. AN END TO RECURRING EPISODES - Atopic skin presents an abnormal development of pathogenic flora, in particular staphylococcus aureus. Passing through the cutaneous barrier, the toxins from this bacteria play a role in maintaining and aggravating the inflammation. The Ecodéfensine® Patent regulates the skin's ecosystem and re-establishes the balance of the cutaneous flora. It thus prevents the recurrence of flare-ups of severe and intense cutaneous dryness.

Visit **www.bioderma.com** for further information



Richmond FOUNDATION MALTA

Secondary Traumatization

If you have chosen a job which involves helping people in some way, chances are you are able to be present to another human being, make contact and empathize with them. If the people you work with on a daily basis are suffering, helpless, in distressed emotional states or who have endured some kind of trauma, you may be vulnerable to experience a variety of psychological and physical symptoms, similar to those experienced by the patients or the victims themselves. As helpers exposed to traumatic events in our work, it can be traumatic for us too. This is referred to as vicarious or secondary traumatization.

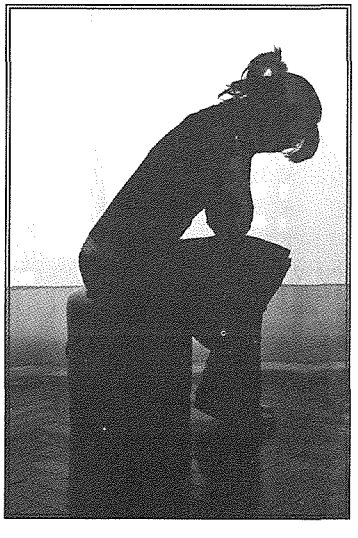
SIGNS AND SYMPTOMS OF SECONDARY TRAUMATISATION

Take some time to think about how your work has affected you. How has it changed your sense of who you are, your ability to build and maintain relationships, your beliefs about life and spirituality, your sense of personal safety and that of your loved ones, your sense of control over your life?

Have you noticed that you no longer enjoy your life as you used to, or seem to have more emotions of sorrow, grief, helplessness and hopelessness? Working with trauma may result in the helpers suffering symptoms of post-traumatic stress disorder: recurrent nightmares, intrusive thoughts, hyperarousal, generalized fear and mistrust in others and the world, and changes in beliefs regarding independence, self-esteem and intimacy. Other symptoms related to depression and anxiety can also emerge. Physical symptoms may also result, such as sleeplessness, headaches, hypertension and backpain as well as gastrointestinal problems such as constipation, diarrhea and irritable bowel syndrome.

Other signs could be the increase in the use of substances such as caffeine, cigarettes, alcohol or drugs.

Moreover, if you have experienced difficult events in your own personal life, the experience of the victim or patient could be a trigger to bring up and bring you in touch with, your own past. If the past experience being triggered is not dealt with adequately, the risk of vicarious trauma (or secondary traumatisation) and its symptoms is increased.



DEALING WITH SECONDARY TRAUMATIZATION

First it is important to be in touch with yourself so that you can become aware quickly of when your work is having a negative influence on your health, your relationships and your life. Notice whether the emotions you absorb at your workplace (such as sorrow, hopelessness or anger), follow you home. It is important to first identify and become aware of the presence of these feelings, then find ways to help you process and express these emotions, so that they do not stay stuck in your mind and body.

This can be done by learning how to take care of yourself. Take care of your physical health by maintaining a balanced diet,

getting adequate sleep and making time for physical activity. Notice what helps you to relax, cope with stress and feel good about your life. This could be spending time with your partner or children, finding a hobby which refreshes you (reading, dancing, sports, art, music, etc) or meeting friends. Spirituality is also very important because it helps to make meaning of your life and focus on what is really important for you.

Another very important way of dealing with secondary traumatisation is never to isolate yourself but to make contact with and find support from others. One idea is to develop a buddy system in the workplace, whereby each employee has an identified person they can talk to and share their experiences and emotions with. This peer support (trust is essential) can offer the safe space to be able to talk about what you are experiencing and how your work is affecting you. Buddies can motivate each other to implement the self care strategies discussed above.

In helping professions such as social work or psychology, supervision is provided at the workplace, whereby each employee is allotted regular time with a more experienced colleague. During this time, the professional is able to discuss challenges in the work with clients and attain ideas of how to move forward. It is also a space in which the person is able to talk about how the work is affecting them on a personal and professional level. Supervision is highly recommended for other helping professions such as nursing, because it can increase the level of support for these front line workers as they meet their daily challenges with patients. The key to good supervision is the relationship between the supervisor and supervisee in which the latter has the opportunity to reflect upon their practice, increase their understanding of their own behaviour, and thus be able to explore new ways of being and relating to colleagues and patients.

Outside the workplace, having a strong network of supportive friends and family members is very important. People with good social support networks feel more positive and are able to handle their life situations and stress more effectively.

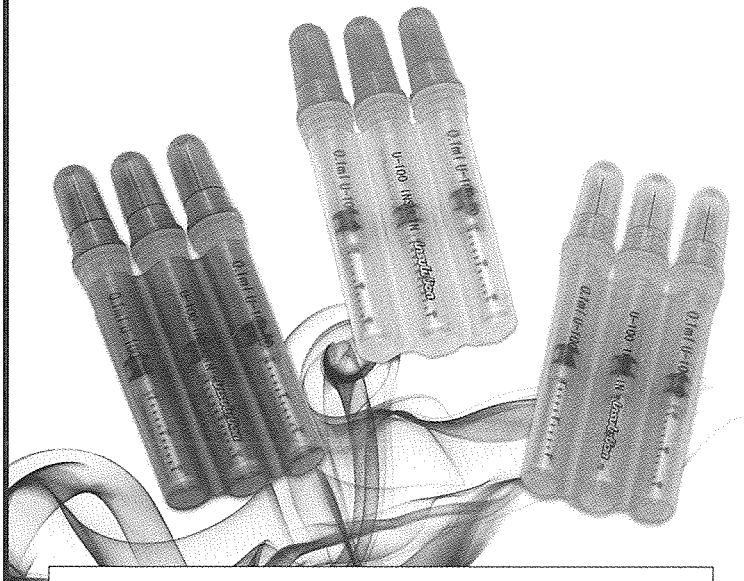
If the symptoms of secondary traumatisation highlighted above are affecting your life, you may also need to seek the help of a professional, such as a psychologist or counselor. This would provide you with a safe space to be able to share your experience and how this is affecting you, attain guidance on how to deal with your work more adequately and relieve symptoms.

Finally it is important to be realistic of what expectations you have of yourself and your job. Expecting yourself to save or help all those who are in your care may not be realistic, but knowing that you will do your best to provide a good service is more achievable.

insulution

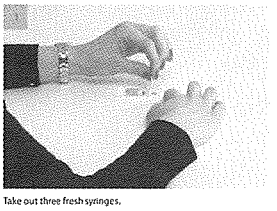
DAILY DOSE

THE SMALLEST INSULIN SYRINGE IN THE WORLD

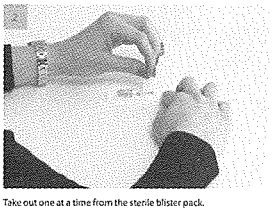


- ☐ **Easy to have with you – whatever you are doing**
  Daily Dose is so small and convenient it will fit in the cash pocket of your jeans.
- ☐ **Simple and discreet to use**
  The syringe is used hidden in your hand – no-one will notice you using it!
- ☐ **A great help for children with diabetes and their parents**
  Daily Dose is discreet and it can be a great help to children sensitive to taking their injections at the right time. Parents can see that the day's doses were taken. Daily Dose can't hold a massive overdose.
- ☐ **No risk of underdosing or overdosing by mistake**
  After you've injected, snap the syringe back in its triple holder. It's that simple! No need to carry a Sharps container with you or to dispose unhygienically. And no temptation to re-use old needles either.
- ☐ **The insulin you use is always fresh**
  Daily Dose holds the three injections that you need when you're away from home. The rest is at home in the fridge staying fresh. Your doses are never in the ambient temperature for more than a few hours.
- ☐ **Safe, simple and discreet disposal**
  The triple holder is translucent - that allows you to see lunchtime dose! No chance of repeating in error or missing a dose that you need.

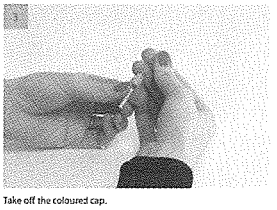
Daily Dose – Use it like this



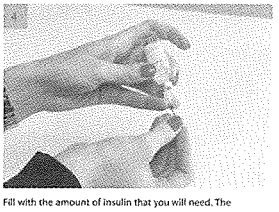
1 Take out three fresh syringes.



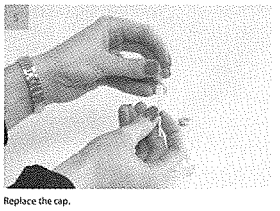
2 Take out one at a time from the sterile blister pack.



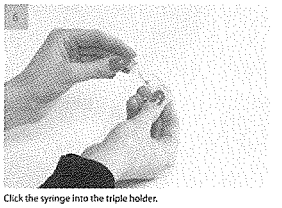
3 Take off the coloured cap.



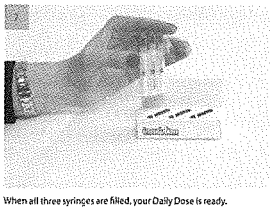
4 Fill with the amount of insulin that you will need. The syringes are graduated and each holds up to ten units.



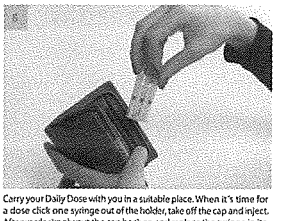
5 Replace the cap.



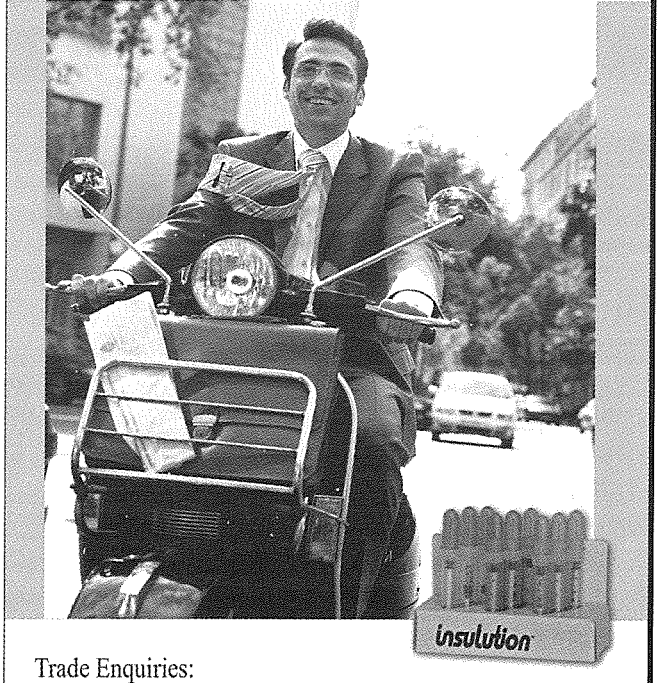
6 Click the syringe into the triple holder.



7 When all three syringes are filled, your Daily Dose is ready.



8 Carry your Daily Dose with you in a suitable place. When it's time for a dose click one syringe out of the holder, take off the cap and inject. Afterwards simply put the cap back on and replace the syringe in its holder.



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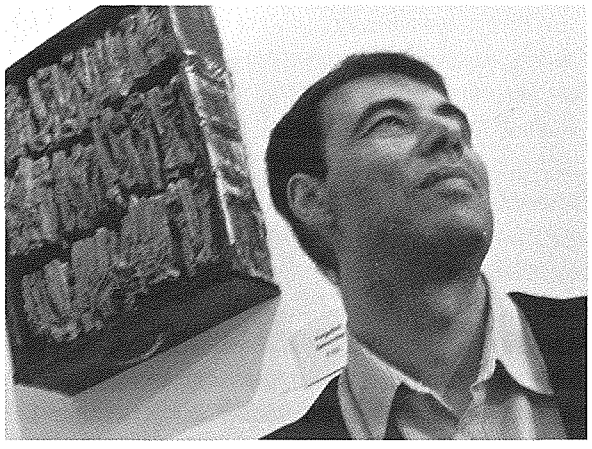


JOSEPH AGIUS

josephagius@gmail.com

Introduction by E. V. Borg

Joseph Agius is not inspired by beauty. He is impressed by life's vicissitudes, decadence and deterioration, by wanton destruction and death, the singularly democratic levelling. He philosophizes on man's despicable brutality and violence. And although he does not moralize he exposes and condemns man's heinous acts, deceit, hypocrisy and betrayal. Joseph Agius was born in 1967.

Joseph started his ceramic studies 13 years ago at the previous School of Art and Craft at Targa Gap Mosta. The artist has participated in several collective exhibitions and organized four personal exhibitions including the personal show at Palazzo Castellania recently in April 2010. With ceramics he often uses rusty sheet metal recycled from 45 gallon tanks abandoned in our countryside. In addition to 'found object' Joseph uses old newspapers that in his opinion transform into a symbolic protest as the media obscure everyday reality.

Q: ***How long have you been in the Nursing profession and in what field are you presently working?***

A: I've been working as a Staff Nurse since 1991 in Fairyland, a paediatric ward.

Q: ***What normally inspires you to create such an art?***

A: The patients in pain and with palsy normally stimulate me to create art.

Q: ***For how long have you been working on ceramics and other material?***

A: Since I was young I always wanted to express my feelings in some sort of way, hence I started attending ceramic classes. I've been doing ceramics for 18 yrs now and this medium helped me to express my feelings since this is a very flexible medium and easy to work with. At times I also make use of other material, in order to make my

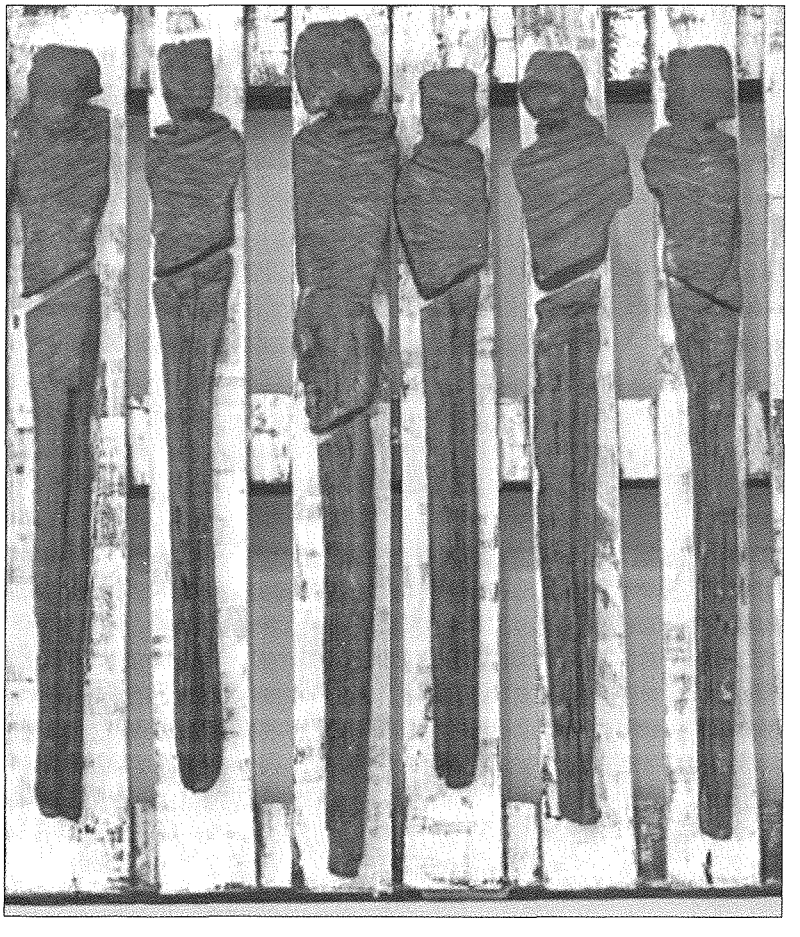
ceramics even more expressive, generally I use wood or metals in a stage of decay as this mingles quite well with ceramics, in my opinion.

Q: ***Any other issues trigger you for such a passion?***

A: From time to time certain occurrences that leave an impact around the world normally trigger me to create ceramics, for e.g. the ceramics I have at the main foyer in Mater Dei. One partlcular example Is that I am very concerned in Ethnic groups and the way they are treated around the world and moreover the suffering they meet ... that is why the ceramic figures I exhibited and are still on display at the main foyer in Mater Dei Hospital, look sad and dull.

Q: ***Joe, I have noticed that underneath the ceramic figures you have displayed newspapers. What is the reason behind this?***

A: Indeed, there are newspapers in the background of the ceramic work that are both painted and sandpapered and not so visible to see either. My message there is that the media, especially when referring to ethnic groups are at times far from saying the truth!



Q: ***How long does it normally take to finish up a piece of work?***

A: The pieces found at Mater Dei were quite a heavy task for me as it took me 3 months to complete. These ceramics have been baked twice, 1st time at a temp of 900 degrees Celsius without glaze and then at a temperature of 1250 degrees Celsius.

These were made up of 50 kgs of clay, 10 kgs of oxides 15 kgs of glaze and about 1 Litre of sweat ... since I completed these in summer.

According to the information on his website, Joseph who is a Staff Nurse and works in Fairyland is mainly inspired by rust, decaying matter and metal. His overall passion though is ceramics. His favourite quote is "Unconcerned but not indifferent" by Man Ray.

For further information with regards to the artist's portfolio, please visit; http://josephagius.com/index.html

Page and Interview compiled by
Tonio Pace

That burning sensation

Indigestion and heartburn are common conditions; most people will experience an episode at some point in their lives.

Indigestion, also known as dyspepsia, is a general term for the pain or discomfort felt in the stomach and under the ribs, usually after eating (althoug' similar symptoms can be experienced on an empty stomach). The most common indigestion symptoms are:

- pain or discomfort in the stomach and under the ribs.
- rumbling or gurgling noises in the stomach.
- feeling bloated or uncomfortably full after eating.
- a clenched or knotted feeling in the stomach.
- excessive burping or flatulence.
- stomach cramps.
- nausea or vomiting.
- trapped wind.

Indigestion can strike at any time and there are many different causes, from rich food and fizzy drinks to stress and eating on the run. Some people get indigestion a couple of times a year but others suffer every day with symptoms ranging from mild discomfort that lasts just a few minutes to severe pain, sometimes accompanied by nausea and vomiting, that goes on for several hours.

You're more likely to suffer from indigestion if you have a busy, stressful lifestyle, if you smoke, you're overweig't or if you don't exercise regularly. Indigestion can also strike on holiday when it's tempting to over-indulge in rich or spicy food and drink more alcohol than usual.

Heartburn is an unpleasant condition that occurs when acid from the stomach rises up into the oesophagus and the throat where it causes a burning pain. This action is called acid reflux.

The main symptoms of heartburn are characterized by:

- Burning pain in the chest after eating.
- Burning sensation in the throat.
- Hot, sour or salty tasting fluid in the back of the throat.

Heartburn is becoming more common, possibly as a result of increased stress, unhealthy diets and over-eating. The pain of heartburn can last for several hours or more and is often made worse by eating. Many people suffer sleepless nig'ts as a result of heartburn because lying down can trigger the condition and increase the pain.

Heartburn is particularly common during pregnancy, affecting 22% of women in the first trimester, 39% in the second and 72% in the third. This is because during pregnancy the body produces the hormone, progesterone, which slows down digestion and causes the muscular valve between the oesophagus and the stomach to relax, increasing the risk of acid reflux.

As a result stomach acid is more likely to leak into the oesophagus and cause a burning pain in your chest and throat. Also, as the baby grows, the pressure on the stomach increases and this can force stomach acid into the oesophagus, again causing gastro-oesophageal reflux.

Causes and prevention

The causes of heartburn and indigestion are very similar. By avoiding the following activities it is possible to reduce your chances of suffering from the symptoms of heartburn and indigestion:

- eating too much or too quickly
- eating rig't before going to bed
- gulping down fizzy drinks and rich spicy food
- drinking too much alcohol
- irregular eating patterns
- stress
- smoking

Treatment

Antacids, available from the pharmacy as over-the-counter medications, work to reduce stomach acidity by neutralizing the excess acid in the stomach giving fast relief from the symptoms of heartburn and indigestion. Your pharmacist can give you some good advice about the management of indigestion and heartburn.

If you suffer from heartburn and indigestion very frequently, it is important to consult your doctor for further advice.

FROM OUR DIARY
Mid-djarju tagħna...

1. The General Secretary of the European Federation of Nurses, Mr. Paul de Reeve, visited Malta to meet with the Hon. Minister of Health, Dr. Joe Cassar. During the meeting several issues were raised in relation to the situation of nurses and nursing in Malta. In the photo Mr. De Reeve is in the middle. On his right side there is the MUMN President and General Secretary while on the other side there is the Hon. Minister and his Permanent Secretary. **2.** Ms. Nancy Caruana is the MUMN's Representative regarding Occupational & Health Nursing issues on the European platform. In this photo Ms. Caruana is second from the left. This photo was taken during a meeting of the Federation of Occupational & Health Nurses in the EU. **3.** Nurses and other staff working at the Ward M3 in Mater Dei Hospital took the initiative to raise funds for the 'Istrina'. They organised a table-tennis marathon over a three day period while other activities took place. Well done for this great initiative.

Strengthening Nursing & Midwifery Practice Through Research

SYMPOSIUM

Call for Abstracts

The Education Committee within the MUMN is inviting Nurses & Midwives who are willing to share their knowledge to participate for a research symposium being held on the 25th of February 2011.

Abstracts and Posters should reach the education committee by not later than the 10th January 2010 via email on **mumnsymposium@gmail.com** or a typed hard copy via post addressed to:

MUMN Education Committee
Les Lapin Courts, Court B No 3,
Independence Avenue, Mosta
MST 9022

Clinical Supervision: A Critical Review

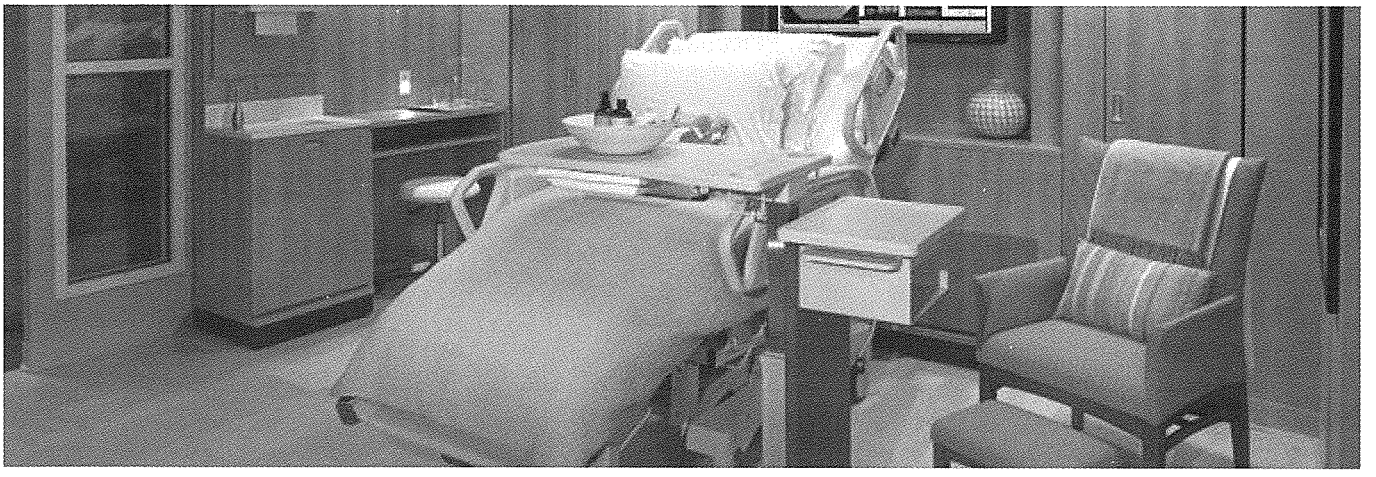
Introduction

A trend in professional development has recently emerged through a process known to many as clinical supervision. Most opinion literature seem to have obscured the proper meaning of clinical supervision especially when addressed from different perspectives. Knowledge through research seems very limited on this material which further leaves the topic open to much debate.

The critical review of the literature presented by the author will address the issues of defining clinical supervision, the advantages and disadvantages of such a process, its perception by nurses, managerial involvement to perform such a task, the costs incurred by such an exercise, and whether this process is feasible in the local government hospitals. Finally a list of recommendations is presented as a final analysis.

What is clinical supervision? What may be the dvantages and disadvantages?

According to the English Illustrated Dictionary, to "supervise" means to oversee, superintend execution or performance of (thing), or movements of work (person). While "clinical" means at the sick bed especially of lectures and teaching. Farrington (1995 A) raises the issue of the difficulty for one to define this term as a concept and admits that clinical supervision is being misinterpreted as being part of a management role or "within the context of mentorship, assessor or preceptor scheme" (Farrington 1995A:874). The United Kingdom Central Council (UKCC) has clearly stated that this concept should not be mistaken for an exercise of managerial responsibility or managerial supervision, neither should it be used as a system of formal individual performance review reports or a trust to undertake the clinical task (Farrington 1995A). Conversely Watts (1987) argues that clinical supervision is closely related to the roles of a clinical supervisor and could be similar to a lower managerial activity in which a group of workers are overseen by a supervisor to ensure that the correct nursing tasks are carried out. However, it seems that clinical supervision is far more than merely checking nursing tasks. Butterworth and Faugier (1994) describe clinical supervision as having three core functions namely: an educative or 'formative' function which enables the development of skills, understanding and abilities by reflecting on and exploring the person's work experience; a supportive or 'restorative' function providing support to enable the person to deal with what has happened and move on; and a managerial or 'normative' function which includes the provision of quality control. Farrington (1995 B) describes a number of models on various clinical supervision approaches which clearly indicate that supervision cannot be regarded as a single concept. Not less than six models are described which mainly originate from Humanistic, Psychoanalytical, and Behavioural schools of practice. These include the six-category intervention analysis model, the triadic model, the multicultural model, the interactive model, and the growth and support model. Although these models vary considerably in their



approach towards clinical supervision, common themes like supervisor-supervisee-client interaction, support, educational development, equality, shared responsibility, and a good interpersonal relationship all emerge from these models. One should bear in mind however that these models are all aimed at clinical supervision in mental health practice (Burrow 1995) which according to Farrington (1995 B) are "well grounded and are becoming more established in mental practice" (p 878). Furthermore, Morris (1995) admits that much of the literature towards the understanding of supervision has been produced or developed by schools of psychotherapy. A question is therefore put forward asking whether these models are the best choice and work similarly when they are exercised in different contexts of clinical practice. Thomas and Reid (1995) conducted a survey and interviewed fifty people (ten nurses, ten occupational therapists, ten psychologists, ten doctors, and ten managers from various background) about the models and practice of clinical supervision and amongst other findings identified five main benefits of supervision. These included support to the practitioner by providing the time and opportunity to reflect and discuss issues arising from clinical practice; improved and developed skills by giving the opportunity to staff to challenge traditional ways of working thus enabling an increased flexible and creative approach to care; team building through the opportunity for clinical leaders to be able to understand and recognise their staff's area of strength and ability that may otherwise be overlooked; monitoring clinical performance; and sharing information which gives the opportunity for staff to feel able to question current practices. Although this survey was done on a small scale, it may be argued that through its qualitative richness the results are valid in the sense that; referring back to the question posed above; the identified benefits in this study can be universal to most clinical set-ups being mental, medical, surgical, or special. On the other hand Butterworth et al (1996) postulate that basing clinical supervision on psychodynamic models often adapted by mental health nurses may be inappropriate for nurses working in acute surgery or intensive care units and urge for the need to develop models which best serve the speciality and locality.

According to Thomas and Reid (1995), the difficulties that clinical supervision might bring about when in operation should not be overlooked. In fact they (Thomas and Reid 1995) identify three major difficulties namely lack of trained staff to carry out this task, lack of structure in supervision sessions which often make the supervisee question the role of the supervisor, and on acute wards presenting faster turnover, increase in admissions and increased workload "supervision is often the first activity to be relinquished and the last to be reinstated" (Thomas and Reid 1995:885). However McCallion and Baxter (1995) insist that clinical supervision can no longer be pushed to the bottom of the agenda and question for how long would it take for this task to be established as part of normal practice. It could be argued though that rushing into things might complicate the situation even further. A major consideration is what Farrington (1995 A) foresees as the most obvious problem that instead of being an exchange between practising professionals in order to enable the development of professional skills, clinical supervision may become "another management stick used to beat nurses with and to police the profession" (p 875) and referring back to the great controversies and problems that the "rushed" nursing process brought about in the late 1970s, Nicklin (1995) warns that no one wants "to participate again in promoting professional and political rhetoric that creates the illusion of innovation without producing change" (p 24). Looking from another angle Kohner (1994) identifies some important benefits of clinical supervision especially aimed at the actual

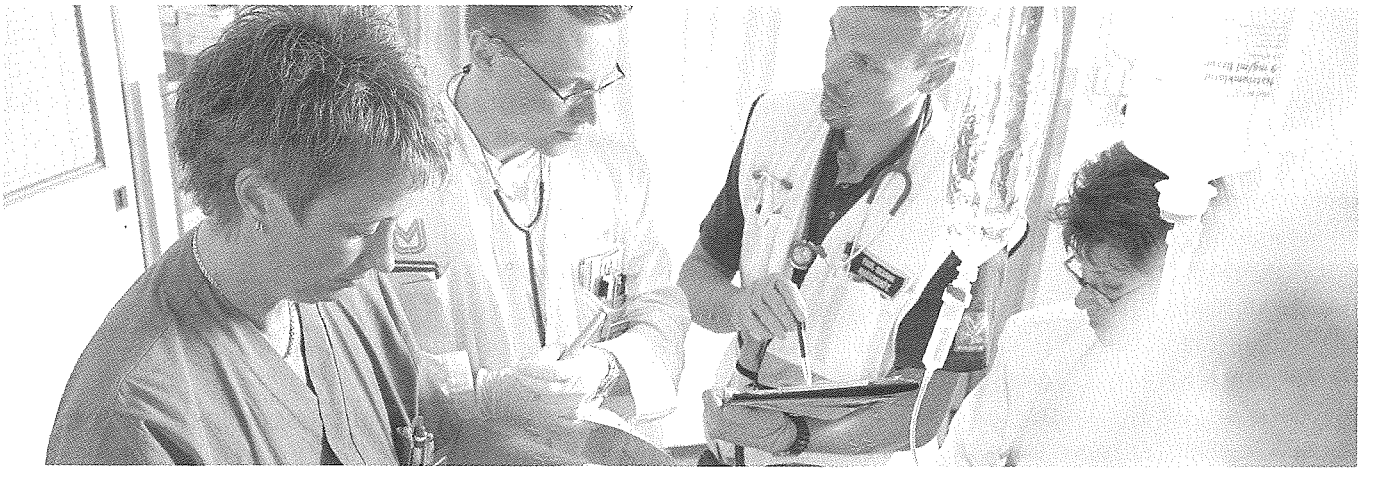
organisation and the service. Firstly it can be a means of improved quality of patient care and enhances the need for standard setting and clinical audit; secondly it can improve staff performance through the development of individual accountability; thirdly it can be viewed as a staff investment since it acknowledges and affirms the value of nurses and nursing; and lastly it can be seen as a professional development which encourages professional growth through experiential learning. Even on a line management approach, Kohner (1994) argues that a positive relationship can develop between nurse (supervisee) and manager (supervisor) which can provide a two way process of feedback and discussion and thus strengthen and improve the team. Coming from an opinion article this rationale is however open for debate especially in the light that very little research has been conducted to identify the full benefits of clinical supervision. Until the knowledge gap on this matter is thoroughly filled, no final conclusions can be drawn about whether these forecasted benefits will actually take place in the future.

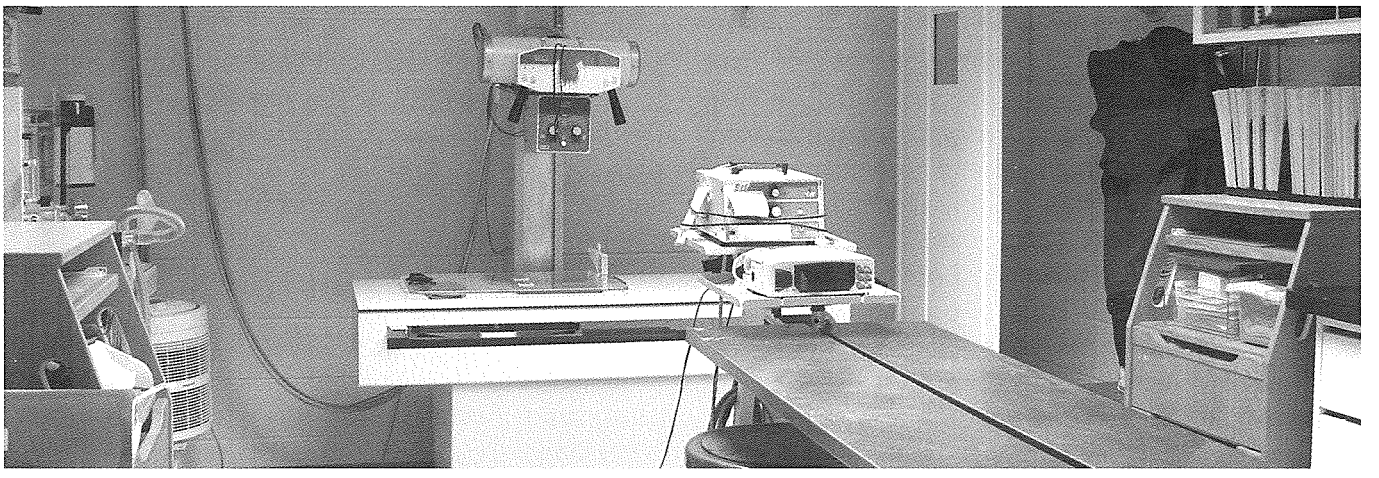
What are the nurses' perceptions of the elements of clinical supervision?

In a study conducted by Fowler (1995) about this subject, it was concluded that nurses perceive the elements of good supervision as those who are knowledgeable in the specialist practices of the area in which they are working; are able to communicate this knowledge in an understandable way; discuss with their supervisee their previous knowledge and experience; interact with the supervisee; and commenting on good practice not just criticising the weak. Although these perceptions are important and most probably emerge in any research study which might be conducted on the subject, the number of respondents in Fowler's (1995) study which totalled to six, seems to be too small a sample despite attempts made by the researcher to justify the validity of the research. Furthermore the respondents were conveniently selected from post registration students who were pursuing ENB courses in the same college of nursing.

Who should perform clinical supervision?

Moving on to the notion that clinical supervision is carried out through a top-down approach, driven by management using a cascade system (McCallion and Baxter1995), the need for managerial support surfaces automatically. Looking through a personal perspective, managing a ward or unit while in the meantime performing clinical supervision might bring about stressful situations where the outcome might end up in a premature collapse. This is strongly supported by McCallion and Baxter (1995) who forecasts constant problems such as issues which nurses would not be willing to raise with their managers, but would be happy to raise them with someone else. Burrow (1995) also argues that if the managerial and supervisory roles are combined within the same individual it will be difficult to see how a supervisor can switch to a disciplinary function with a supervisee without seriously affecting the close relationship which supervision tends to build . Conflict of interest, difficulty to maintain confidentiality and trust, and limited supervision through constrained interaction are some of the issues which are put at risk (Kohner 1994). Such settings should therefore not be insisted upon. One alternative to overcome such problems as suggested by McCallion and Baxter (1995) is that a lead person could be identified to implement clinical supervision throughout the organisation and if possible this should be a prime focus of the role. McCallion and Baxter (1995) further advise that certain nurses and nurse managers may seek supervision from someone from





another discipline or from outside the organisation to enrich their view of practice. Kohner (1994) postulates that clinical supervision should not be used for and should be clearly separated from matters relating to pay, promotion or discipline.

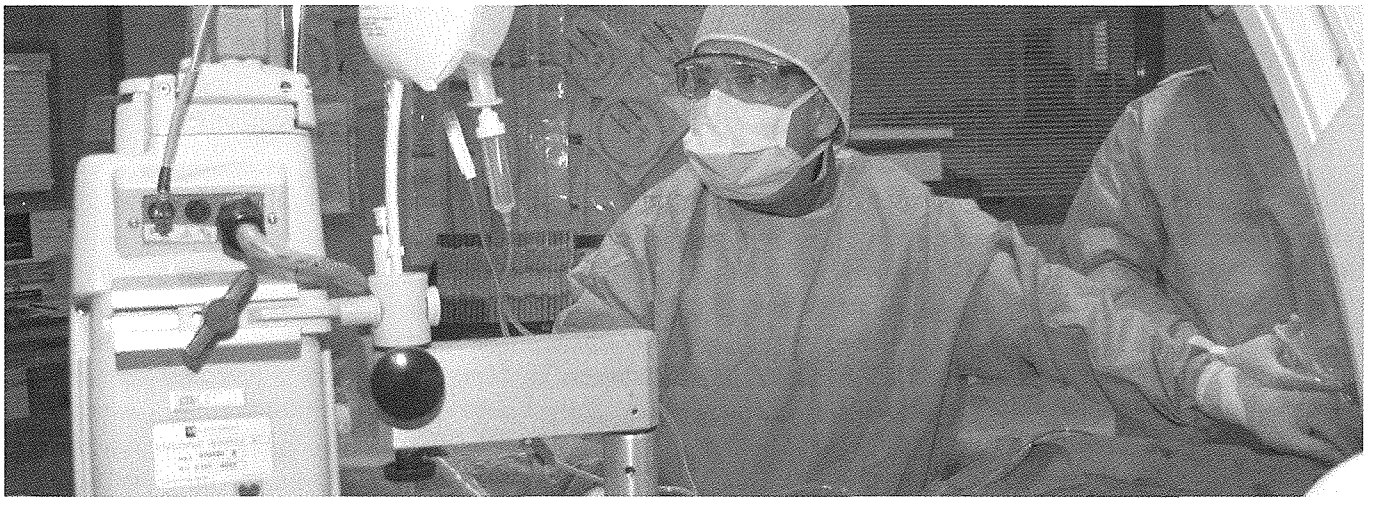
What are the costs incurred?

The evidence tends to suggest that two main approaches towards clinical supervision are sought. Either one-to-one or group supervision. It seems obvious that one-to-one supervision is the most expensive approach since it requires the training of far more supervisors than group supervision demands, although it may be more cost effective (McCallion and Baxter 1995). On the one hand Butterworth et al (1996) indicate that there has been a view that the cost consequences of implementing clinical supervision may hinder its implementation. On the other hand Dudley and Butterworth (1994) argue that there is little evidence which show the consequences to be less significant than many might suppose. Kohner (1994) demands the need for training to enable supervisors to provide high quality supervision and suggests that in order not to make demands on nurses' personal commitment or time, the staff should be released during supervisory sessions. This poses a financial burden for organisations since it insists for the provision of extra nurses to replace candidates attending the supervisory sessions. McCallion and Baxter (1995) argue that when costing the time required for each supervision session it is necessary to quantify the cost of both supervisee and supervisor's time out of the practice area. Added to this is the cost of training and the need for all supervisors to receive supervision themselves. However; besides an initial exploration paper presented by Dudley and Butterworth back in 1994 about the costs and benefits of clinical supervision; there seem to be no literature available or studies which have thoroughly evaluated the costs incurred towards one-to-one or group supervision and whether these costs are justifiable enough to embark on such a programme which could render organisations to work more efficiently. In the light of this argument it is sensible for Burrow (1995) to suggest that it is too optimistic to expect that organisations will invest in the process of supervision without being satisfied that there are tangible improvements to a service.

Is there a place for clinical supervision in our local hospitals?

In the light that local government hospitals are mostly dominated by hierarchical managerial frameworks practised in a top down approach with little space for nurses to decentralise managerial tasks, the pitfalls of managerial - supervisee clashes are most likely to happen. Furthermore financial constraints and the limitation in human resources seem to be a major obstacle for the introduction of clinical supervision. From the literature one can conclude that a slice of human resources needs to be sacrificed initially to furnish the hospitals with clinical supervisors. It is the author's opinion therefore that in view of these limitations it will be wiser for the hospital authorities to invest in continuing education courses such as intravenous therapy, advanced resuscitation and the like in order to enhance the roots of professional development. When human resources, financial resources, and managerial frameworks are drastically improved, then the time might be mature enough to further our professionalism and invest in clinical supervision. In the final analysis a number of themes emerge needing further clarification to help fine tune clinical supervision.

Common Definition:
Definitely needed in order to eliminate different perceptions.



Setting Boundaries:
Ground rules as suggested by Butterworth and Faugier (1994) include constant improvement and re-definition of skills throughout professional life, and constant critical debates about practice.

A Separate Profession:
Introduction to a process of clinical supervision should begin in professional training and education and continue thereafter as an integral part of professional development (Butterworth and Faugier 1994).

Level of Nursing:
In the light that clinical supervision in today's professional climate is especially problematic because of the insufficient differentiation between managerial and clinical supervision (Burrow 1995), appropriate staff should be identified and enabled to take on the supervisory role (Kohner 1994).

Universal Assessing Tools:
Should be established and used as a means to supervise, evaluate and audit clinical care.

Conclusion

The literature clearly shows that a dichotomy of opinion and interpretation of clinical supervision exists. Some authors appraise it and think of it as the latest innovation for professional development and seem very optimistic of its future outcomes. Others think that this is another 'gimmick' which will primarily be abused by ward managers on their staff and therefore show scepticism towards its development. Others advise for organisations to be pragmatic in their approach especially in the absence of broad research knowledge about the subject. The financial commitments towards clinical supervision are still unclear and in an environment of continuous competition, organisations seem to be very cautious to take a step into the 'unknown'.

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Vince Saliba MSc Nurs Educ, Dip Nurs Studies (Manchester), N.O., S.N. –

First published 1997.

The FNBF joins in "Il-Musbieħ"

The Florence Nightingale Benevolent Fund has the pleasure to be able to reach out its members through the "Il-Musbieh" magazine of the MUMN. This for us is considered as forming another loop within a chain for the good of Nursing and Midwifery.

The FNBF has been working silently since 2001 but for sure it has left a big impact especially with those members who found an outreach helping hand in that particular moment of need. Slowly the fund has built up a system that is sustained by its own members and run by a small committee from amongst them by giving a great deal of input.

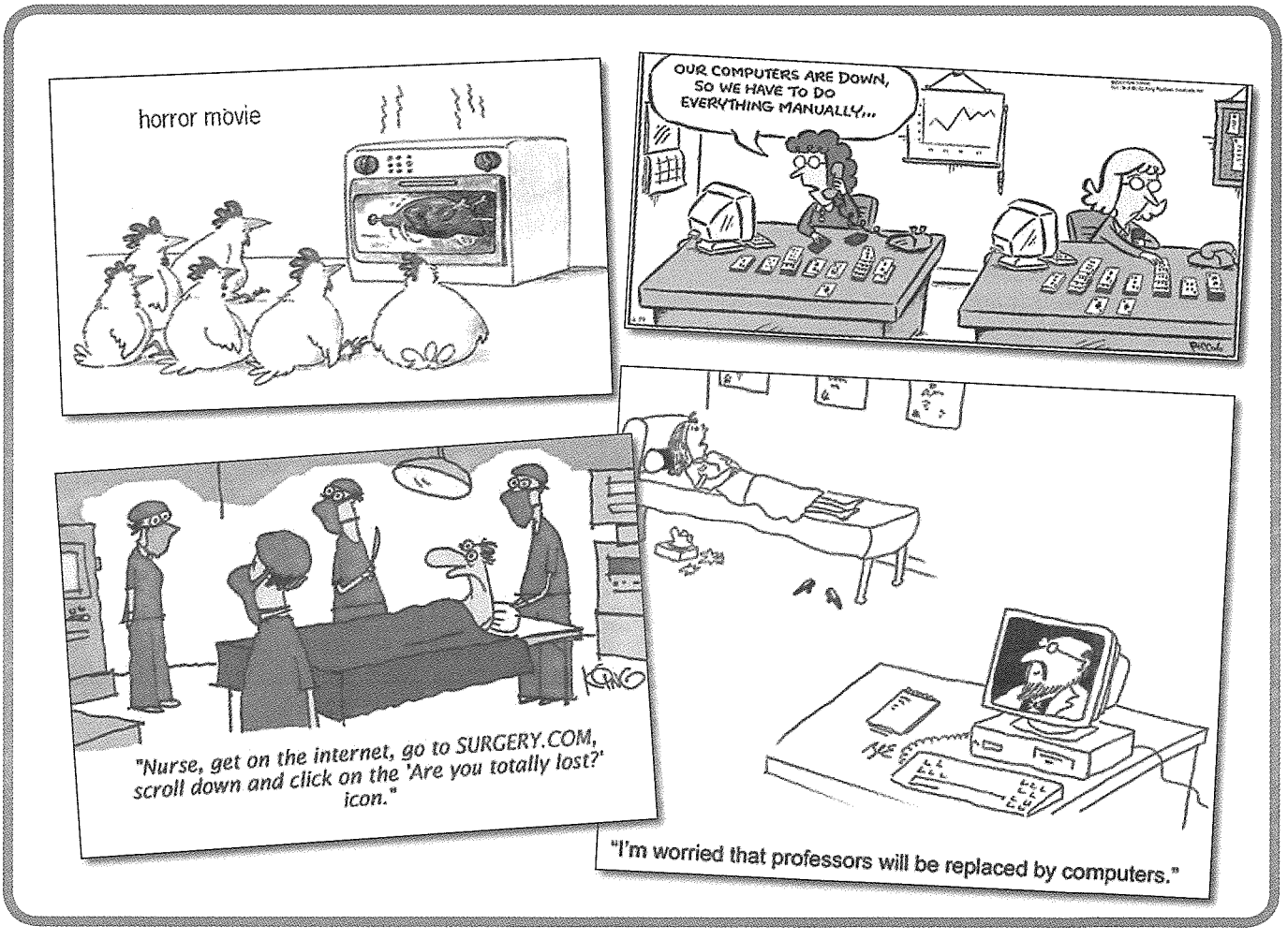
This mechanism has managed to eliminate all the shame that one would go through when illness and misfortune knocks at the door. Now, it has become the right of every member to claim for some help and assistance without the need to go public. Though, one has to keep in mind that this is not an insurance policy but only a benevolent fund. Still there are many sorts of assistance, like individual or group counselling, retirement functions and more... and all this with the same members' money. So this gives all the members the right without any prejudice or obligation towards work colleagues.

Since the committee gives a number to every request, anonymity becomes the rule of the day. No names are mentioned on minute books, just a number. This helps the member to come forward with the request when in need without embarrassment. All requests are carefully followed and necessary backing documentations are usually asked for. This way the FNBF is able to help genuine claims and support decisions taken.

The Fund is looking forward to introduce more help and restructure the existent ones so that it will be able to reach out more of its members' needs. This way and with all the members' input the fund will grow healthier and can remain united as one big family.

The committee members would like to take this opportunity to wish all the Nurses and Midwives a Happy Christmas and New Year full of peace.

George Fenech
Chairperson FNBF



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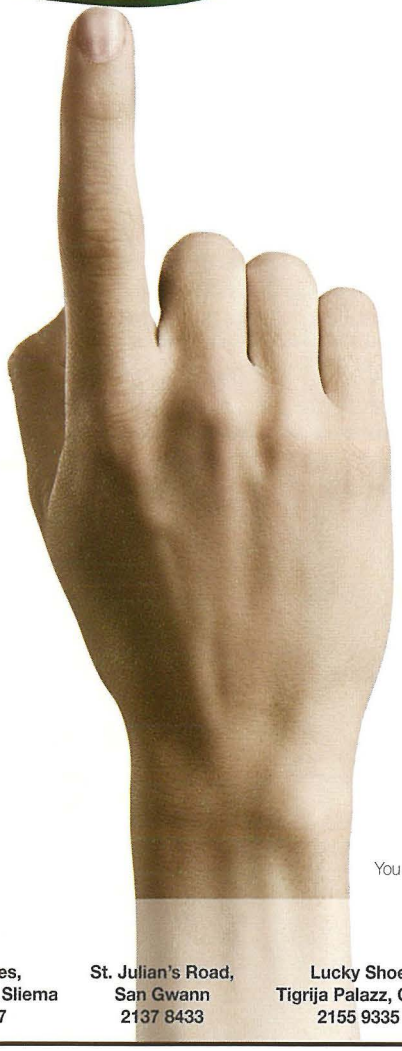

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Itjeb u aħjar...

Dan l-aħħar kelli ix-xorti niltaqa ma wieħed diletant ta' l-inbid. Qalli hawn żewġ kwalitajiet ta' għeneb ta' Malta: l-iswed u l-abjad/isfar, bħal taż-żebbuġa, maskarell, u oħrajn. Għalkemm issa hemm kwlitajiet oħra bħal chardonnay, charabrez, merlot, u oħrajn.

Beda billi spjegali il process ta' l-għasir. Wara li l-għeneb isir jinqata u jitpoġġa ġo għasara (għoda li tasar), li tkun ġo vaska jew bettiegħa għal xi tlett ijiem. Wara jitpoġġa ġo stringitur għal ftit żmiem. F'dan iż-żmien ikun waqaf il-għali jew ibaqbaq. Inbagħad jerġa' jintefa ġo tramunġani u jiġi jissiġillat għal xi tmien ġimgħat biex fl-aħħar jitpoġġa fil fliexken.

Dan il-proċess isir kollu b'attenzjoni stretta u f'indafa kbira għax inkella l-inbid jaqta u jsir ħall.

Sirt namruż ta' l-inbid. Fettelli jmur ġo ħanut biex nixtri. Indunajt li hemm differenzi fil-prezzijiet għal l-istess marka ta' fliexken. Staqsejt il-għala l-istess kwalità u hemm qabża sostenzjali fil-prezz min wieħed għal ieħor. Malajr irrispondieni: qalli ma tifhemx sieħbi: ir-ruġuni hi l-għaliex iktar ma jkollu żmien l-inbid jsir itjeb u aħjar.

Malajr skużajt ruħi u ġo qalbi ftakart kemm impjegati anzjani ġew imwarrba min awtoritajiet.

Kos, naħseb li l-awtorità għamlet sew li ftehmet mal-MUMN u reġgħet ingaġġat lill-impjegati ta' l'fuq min wieħed u sittin, għax għalkemm huwa sew li tinvesti fiż-żagħżagħ, mhux ta' min jitlef impjegati b'ċerat esperjenza li żgur huma ta' utilità u tgawdi minnha il-kumunità.

Thomas Aguis, *Part-timer u penzjonant*

MINISTERU GĦAS-SAĦĦA,
L-ANZJANI U KURA FIL-KOMUNITA'

MALTA

MINISTRY FOR HEALTH,
THE ELDERLY AND COMMUNITY CARE

Uffiċċju tas-Segretarju Permanenti

Office of the Permanent Secretary

10 ta' Dicembru, 2010

Att: Sur Paul Pace
President
MUMN
Les Lapin Courts,
Court B No 3
Independence Avenue
Mosta MST 9022,
Malta.

Ghaziz Sur Pace,

B'referenza ghal-laqghat li saru bejn id-Divizjoni tas-Sahha u l-MUMN dwar prattici u sistemi godda ta' xoghol fl- isptarijiet u centri tas- sahha, qieghed niktiblek din l- ittra biex insemmilek il punti ewlenin li l-Ministeru ha jindirrizza fiz-zmien li gej hekk kif irrizulta mid-diskussjonijiet.

Nixtieq nghid li l-kontenut tal- laqghat taghna ttrattaw principarjament dwar dawn il- punti imsemmija hawn taht:

1. Divizjoni tas- Sahha
2. Sptar Mater Dei
3. Sptar Monte Carmeli
4. Centri tas- Sahha
5. Residenza San Vincenz de Paule

Ha nghaddi issa biex nikkummenta fuq kull punt imsemmi hawn fuq.

1. Divizjoni tas- Sahha

A: Id-Diviżjoni tas-Saħħa ser tirrevedi l-*Man Power Plan* b'konsultazzjoni mal-MUMN b'referenza diretta fil-qasam tan-*nurses* u l-*midwives* bil-għan li jkunu jistgħu jsiru pjanijiet aktar fit-tul għas-servizzi mogħtija fil-qasam tas-saħħa;

B: Id-Diviżjoni tas-Saħħa tista` tagħmel *audit* tal-*workforce* fil-qasam tan-*nurses* u l-*midwives* sabiex, bi qbil mal-*Union,* tistabbilixxi l-proċessi tax-xogħol, tiddetermina l-modifiki meħtiega, u tippjana u timplimenta l-bidliet indikati.

PALAZZO CASTELLANIA, 15, MERCHANTS STREET, VALLETTA, MALTA
TELEPHONE 2299 2373: TELEFAX: 2299 2657
Site: www.sahha.gov.mt email: permsec.hecc.mhec@gov.mt

2. Sptar Mater Dei

A: Fid-dipartiment tal-emergenza tkompli tiġi msaħħa it-taqsima li tilqa' pazjenti sakemm jiġu t-trasferiti lejn is-swali. Dan se jsir b'*nurses* li jkunu allokati f'din it-taqsima, b'*management* fiss sabiex tiġi mħarsa aktar il-kontinwita` fil-kura mogħtija kif ukoll bis-servizz ta' *ward*;

B: Fejn hu possibli, is-servizz tal-*ward clerks* se jkun imtawwal sal-ħin ta` 18.00 hrs sabiex in-*nurses* u l-*midwives* ikunu aktar f'poziżżjoni li jiffukaw fuq il-ħtigijiet tal-pazjenti;

C: Se tissaħħah b'mod sostanzjali il-*portering system* fl-isptar sabiex in-*nurses* u l-*midwives* ma jkollhomx għalfejn joħorġu mis-swali iktar spiss milli suppost u b'hekk l-attenzjoni tagħhom tkun aktar diretta lejn il-pazjenti nkluz il-ġbir ta' kull tip ta' mediċinali mill-ispiżerija;

D: Se jiġi mwaqqaf kumitat apposta bejn id-Diviżjoni tas-Saħħa u l-MUMN sabiex jagħti r-rakkomnadazzjonijiet tiegħu kif ir-rwol tal-*midwives* fil-komunita' jkun aktar imsaħħah f'dak li huwa *ante-natal care* li jirrizulta fi *skill mix* aħjar;

E: Il-*management* tal-isptar se jintroduċi sistema aktar informattiva tas-salarji tal-impjegati, li tinkludi dettalji dwar l-*allowances* u d-*deductions*;

F: Se tiġi ppubblikata *policy*, li tkun maqbula mal-*Union*, sabiex id-*Day Ward Attendants*, sakemm ikun possibili fil-parametri klinici, jibdew jiġu nvistati fid-dipartiment ta' l-*out-patients* u kliniċi oħra sabiex b'hekk tiġi limitata l-attendenza tagħhom fis-swali bl-oġġettiv li jiġi evitat l-isparpaljal tan-*nurses* fis-swali;

G: Se nibdew il-process ghal sejħa ghall-applikazzjoni sabiex jiġu appuntati zewg *Occupational Health Nurses*, wieħed/waħda responsabbli fl-isptar Mater Dei u l-ieħor/oħra responsabbli fl-isptarijiet l-oħra u ċ-ċentri tas-saħħa;

3. Sptar Monte Carmeli

A: In-*nursing complement* fis-swali għandu jingħata l-prijorita dovuta bil-għan li jimtlew il-vakanzi kollha ta' *nurses* fis-*shifts*.

B: Se ssir *policy* mill-*management* tal-isptar, maqbula mal-*Union*, li tindirizza l-*Level 1 supervision* tal-pazjenti.

C: Se ssir *policy* mill-*management* ta' l-isptar, maqbula mal-*Union*, għall-eventwalita` li jkun hemm *overcrowding* fis-swali akuti sabiex il-pazjenti rikoverati jingħataw servizz aħjar;

D: In-*nurses* kollha, nkluż dawk li jagħmlu parti mis-servizz mentali fil-kommunita` se jkunu *accountable* għall-*Manager Nursing Services* tal-isptar Monte Carmeli;

E: Se jiġi msaħħah is-servizz tal-*courier* f'dan l-isptar bil-għan li n-*nurses* ikunu aktar iffukati fuq il-pazjenti;

F: Intlaħaq qbil fil-prinċipju li meta fl-isptar jinqata` d-dawl, in-*nurses* u l-pazjenti ma jsofru l-ebda konsegwenzi billi jidhlu fis-seħħ sistemi alternattivi ta' dawl. Waħda mill-alternattivi tista' tkun l-istallazzjoni ta' numru ta' *generators* zgħar mqassmin mal-isptar li jidħlu fis-seħħ fuq perjodu ta' żmien miftiehem bejn iz-zżewġ partijiet;

G: Jekk il-finanzi jippermettu, mis-sena d-dieħla ser jibda x-xogħol ta' kostruzzjoni sabiex tiġi mwaqqfa l-*multi-purpose unit;*

H: Ser tiġi riveduta l-*policy* tal-ġbir u l-ogħti tal-Methadone lill-pazjenti sabiex b'hekk din il-*policy* tkun tirrifletti aktar il-ħtiġijiet tal- llum u tkun aktar addatta għall-bżonnijiet tal-pazjenti.

4. Ċentri tas-Saħħa

A: In-*nurses* kollha li jaħdmu f'dawn iċ-ċentri ser jingħataw *allowance* tal-ikel bl-istess rati li jingħataw in-*nurses* li jaħdmu fl-Sptar Mater Dei;

B: Ser jiġi mwaqqaf *pool* ta' *nurses* mal-uffiċċju tal-*Manager Nursing Service* ta' dawn iċ-ċentri fuq bażi ta' *overtime* sabiex b'hekk jiġu ndirizzati n-nuqqas ta' *nurses* fix-*shift* kif ukoll talbiet għall-*vacation leave*;

C: Iċ-ċentri tas-saħħa ta' Qormi, Rabat u Cospicua ser jibdew jagħtu servizz ukoll nhar ta' Ħadd għall-pazjenti li jinħtieġu tibdil fil-medikaturi u xogħol ieħor relatat. Barra minnhekk id-Diviżjoni tas-Saħħa se tesplora l-possibilita` li ssir ħidma mal-Kunsilli Lokali sabiex iċ-ċittadini tal-lokal jibdew igawdu minn servizzi oħra marbuta mal-kura primarja.

5. Residenza San Vincenz de Paule

A: Sabiex tiġi ndirizzata il-kwestjoni tal-*vacation leave*, intlaħaq qbil li fuq perjodu ta' sentejn, ir-*relieving pool* f'din ir-residenza se jkun jammonta għall-tlettin *nurse*;

B: F'din ir-residenza ġiet introdotta sistema fejn in-*nurses* mhux se jkunu jinħtieġu li jmorru huma l-ispiżerija biex jiġbru l-mediċinali kollha, inklużi dawk il-mediċinali li jaqgħu taħt id-DDA, biex b'hekk jiffukaw aktar l-attenzjoni tagħhom fuq ir-residenti.

Nixtieq nigbed l-attenzjoni li dawn il-punti msemmija hawn fuq ghandhom ikolhom skop wiehed ewlieni, dak li s- servizz offrut lejn ic- cittadin jkun aktar effettiv u ta' kwalita ahjar. Fid-dawl ta' dan wiehed irrid jifhem li l- operazzjoni ta' diversi entitajiet u divizjonijiet fil- Ministeru tas-Sahha hija xi haga hajja u ghaldaqstant il kontenut ta' din l- ittra huwa suggetti ghal tibdil minn zmien ghal zmien skont l- esigenzi tax- xoghol u tas-servizz.

Huwa l-hsieb tal-Ministeru li jkompli jahdem id f'id maghkhom biex inkomplu ntejjbu s-servizz lejn ic-cittadin kif diga qeghdin naghmlu.

Inselli ghalik.

Dejjem tieghek,

Dr. Kenneth Grech
Permanent Secretary

cc: Ministru ghass-Sahha, l-Anzjani u Kura fil-Kumunita

SIDE LETTER

TO THE

ADDENDUM TO THE AGREEMENET OF THE CLASSIFICATION AND GRADING OF THE NURSING SERVICE GRADES AND THE AGREEMENT ON THE CLASSIFICATION OF THE MIDWIFERY SECTION SIGNED ON THE 25TH OCTOBER 2007.

It is hereby being declared that, on a one-time only agreement basis and pursuant to the aforementioned Addendum signed on the 25th October 2007, part-time enrolled nurses who were engaged by Government on a casual basis and who had their engagement regularized by the PSC on 3rd August 2010 and 14th October 2010 in as shown in Appendices I and II respectively, shall have the computation of the bridging clause effective as from the date of signing of the Addendum, that is 25th October 2007.

Dr Kenneth Grech
Permanent Secretary, MHEC

Dr John M Cachia
Director General, Health Care Services, MHEC

Mr Paul Pace
President, MUMN

Mr Colin Galea
Secretary, MUMN

9/12/10

SIDE LETTER
TO THE
ADDENDUM TO THE AGREEMENET OF THE CLASSIFICATION AND GRADING OF THE NURSING SERVICE GRADES AND THE AGREEMENT ON THE CLASSIFICATION OF THE MIDWIFERY SECTION SIGNED ON THE 25TH OCTOBER 2007.

It is hereby being declared that, on a one-time only agreement basis and pursuant to the aforementioned Addendum signed on the 25th October 2007, part-time nurses and part-time midwives, who were eligible and submitted their application in response to the **first call for application only** which was issued after the signing of the said addendum (that is call for part-time nurses issued on 2nd June 2009 in Government Gazette No.18432 and call for part-time midwives issued on 7th August 2009 in Government Gazette No.18463) in order to regularise their employment, shall have the computation of the bridging clause effective as from the date of signing of the Addendum, that is 25th October 2007.

Dr Kenneth Grech
Permanent Secretary, MHEC

Dr John M Cachia
Director General, Health Care Services, MHEC

Mr Paul Pace
President, MUMN

Mr Colin Galea
Secretary, MUMN

9/12/10
Date

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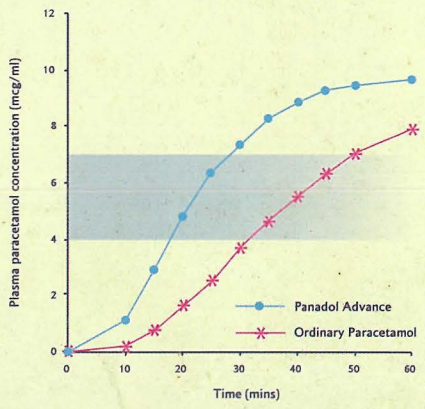

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gsk GlaxoSmithKline Consumer Healthcare