IL-MUSBIEH

MALTA NURSING AND MIDWIFERY JOURNAL
MALTA UNION OF MIDWIVES AND NURSES
No. 50 - Marzu 2011

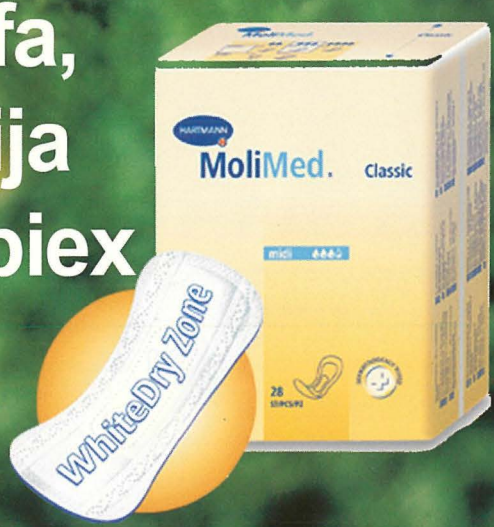
The Cochlear Implant

- Compassion Fatigue
- Dual Diagnosis Unit
- Patient's Rights in Cross-Border Healthcare Directive

HARTMANN

Molimed

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



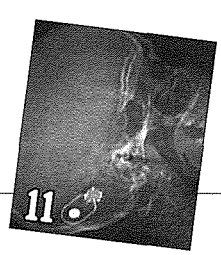
Cempel fuq 21446205 ghal aktar informazzjoni fuq dan il-prodott

IL-MUSBIEĦ

MALTA NURSING AND MIDWIFERY JOURNAL

Ħarġa Nru. 50 • Marzu 2011

F'Din il-Ħarġa



Pubblikat: Malta Union of Midwives and Nurses
Les Lapins Court B, No. 3, Independence Avenue, Mosta MST9022 • Tel / Fax: 21 44 85 42 • Website: www.mumn.org • E-mail: mumn@maltanet.net

Ritratt tal-faċċata: MUMN

Set & Printed: A&M Printing Ltd. - 2155 3217

editorial

The speculations that nursing and midwifery is to become a graduate profession has led to accusations that both nurses and midwives will become 'too clever to care' as though academic achievement and safe, compassionate care are mutually exclusive.

Safe, compassionate care should be expected from all clinicians, from the most senior consultant to the most junior healthcare assistant. However, for nurses and midwives, this is no longer enough. Much of the 'hands on' care traditionally viewed as the mainstay of the nurse and the midwife is now undertaken by healthcare assistants – technological developments mean that more advanced care can be delivered both within the hospital and community setting, and furthermore, the implementation of evidence-based practice is now a nursing and midwifery responsibility. Nurses and midwives need to have the skills and knowledge to undertake this high level of clinical decision-making. Experience is an essential part of the journey towards expertise but so is academic study.

The good news is that acquiring academic knowledge does not mean excluding the traditional values of safe, compassionate care. This is the future of nursing and midwifery: we should embrace it, not decry it.

To do our jobs well, nurses and midwives need hands-on experience of caring for patients, backed with expert knowledge and training, so they can keep up with the increasingly technical aspects of the job. There is no reason why these two sets of skills are mutually exclusive. To be a good nurse and midwife in the 21st Century, you need both.

The demands of modern medicine mean that nurses and midwives are doing increasingly complex procedures. Making nursing and midwifery a degree level profession may go some way to helping nurses and midwives meet these challenges.

But, in the push to make nursing and midwifery a degree level profession, we cannot lose sight of the importance of compassionate care. Our members working as nurses and midwives tell us the main reason they go into the profession is to spend time directly caring for patients. And many of them are worried that more qualifications will mean this time is cut down. This would lead to a decline in job satisfaction for nurses and midwives, and patients would miss out on their specialist care.

Critics should also remember that times have changed. As well as being compassionate, modern nurses and midwives must be able to lead teams, analyse data and manage complex care. The role has changed and so the training should too. Being able to provide patients with good quality care does not mean compassion is any less important.

Many other caring professionals, are trained to degree level without being tarred with the same brush. Prospective nurses and midwives, like other degree-educated healthcare professionals, enter the profession because they genuinely want to help and care for others. To say that because they have a degree they are unable to care is simply illogical.

The Editor

message *from the president*

Paul Pace President
mumn@maltanet.net

When this article is being written, the biggest event which will be chiseled in the Maltese Nursing history is round the corner. I am referring to the International Nursing Council Conference (ICN). Having such a dynamic conference which will bring 2500 nurses from all over the world to our small country is mind bobbling. I encourage all nurses that with all the financial constraints, to attend a onetime life experience that you will remember for the rest of your life. We have made arrangements with the Cpd department for a more efficient reimbursement methodology on not just the ICN conference but even for other academic expenses. The special arrangement which was done for the ICN conference is that nurses could utilize the Cpd allowance allotted for next year so as to cover the necessary amount for registration.

In this issue of the Musbieh, you will find some letters send to the health division which are of utmost importance. One particular letter is that I have sent to Dr. Grima who is the Principle Permanent Secretary in the Office of the Prime Minister, to start negotiating a new sectoral agreement for all nurses and midwives. This was already discussed with the Prime Minister last year and it was agreed that a new sectoral agreement can be initiated after the government collective agreement has been finalized this year. We could say that the government collective agreement is 75% ready but there are still major obstacles that MUMN is contesting. The financial aspect still has to be discussed but what I can guarantee to every member of MUMN is that prior signing the government collective agreement, MUMN will be holding a general meeting for the member's approval of such an agreement. Then the sectoral agreement should follow were the point of contention would be the introduction of a career leader in all the clinical areas. Till this day the only career progression available for us nurses and midwives is the management pathway. What is happening today is that nurses/midwives with a wealth of experience and knowledge are being "lost" in the management waste stream. What is being proposed is twofold. One is an adjustment in salary structures in the present management nursing/midwifery hierarchy and the second issue would be that the nurses/midwives who are resorting to the clinical aspect will start also to find a career pathway as regards salary structure.

The long standing issue of the numerus clauses for the nursing and midwifery courses has finally been resolved. MUMN still has its reserve since there was no mention if the mature students who are eligible to join the nursing or midwifery courses will be accepted. We have fought for five years even resolving to industrial actions to remove such numerous clauses. The lack of staff and frustrations to take one's vacation leave had in its main contributory the numerous clauses at the university courses. The issue of shortage of nurses/midwives staff is far from resolved. Even if the nursing/midwifery courses would have a good intake this year, this would only start to leave the desired effect in three years time. But we finally got some people back to their senses.

Four years have passed from the present council. The MUMN council and the members of every subcommittee within every hospital have all been at your service and in my opinion have all performed to the best of their ability. Being active in a union is not a fulltime job but a full LIFE job. Sundays, feasts days and public holidays do not even stop the work of the union but I can say that in the name of all the activist of the union, we were proud and thankful to the quest which the nurses and midwives have put on our shoulder. A look on statistics, MUMN can boast to be the most active union in the country which could proudly say was always there for the nurses/midwives and even for the patient. I am ready to serve another four years and I am sure that the ones who have forwarded their names for the coming MUMN elections will definitely do us proud. If nurses and midwives do not find comfort in our family of nurses and midwives, then who will offer such comfort. As President of MUMN as far as I know, no issue of nursing/midwifery, no nurse or midwife was ignored or refused any service which MUMN could deliver.

My appeal to all nurses and midwives is to ask also yourself what you can do for the nursing/midwifery. In the name of the MUMN council, in the name of all the members of every hospital committee, in the name of every member in the various sub committees within MUMN, I say thank you for trusting us all in representing you these last four years. Also in the name of all the MUMN members to all the activists in the union a sincere thank you is definitely merited. We should always be one big family, we should never take anyone for granted and we should always be there to help each other in both in our private lives and in our professional commitments. Thank you all for everything and take care of your families.

Paul Pace
MUMN President

messaġġ *mis-segretarju ġenerali*

Colin Galea Segretarju
mumn@maltanet.net

L-elezzjoni sabiex jiġi elett Kunsill ġdid tal-MUMN għall-erba' snin li ġejjien qegħda wara l-bieb. Din ser tkun il-ħames elezzjoni sabiex jinħatar Kunsill ġdid. Applikaw 17 -il kandidat li minnhom iridu jiġu eletti 10. Mis-17 -il kandidat hemm 9 li llum jgħamlu parti mill-Kunsill tal-*Union* u 8 kandidati ġodda. Għall-ewwel darba kemm ilha mwaqqfa l-*Union* f'din l-elezzjoni ser ikun hemm kandidat li jaħdem fl-Isptar Ġenerali f'Għawdex. Mis-17 -il kandidat hemm 2 Midwives u 15 -il Nurse.

Skond l-Istatut tal-Union, l-10 kandidati l-aktar li jġibu voti jiġu eletti bil-kundizzjoni li jkun hemm waħda minnhom li hija *Midwife*. Jekk ma l-ewwel 10 kandidati eletti ma jkunx hemm *Midwife*, allura min jiġi fl-10 post irid iċedi postu għal dik il-*Midwife* li l-aktar iġġib voti. Dan il-provediment fl-Istatut kien sar peress li mill-2500 membru, 100 biss huma *Midwives* u għalhekk il-kandidati *Midwives* huma dejjem fl-iżvantaġġ, u peress li din il-*Union* hija tan-*Nurses* u l-*Midwives*, inħasset il-ħtieġa li jiġi assigurat li ta' l-anqas, siġġu wieħed fil-Kunsill ikun okkupat min *Midwife*.

Wara li fil-Konferenza Ġenerali, li ser issir fit-3 ta' Ġunju 2011 fl-uffiċju tal-MUMN fil-Mosta, jiġu mħabbra l-10 kandidati eletti, dawn iridu fi żmien 48 siegħa jiltaqgħu u fl-laqgħa apposta jeleġġu bejniethom il-karigi stabbiliti fl-Istatut. F'din l-ewwel laqgħa tal-Kunisll, jiġu eletti minn fost dawk l-10 membri, il-President, is-Segretarju Ġenerali, il-Viċi-President, is-Segretarju Finanzjarju, tlett *Chairpersons* li jkunu responsabbli mit-tlett Kumitati Eżekuttivi tal-*Union*, l-Assistent Segretarju Ġenerali u l-Assistent Segretarju Finazjarju.

Għalkemm ma hemm l-ebda garanzija li min jiġi minn ta' quddiem fil-voti jinħatar President jew Segretarju Ġenerali, sa issa dejjem hekk sar. Fl-aħħar erba' elezzjonijiet li għaddew, il-President u s-Segretarju Ġenerali dejjem ġabu l-akbar ammonti ta' voti.

Kull membru ser ikollu l-opportunità li jivvota fil-post fejn jaħdem. Il-kaxxa tal-voti tkun preżenti f'kull sptar, ċentru tas-saħħa u fiż-żewġ djar ta' l-anzjani skond *time-table*. Mill-Ħadd 29 ta' Mejju sa l-Ħamis 2 ta' Ġunju il-kaxxa tal-voti ser iddur kullimkien. Għal din l-elezzjoni ser ikun hemm tlett kaxex tal-voti biex b'hekk fl-isptarijiet il-kbar ser tkun preżenti tlett darbiet, fi ġranet u ħinijiet differenti, filwaqt li fl-isptarijiet l-oħra u fiċ-ċentri tas-saħħa ser tkun preżenti darbtejn bl-eċċezjoni taċ-ċentru tas-saħħa ta' Birkirkara, l-Mtarfa Home u l-Mellieħa Home li ser tkun preżenti darba.

Kull *Nurse* u *Midwife* tista' wkoll tivvota f'postijiet oħra tax-xogħol. Jekk fil-ġranet li l-kaxxa tal-voti tkun preżenti fuq il-post tax-xogħol ikun hemm *Nurses* jew *Midwives* li jkunu *off duty*, ser ikunu jistgħu jivvutaw f'postijiet oħra wkoll. Dan ser ikun permess peress li ser jiġi ppubblikat dokument tal-vot għal kull *Nurse* u *Midwife* membri tal-*Union* fejn dan l-istess dokument irid jiġi ppreżentat qabel wieħed jivvota. Mingħajr dan id-dokument ħadd mhux ser jitħalla jivvota biex b'hekk jiġi assigurat li ħadd ma jkun jista' jivvota aktar minn darba peress li fl-istess ħin ser ikun hemm tlett kaxxi tal-voti għaddejin bil-proċess tagħhom.

Ġew maħtura 15 -il membru li ser ikunu qed jassistu l-kaxxi tal-voti. Dawn kollha huma *Nurses* u *Midwives* pensjonanti li fil-passat mexxew b'suċċess l-elezzjonijiet kollha ta' l-MUMN. Ma' kull kaxxa ser ikun 5 membri biex b'hekk jiġi assigurat li dan il-proċess jitmexxa b'effiċjenza kbira. Il-kandidati kollha ser ikollhom l-opportunità li jiltaqgħu ma dawn il-15 -il membru sabiex jekk ikun hemm xi oġġezzjoni għal wieħed jew waħda minnhom, jiġu s-sosstitwiti minn persuni oħra.

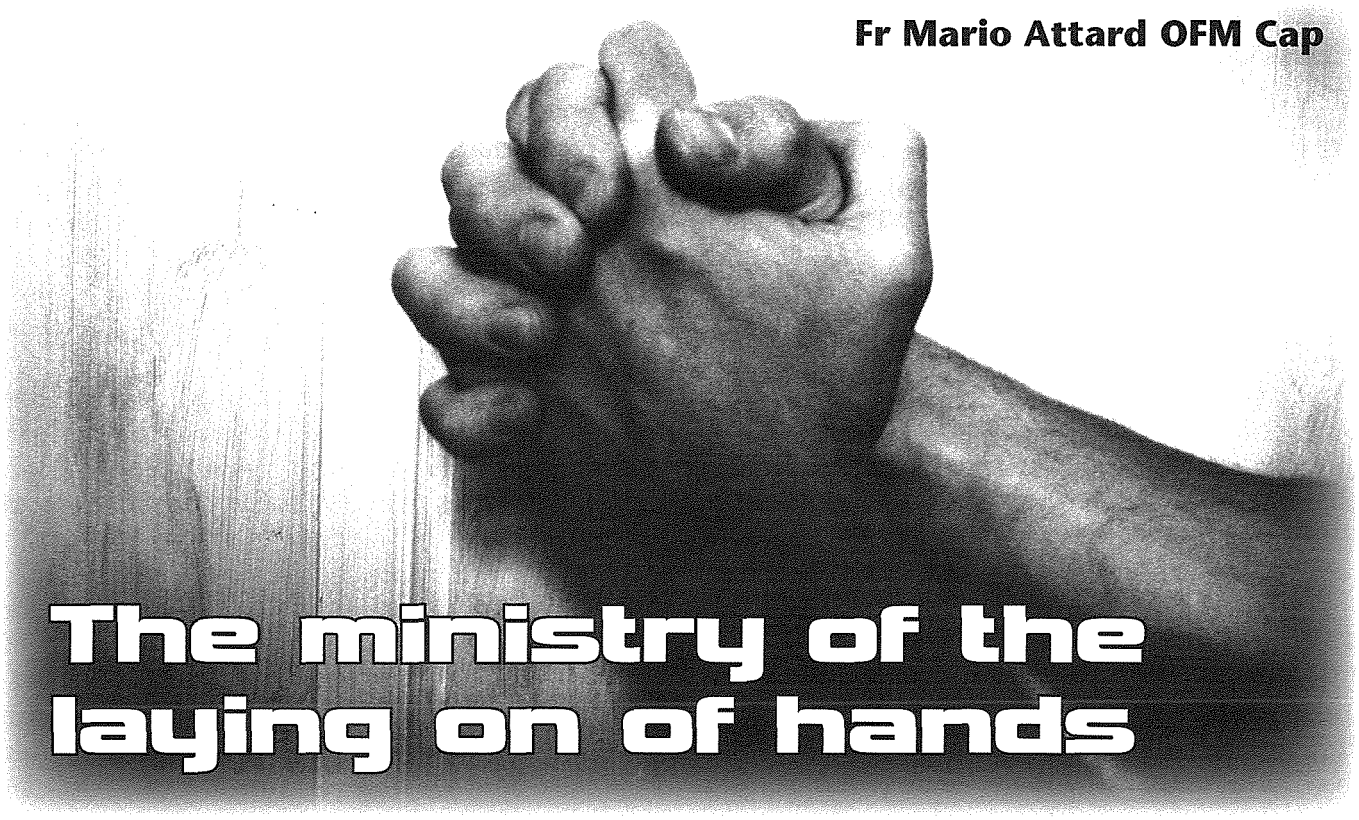
Skużani li għal din id-darba kelli nillimita l-kelmtejn tiegħi fuq l-elezzjoni biss però nemmen li kull membru għandu jkollu l-informazzjoni kollha sabiex b'hekk il-proċess ikun wieħed demokratiku u trasparenti. Aktar informazzjoni ser tirċeviha fir-residenza tiegħek speċjalment il-lista tal-kandidati u t-*time-table* fejn u meta l-kaxxa tal-voti ser tkun fuq il-post tax-xogħol tiegħek.

Huwa importanti ħafna li kull *Nurse* u *Midwife* tagħmel id-dover tagħha u tivvota sabiex tiġi eletta t-tmexxija ġdida tal-MUMN għal dawn l-erba' snin li ġejjien. Fil-passat dejjem kien hemm perċentaġġi sbieħ ta' membri li kkonkorrew u ppartecipaw billi tefgħu l-vot tagħhom. Inħeġġeġ lil kulħadd biex għal din l-elezzjoni jerġa jsir l-istess, anzi jinqabżu l-perċentaġġi li nksibu fl-elezzjonijiet preċedenti.

Filwaqt li nawgura l-Għid it-Tajjeb lilek u l-familja tiegħek, nixtieq nieħu din l-opportunità sabiex nirringrazzjak tas-support u l-fiduċja tiegħek li dejjem urejt fil-Kunsill tal-MUMN.

Colin Galea
Segretarju Generali

Fr Mario Attard OFM Cap



The ministry of the laying on of hands

A very intriguing saying by the English poet and writer, John Masefield, has always set me thinking deep in my thoughts. "God warms his hands at man's heart when he prays". I wholeheartedly agree and bear witness to this resourceful piece of wisdom's validity, especially when I exercise the ministry of the laying on of hands, as this article will shortly show.

When I am paged to administer the Sacrament of the Anointing of the Sick, the first thing that comes to my mind is that this sacrament is essentially an ecclesial one. It is the whole Church, as represented by its leaders, who is totally involved in the praying for the sick person to get healed. Thus, the letter of James suggests: "Is any among you sick? Let him call for the elders of the church, and let them pray over him, anointing him with oil in the name of the Lord; and the prayer of faith will save the sick man, and the Lord will raise him up; and if he has committed sins, he will be forgiven" (Jas 5, 14-15). Nevertheless, both my pastoral praxis as well as a much further enquiry into various biblical verses unraveled to me the importance of laying on of hands on the patients I serve. From my pastoral care experience such a ministry proved to be a pivotal aspect for the eventual well-being of the person and his/her entire family.

Jesus made the laying on of hands a backbone of his messianic ministry, precisely in healing the sick. Luke gives an excellent portrayal of such a leading characteristic of Jesus' public life. "Now when the sun was setting, all those who had any that were sick with various diseases brought them to him; and he laid his hands on every one of them and healed them" (Lk 4, 40). The laying on of hands was a visible gesture of Jesus' merciful heart. Particularly, we encounter this aspect in the story of the woman who had a disabling spirit for eighteen years. Luke tells us that this woman was bent over to the point that she could never straighten herself completely. Jesus freed her. "And he laid his hands upon her, and immediately she was made straight, and she praised God" (Luke 13, 13). Before going to the right hand of his Father in glory, Jesus taught his disciples that the laying on of hands was one of the concomitant signs that will accompany the Gospel's preaching. "And these signs will accompany those who believe: in my name they will cast out demons; they will speak in new tongues; they will pick up serpents, and if they drink any deadly thing, it will not hurt them; they will lay their hands on the sick, and they will recover" (Mark 16, 17-18). In reading through this text one is convincingly led to believe that this practice was to carry on till His eventual return at the end of times.

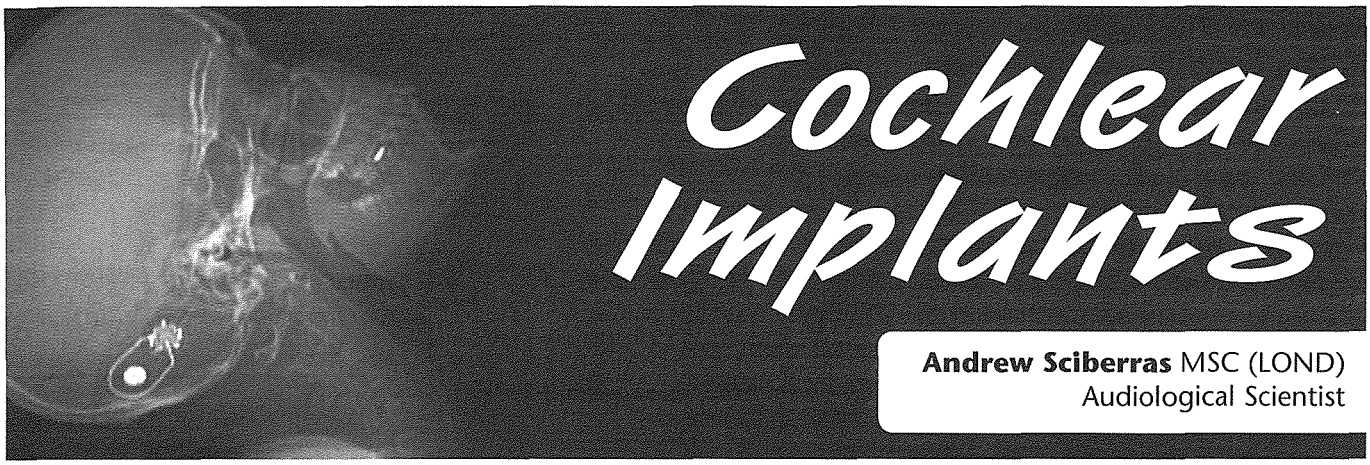
The ministry of the laying on of hands is an act of faith and obedience to God's authoritative Word. Its success heavily relies on God that grants the increase, obviously not depending on the human person's feelings. The book of Acts accounts how God utilized the laying on of hands by those who believed in Jesus to perform miraculous healings and other supernatural signs affirming His Word: "So they remained for a long time, speaking boldly

for the Lord, who bore witness to the word of his grace, granting signs and wonders to be done by their hands" (Acts 14, 3). The Apostles worked out many healings through the laying of their hands as these two biblical references taken from the book of Acts tenably recommend. "Now many signs and wonders were done among the people by the hands of the apostles" (Acts 5, 12). "It happened that the father of Publius lay sick with fever and dysentery; and Paul visited him and prayed, and putting his hands on him healed him" (Acts 28, 8).

As it clearly emerges from my direct dealings with patients and their relatives, the laying on of hands purports a warm action of identification, comfort, friendship and blessing. For instance, the Markan Jesus was open to bless the children of people who were keen to receive him in their lives. "And they were bringing children to him, that he might touch them; and the disciples rebuked them" (Mark 10, 13). "And he took them in his arms and blessed them, laying his hands upon them" (Mark 10, 16). Through touching, mainly in the laying on of hands, there is a spiritual transference between persons as has been the case of the woman with a blood problem for twelve years who touched Jesus in faith and Jesus perceived it. For He asked: "'Who was it that touched me?' When all denied it, Peter said, 'Master, the multitudes surround you and press upon you!' But Jesus said, 'Some one touched me; for I perceive that power has gone forth from me.' And when the woman saw that she was not hidden, she came trembling, and falling down before him declared in the presence of all the people why she had touched him, and how she had been immediately healed. And he said to her, 'Daughter, your faith has made you well; go in peace'"

(Luke 8, 45-48). What this passage demonstrates is that something has gone out of Jesus, he perceived it, the woman accepted in faith what Jesus has done to her, and, automatically comfort, friendship and blessing restored her holistically.

In his book "The Mystery of the Human Person", Bishop Kallistos Ware wrote: "As Christians we are here to affirm the supreme value in direct sharing, of immediate encounter — not machine to machine, but person to person, face to face". Through the ever sound ministry of the laying on of hands the healing power of Jesus is effected through an immediate encounter, from person to person, from face to face!



Cochlear Implants

Andrew Sciberras MSC (LOND)
Audiological Scientist

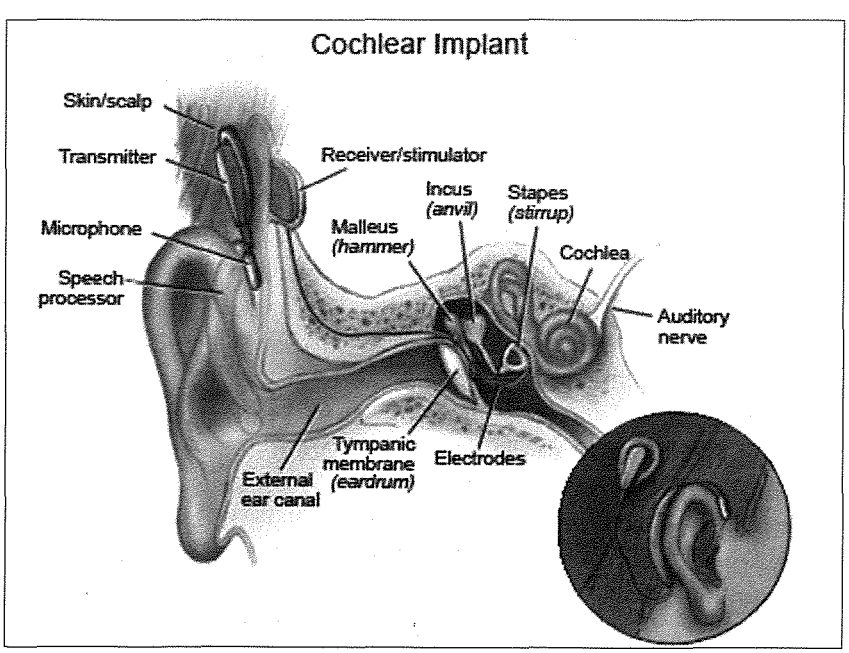
Sometimes called a "bionic ear," the cochlear implant offers the hope of regaining or restoring the ability to sense sound for some people who have experienced significant hearing loss.

Although they're not miracle devices, cochlear implants help some children and adults, whether they're born deaf or whether hearing loss occurs later in life, experience talking on the phone, listening to music, and hearing the voices of their friends and loved ones.

WHAT IS A COCHLEAR IMPLANT?

A cochlear implant is a surgically implanted device that helps overcome problems in the inner ear, or cochlea. The cochlea is a snail-shaped, curled tube located in the area of the ear where nerves are contained. Its function is to gather electrical signals from sound vibrations and transmit them to your auditory nerve (or hearing nerve). The hearing nerve then sends these signals to the brain, where they're translated into recognizable sounds.

If important parts of the cochlea aren't working properly and the hearing nerve isn't being stimulated, there's no way for the electrical signals to get to the brain. Therefore, hearing doesn't occur. (Sometimes referred to as nerve deafness, this is called sensorineural hearing loss.) By completely bypassing the damaged part of the cochlea, the cochlear implant uses its own electrical signals to stimulate the auditory nerve, allowing the person to hear.



HOW NORMAL HEARING OCCURS

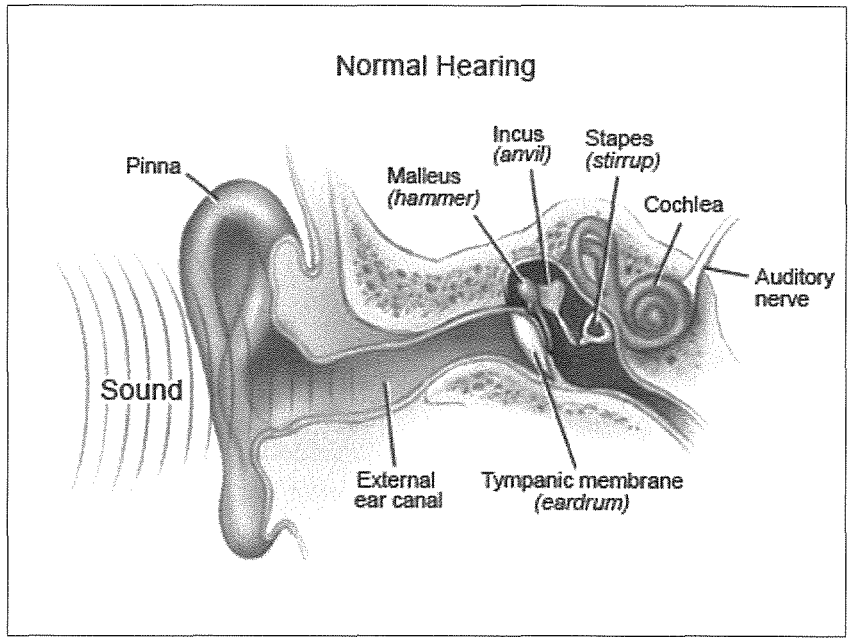
The ear is made up of three parts, and sound for a person who has normal hearing passes through all three on the way to the brain. The outer ear is made up of the outer, visible part of the ear and the ear canal.

When a person is exposed to a sound, the outer ear captures the sound vibration and sends it through the ear canal to the middle ear, which consists of the eardrum and three tiny bones. The sound vibration then causes motion in the three tiny bones, which makes the fluid in the cochlea move. The motion of the fluid stimulates the hair cells, which are thousands of tiny hearing receptors inside the cochlea. The hair cells bend back and forth and send electrical signals to the hearing nerve, and the hearing nerve then carries these signals to the brain, where they're interpreted.

Through aging, heredity, disease, infection, or repeated or severe exposure to loud noise, hair cells can be damaged or destroyed. If the hair cells don't work, the hearing nerve can't be stimulated and therefore can't send information to the brain. Thus, the person is unable to hear. Hearing loss can be mild, moderate, or severe, depending on the number of hair cells that are defective, damaged, or destroyed. People with mild or moderate hearing loss may find that hearing aids, which simply make sounds louder, help. Those with profound or severe hearing loss might even have trouble understanding loud sounds. A hearing aid won't help in these cases, and a doctor might recommend a cochlear implant.

WHAT A COCHLEAR IMPLANT DOES

The cochlear implant artificially stimulates the inner ear area with electrical signals, sends those signals to the hearing nerve, and allows the user to hear. Although sound quality is sometimes described as "mechanical" and not completely like that experienced by a person with normal hearing, the cochlear implant provides users with the ability to sense sound that they couldn't hear otherwise. Improvements in the way the implant processes sound information are continuously being made to make the sound seem more natural.



The actual cochlear implant consists of an implant package, which is secured inside the skull, and a sound and speech processor, which is worn externally (outside the body). Several components of the cochlear implant work together to receive sound, transfer it to the hearing nerve, and send it to the brain.

The implant package is made up of:

- a receiver-stimulator that contains all of the electronic circuits that control the flow of electrical pulses into the ear
- an antenna that receives the signals from the external sound and speech processor
- a magnet that holds the external sound and speech processor in place
- one wire containing electrodes that are inserted into the cochlea (the number of electrodes can vary depending on the cochlear implant model type used). The electrodes act much like normal functioning hair cells and provide electrical charges to stimulate the hearing nerve.

The sound and speech processor is a minicomputer that processes sound into digital information, and then sends that information to the implant package in the form of electrical signals. The sound and speech processor is worn externally and looks a lot like a normal hearing aid. Depending on the type of sound and speech processor used, it can either be worn as a headset behind the ear or in a belt, harness, or pocket. The components of the sound and speech processor include:

- the actual sound and speech processing device (which can either be a body-level model that can be clipped onto clothing like a portable radio, or an ear-level model that's hooked over the ear)
- a microphone
- a transmitter that sends the signals to the implant package. The transmitter also includes a magnet that helps the user align the processor with the implant package.

For the cochlear implant to work, the implant package and the sound and speech processor must be aligned — that's what the magnets are for. By lining up the magnets, both the implant package and sound and speech processor are secured and work as one device. When the implant package and the sound and speech processor aren't completely aligned, the device doesn't work and the person can't hear. Because both components need to be aligned for the user to hear, some people take the sound and speech processor off at night to sleep soundly. Others leave it on all the time.

HOW A COCHLEAR IMPLANT WORKS

Knowing what, exactly, the cochlear implant does may help kids better understand their new bionic ear and the cool technology behind it that allows them to hear better. Here's how the implant works:

- The microphone picks up sound.
- Sound is sent to the sound and speech processor.
- The sound and speech processor analyzes the sound and converts it into an electrical signal. (The signal contains information that determines how much electrical current will be sent to the electrodes.)
- The transmitter sends the signal to the implant package, where it's decoded.
- The implant package determines how much electric current should pass to the electrodes and sends the signal. The amount of electrical current will determine loudness, and the position of the electrodes will determine the sound's pitch.

- The nerve endings in the cochlea (the area where the hair cells are located) are stimulated and the message is sent to the brain along the hearing nerve.
- The brain interprets the sound and the person hears.

COCHLEAR IMPLANT SURGERY

The actual surgical procedure, which takes 2 to 4 hours and uses general anesthesia, involves securing the implant package under the skin and inside the skull, and then threading the wires containing the electrodes into the spirals of the cochlea.

To secure the implant, the surgeon first drills a 3- to 4-millimeter bed in the temporal bone (the skull bone that contains part of the ear canal, the middle ear, and the inner ear). Next the surgeon opens up the mastoid bone behind the ear to allow access to the middle ear. Then, a small hole is drilled in the cochlea and the wires containing the electrodes are inserted. The implant package is then secured and the incision is closed.

After having cochlear implant surgery, a child:

- will probably be able to go home the next day
- will have to wear a dressing over the implant area for 24 hours
- may be off-balance or dizzy for a few days
- may experience mild to moderate pain (the doctor may recommend giving pain medications)
- won't have to have the stitches removed — they're absorbable and dissolve on their own
- can lie on the side with the cochlear implant in a few days

Two to four weeks after surgery, the sound and speech processor is matched with the implant package and is programmed and fine-tuned to meet the child's individual hearing needs.

LEARNING TO USE A COCHLEAR IMPLANT

Because the extent and type of hair cell damage, electrical signal patterns, and sensitivity of the hearing nerve are different for each person, a specialist must fine-tune the sound and speech processor for every patient.

By measuring the lowest and highest current for each electrode, the clinician finds the softest and loudest sounds that will be heard (each electrode produces a different sound with different pitch). The sound and speech processor matches sounds on different electrodes with different volumes and attempts to create an accurate version of the original sound. However, because a limited number of electrodes are taking over the function of the thousands of hair cells in a normal ear, sounds won't be totally "natural."

After the first few programming sessions, the user begins to pick up sounds with the implant, but giving the implant full power is a gradual process that takes several months. In children who are born deaf, the stimulation from the implant will allow them to develop the brain pathways necessary to hear sounds. This is an extended process with programming and intensive therapy that often lasts for several years.

During the programming process, the user attends speech and language therapy sessions to help identify and interpret the new sounds he or she is hearing. In addition, an important part of the therapy includes parent education and training.

Therapy will help a child develop and understand spoken language through detecting, imitating, and associating meanings of sounds. These sessions last at least a year, along with parent education and training programs. In many cases, therapy has helped kids with cochlear implants develop speech and language on par with their peers and attend mainstream schools.

Some families choose to have implants in both ears. This can help with speech detection when there is background noise and in localizing the source of sounds.

CAN A COCHLEAR IMPLANT RESTORE HEARING FOR EVERYONE?

Cochlear implants are very successful for some people, but not everyone is a candidate to receive one. Ideally, children 12 months of age or older with profound hearing loss in both ears are excellent candidates, but not every child is eligible.

Some common reasons that a child may not be eligible for a cochlear implant:

- the child's hearing is "too good" (meaning the child can hear some sound and speech with hearing aids)
- the reason for hearing loss isn't a problem with the cochlea
- the child has experienced profound deafness for a long period of time
- the hearing nerve itself is damaged or absent

Each potential candidate must be evaluated by a cochlear implant team to determine whether a cochlear implant is the best option.

For those who do receive a cochlear implant, benefits can vary. The length of rehabilitation varies from person to person, and many factors (such as the condition of the hearing nerve or the presence of scar tissue in the cochlea) can hinder the success of the implant.

Expectations should be realistic, and the doctor or surgeon will help you understand the level of success the implant can reasonably achieve for your child.

Traumatic events leave indelible marks on those who are touched by them. Those who care for or help individuals who are working through a traumatic event can also experience stress. *Compassion fatigue* is the term used to describe the emotional effect of being indirectly traumatized by helping someone who has experienced primary traumatic stress. To date, compassion fatigue has been studied primarily in nonnursing groups.

When watching a patient go through a devastating illness or trauma, the nurse may react by turning off his or her own feelings, or by experiencing helplessness and anger. Many nurses find themselves repeatedly on the margin of a traumatic event in the course of patient care.

Compassion fatigue may occur in situations when an individual cannot be rescued or saved from harm, and may result in the nurse feeling guilt or distress. Hospice nurses; nurses caring for children with chronic illnesses; and personal triggers, such as overinvolvement, unrealistic self-expectations, personal commitments, and personal crises, are linked to compassion fatigue.

Compassion fatigue is often linked to burnout, a related but different concept in which the nurse experiences slowly developing frustration, a loss of control, and generally low morale.

The purpose of this study was to describe the prevalence of compassion fatigue among a broad spectrum of nurses and to investigate the situations that lead to compassion fatigue and nurses' methods of coping.

A questionnaire with cover letter was placed in the hospital mailboxes of registered nurses in selected units of a Midwestern hospital. The convenience sample yielded a 60% return rate (n = 106) with 71 complete responses to both the quantitative and qualitative components of the survey. In addition to demographic information, the Professional Qualify of Life Scale, which includes a compassion fatigue test, and scales for compassion fatigue, burnout, and compassion satisfaction were included. Two questions requiring a narrative response provided data for the qualitative part of the study. The participants were asked to describe a situation during which they experienced either compassion fatigue or burnout and what strategies they used to deal with the situation, or how they got through the experience.

The burnout and compassion fatigue/secondary trauma scales correlated, suggesting that they measure overlapping phenomena. Compassion fatigue/secondary trauma was significantly higher in nurses who worked 8-hour shifts compared with nurses who worked 12-hour shifts. Compassion satisfaction was significantly higher in intensive care unit nurses than in emergency department nurses. Nurses with the least experience reported

significantly higher rates of compassion satisfaction than the more experienced nurses. Compassion satisfaction was strongly negatively correlated with numerous items on the compassion fatigue/ secondary trauma and burnout subscales. Nurses who had higher compassion satisfaction scores were more interpersonally "fulfilled," as defined by scores on "being happy," "being me," and "being connected to others." These nurses did not feel as trapped and did not experience difficulty separating personal life and work. They were less likely to feel exhausted, bogged down, or "on the edge."

Compassion fatigue was often triggered by patient care situations in which nurses:

- Believed that their actions would "not make a difference" or "never seemed to be enough";
- Experienced problems with the system (high patient census, heavy patient assignments, high acuity, overtime, and extra workdays);
- Had personal issues, such as inexperience or inadequate energy;
- Identified with the patients; or
- Overlooked serious patient symptoms.

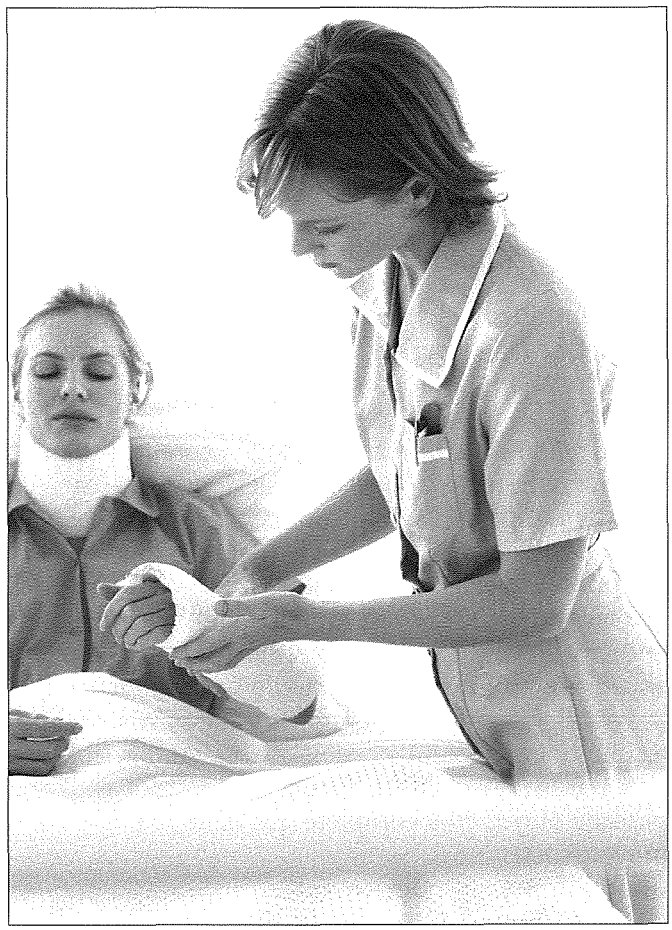
Coping strategies included making a change in personal engagement with the patient or the situation -- ignoring, disengaging; or changing the nature of their work involvement (leaving an organization, leaving nursing, transferring to other nursing units, changing from full-time to part-time hours, and changing shifts). Taking extra days off or taking a break from a patient were helpful short-term strategies. Nurses also requested help from other nurses or used informal debriefing to help them cope with stressful situations. Some nurses developed personal coping strategies to manage non-work-related stresses in their lives, such as praying, focusing on activities and relationships outside of work, and introspection.

This study found that some nurses were at high risk for compassion fatigue. Nurses were aware of the stress under which they worked, and some had articulated strategies for coping with it. Yoder suggested that nurses need to be given opportunities to recognize and talk about their stress and to make plans as individuals for how to cope with it.

VIEWPOINT

Caring is one of the foundational tenets of nursing. When nurses cannot care for patients at the therapeutic level, they will be ineffective. However, caring too much is a major risk for nurses.

Compassionate nurses are an essential and dwindling resource in today's healthcare system.



The growing nursing shortage mandates that the nurses who remain must also be supported and cared for.

Although it is easy to say that nurses should be given the opportunity to recognize and talk about the stress that they experience, and to make plans for coping, these are challenging tasks. Trauma research indicates that people involved in traumatic events need to be able to "tell their story" 8 or 9 times to defuse the physiologic and psychological impact of what they have been through. Providing opportunities for nurses to get together to talk and support each other is common sense. As laypeople, we support and care for each other during stressful times. Somehow, we have to provide that same sort of commonsense therapy for healthcare professionals. Once people share what they are feeling, then strategies can be developed to cope with those feelings. However, in busy hospitals and clinics, it will be a challenge to find the time to provide these experiences.

Nurses don't have a monopoly on compassion fatigue. Other studies have demonstrated that psychiatrists, in particular, have high rates of suicide, severe depression, and general compassion fatigue. All healthcare providers need to find methods of mutual support for the anger, frustration, and helplessness that they experience at work.

Choosing the Right Absorbent Continence Device

Incontinence has significant negative effects on the quality of life of patients including social isolation, loneliness and sadness, embarrassment, stigmatization, disturbed sleep and negative effects on sexual relationships. Incontinence may also be a factor for a person to be admitted to long term care and to induce low staff morale in health-care institutions. Correct advice, management and nursing care of incontinent persons greatly influences their quality of life and that of their carers.

Types of Incontinence: Bladder Incontenence involves the unintentional loss of urine that is sufficient enough in frequency and amount to cause physical and/or emotional distress in the person experiencing it.

Faecal Incontinence is the loss of bowel control, resulting in involuntary passage of stool. This can range from an occasional leakage of stool with the passage of gas, to a complete loss of control of bowel movements.

Choosing the right device:

Main products used in continence care include pads and pull-up pants for bladder incontinence; and pads, diapers and pull-up pants for total 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. Whereas, high absorbency products are better utilised for persons suffering from heavy incontinence, who are highly concerned about security from leakage, especially during sleep/night-time where changes are less frequent. However, absorption capacity does not always totally determine nor ensure security against leakage. Other factors, such as anatomically shaped products, in order to fit body contours, may critically influence the level of security and wearing comfort. Hence, it is also very important to choose the right product size according to waist/hip measurement, whichever is the greatest, in case of pull-up pants or diapers. Some products are also specifically designed according to gender, male and female versions of products to ensure a perfect fit. Patients' 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 tailored to fit closely and safely to the body
- Discretion having an odour neutralizer, are not bulky, and do not rustle on movement
- Security through the use of a system that locks wetness away quickly & safely usually achieved through the use of super absorbent gels such as poly-acrylate in the core material
- 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.

Choosing the right product to address patient needs will lead to better use of the products' potentials thus avoiding excessive consumption and waste. Individualising product requirements of patients involves identification of the correct kind of product thus avoiding unnecessary oversizing and malpractice. In elderly homes, involving personnel in the correct management of continence devices helps achieve correct use of products and cost control in continence care. The main advantages to be achieved are:

- Better comfort for the residents
- Reduced workload for the personnel
- Substantial savings in laundry costs
- Reduced waste
- Less skin problems

Quality continence products are considered to make an integral part of professional continence therapy as a cornerstone for a professional holistic approach to patient care. Patients usually seek professional advice from nurses, carers, pharmacists and doctors. The busy and often times overloaded health professional can gain the best advantage for the patient by seeking advice from healthcare professionals specialised in continence care or suppliers of quality continence devices, in order to meet patients' needs in the best way possible.

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

ICN CONFERENCE – MALTA

'Nurses driving access, quality and health'

2nd - 8th May 2011 – Mediterranean Conference Centre

As President of The Malta Union of Midwives and Nurses (MUMN), I would like to welcome you to the Maltese islands for the International Council of Nurses Conference (ICN). On behalf of all the Maltese nurses and citizens, we are proud that such a historic event is taking place on our small island which is famous for its hospitality. Malta's history is dominated by its active role for caring of the sick in various wars around the Mediterranean region and such involvement earned her the nick name as "The nurse of the Mediterranean".

The theme of the conference is a challenging - Nurses driving access, quality and health.

In today's global recession, nurses are facing challenges that are unprecedented in the history of nursing.

The main challenges today are the depleted nursing work force and the huge budget cuts into the health systems due to the global recession. These two factors are not just affecting us nurses as health care providers but are also compromising patient's care and safety in most countries in the world. Nurses are to be the driving force of any health sector and should be the advocates not just for ourselves but also of the patients so it is time for nurses to be involve also in the politics of their country since politics affects all aspects of life. Political decisions determine the quality of life of people, their human rights and security, the economy of a nation which affects every household; housing and working conditions, education, social support, health and well being of individuals and families. Strategies to affect these determinants of the standard of living of people involve policy development and political action.

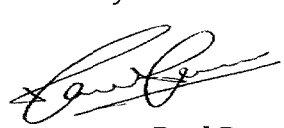
The nurse's holistic view on their role and responsibility in the health care system and their knowledge based on research and experience is valuable for the ongoing evolution of the health care system. For this knowledge to affect the provision of health care it must reach the policy makers and health policy must reflect the knowledge generated by research and experience. Many of the most significant advances in public health policy can be made only in the context of political debate and it is in this forum that experience and research are transmitted to policy. Let us all face the facts. Nursing shortage has reached unprecedented levels in most country. At the present time, most countries suffering from a growing disparity between supply and demand in the case of nurses. This disparity is leading to the severe nursing shortage and health care crisis. This nursing shortage is classified as more severe and presents a real threat to the nation's health. It would be difficult to pinpoint each individual contributing factor that has impacted the nursing shortage over the years. However, there are a few main factors that should be examined in order to better understand the reasons behind this dramatic shortage.

Nurses and nursing are part of an evolving health system. Changes in society (demographics, economics, environment, education, and politics) affect the nurses' personal and professional lives and influence the way they deliver care. The aging nurse workforce and shrinking student pool in the world are contributing to a critical nursing shortage threatening patient's access to quality care.

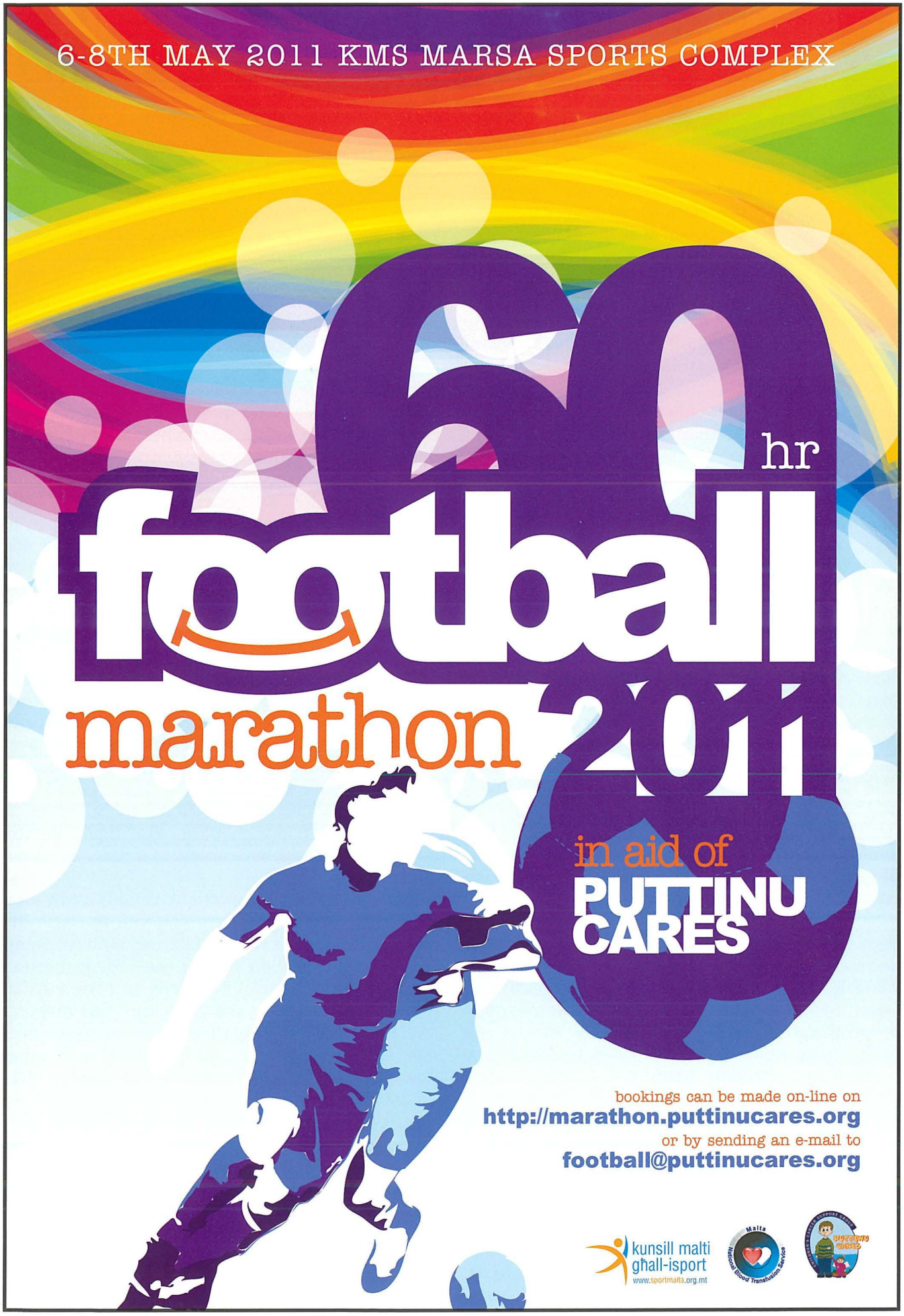
The ICN conference and the CNR are golden opportunities for us nurses to analysis, evaluate and strengthen our main goal to be a service to our patients. Such a conference is like beautiful sun rays penetrating through dark clouds since such conference inspires nurses to be better and more knowledgeable to the benefit of our patients. Nurses can leave an impact in any country and through unity we can make a difference.

During the conference our mind should go also to the people suffering and fighting to introduce democracy in their countries. I am sure that nurses in such countries were definitely trying to save lives and seeing the welfare of their patients. Our thoughts should also go to the people who do not have access to medical supplies or any health service. Although we are living in a technology era, there are still people who do not have access to a nurse or even a tablet.

This beautiful country with its famous warm local hospitality would be welcoming you to share the experience of a live time. Malta was always famous for important meeting such as the famous meeting between the American President and the Russian premier which ended the cold war. This meeting Malta will see the biggest number of nurses ever before to meet, discuss and learn from each other how we can improve ourselves. ICN honored us and I on behalf of all the nurses, I would like to thank them for their work in bringing so many nurses together for such a huge event. I wish you all not only a successful conference but a wonderful memory to take with you home and remember all your life.



Paul Pace
MUMN President


6-8TH MAY 2011 KMS MARSA SPORTS COMPLEX
60 hr
football
marathon 2011
in aid of
PUTTINU CARES
bookings can be made on-line on
http://marathon.puttinucares.org
or by sending an e-mail to
football@puttinucares.org
kunsill malti għall-isport
www.sportmalta.org.mt
Malta
National Blood Transfusion Service

from our diary...


1


2


4

5

7


8

1 After a series of Industrial Actions MUMN and the Health Division finally reach an Agreement regarding general conditions of work.

2 Once again Bank of Valletta plc confirms its support to MUMN. This is the third support agreement reached where the two organizations express their mutual respect and benefits.

3 Last Christmas MUMN organized a very successful activity. A big thank you to the Entertainment Group Committee.

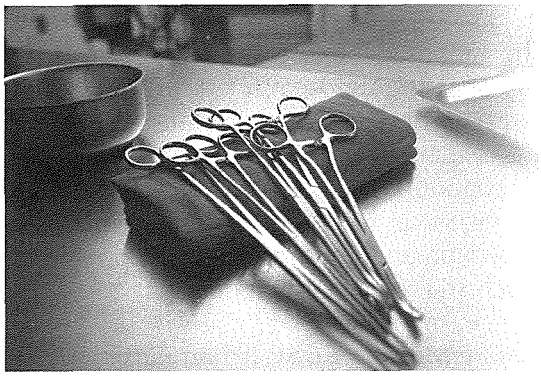
4 ICN officials visited Malta once again to hold a meeting for the volunteers who will be assisting the delegates during the ICN Conference in Malta.

5 MUMN President was invited to participate on a TV program discussing health issues related to Nurses and Midwives.

6 On. Health Minister Dr. Joe Cassar visited MUMN premises to address the Midwives regarding Midwifery issues.

7 MUMN and the Malta Operating Theatre Nurses Association (MOTNA) signed a mutual agreement that would enable MOTNA to be part of MUMN in the interest of the Operating Theatre Nurses.

8 MUMN and the Malta Critical Care Nurses Association (MCCNA) signed a mutual agreement that would enable MCCNA to be part of MUMN in the interest of the Critical Care Nurses. This is the fifth Nursing Association that was established on our island and the fifth association that decided to be part of MUMN.



Dual Diagnosis Unit

Individuals with dual diagnosis have complex requirements relating to their personal health, emotional, psychological, social, legal, and economical problems which can often be aggravated by their substance misuse. According to the World Health Organization (2008) the term dual diagnosis refers to the co morbidity or the co-occurrence in the same individual of a psychoactive substance use disorder and another psychiatric disorder. Evidence demonstrates connections between psychiatric problems, psychological disorders and substance misuse (Bushell, Crome & Williams, 2002).

Drug addiction is often associated with several psychiatric disorders such as anxiety disorders, depression, schizophrenia and personality disorders, mainly due to illicit substance abuse or when the individual abuses of illicit substances to experience relief from their psychiatric disorders also referred as self medication. These independent disorders may make certain vulnerable patients more prone to developing drug/alcohol related problems (Kessler, R. C., Crum, R. M., Warner, L. A., Nelson, C. B., Schulenberg, J., & Anthony, J. C. 1997). Dual diagnosis patients have the same entitlement as other patients to the services provided both by the government and the NGO's. Consequently a 'Dual Diagnosis Unit' was opened in 2004 to serve this purpose therefore enhancing the care for such patients. During the last few years DDU provided care for approximately 150 male service users per annum.

On October 2009, Dual Diagnosis Unit (DDU) went through some big changes and a refurbishment of the premises was carried out. The bed state was increased from 6 to 8 and this created the opportunity to treat more patients at the same time. Security cameras have been installed as a preventative measure to reduce the possibility of unit policies infringement and also aid in observance of a safer environment. A well sized pantry and ample comfortable space have been provided to create a more homely and safer environment for both patients and staff.

Dual Diagnosis Unit's aim is to enable individuals with dual diagnosis to receive mainstream treatment and nursing support for both their mental needs and substance misuse problems. Like most acute wards at Mt Carmel Hospital, patients can be referred to DDU by General Practitioners, Detox Center, and Health Centers or also transferred from other wards. Throughout these last few months, a patient's therapeutic contract was also introduced after thorough discussion and consultation between DDU's nursing staff, consultants and hospital management. Prior to admission the patient is informed about this contract and its contents are explained to him. This therapeutic contract is intended to improve unit's safety and enhance therapeutic relationship between staff and patients by clearly defining what is expected of the patient.

Throughout hospitalization, the multidisciplinary team (consisting of consultant psychiatrists, medical house officers, psychologists, social workers, occupational therapists, and nurses) collaborate to treat the patient holistically and facilitate quality patient's care. Multidisciplinary teams form one aspect of the provision of a streamlined patient journey by developing individual treatment plans that are based on the best holistic care. The team's aim is to address requirements that are focused on the physical, social and psychological requirements of the person diagnosed with dual diagnosis. Comprehensive assessment including a detailed mental and physical history, a detailed substance use history and an assessment of clients' motivation to change and risk assessment are regularly carried out by, the DDU's staff. This further enhances discussions and counseling in relation to management of treatment with service users who are partners in the process and future plans.

Dual Diagnosis patients need to be constantly supported and counseled during the early stage of detoxification. The main goal of this phase is to help stabilize the acute symptoms of the psychiatric illness and/or the drug use withdrawals and cravings. Furthermore it motivates patients to continue complying to treatment once the acute crisis is stabilized and thus reduces the number of drop outs.

Presently DDU offers our residents the possibility of gaining coping skills to promote self-responsibility and recovery. These include helping the patients to follow a time table by involving themselves in daily basic house chores, participating in unit's activities/crafts, and taking care of their personal care and belongings. Nearly every day a morning group meeting, lead by nursing staff, discusses various issues such as 'Responsibilities', 'Craving and Addiction Intervention

Planning', 'Managing denial', ' High risk situations that may lead to relapse' and other valuable topics. Narcotic Anonymous meetings are also held at the DDU premises on a fortnight basis (on Sundays). Here residents and NA members can share their feelings, experiences, support and thoughts among the group.

On a weekly basis, the hospital chaplain visits the unit to encourage and guide the residents spiritually or for confession. A mass is also held inside the unit so that residents can actively participate and fulfill their spiritual needs.

The efficient service offered to dual diagnosis patients would never function adequately, had it not been for the effective communication which takes place between the agencies, and non governmental organizations (N.G.O.s) such as Detox Out-Patients, Sedqa's Community Services, Dar l-Impenn, Komunita Santa Marija Rehabilitation Programme, Caritas outreach and shelter, San Blas Rehabilitation Programme, and Oasi Programme, together with DDU staff. An immediate and a long term plan are set up in conjunction with the respective Agency following up the client requests and requirements.

Unfortunately like most patients that are being treated at Mt Carmel Hospital, DDU patients also have to face the problem of stigma. According to Hayward and Bright (1997) stigma is the negative effect of a label or the process of establishing deviant identities. There is no method to assess stigma, but by evaluating public opinion regarding addictive persons and mental disorders. Anti-stigma activities should recognize the various features of stigma, as well as the responsibility that mental health professionals may take part in structuring and reducing the stigma that such patients' experience. In the words of the World Health Organization (2011), new understanding has indeed brought some hope and stigma is receiving its due attention on a regional and international level, although much still remains to be done.

Article written by ***Mario Cassar****, acting nursing officer DDU and vice president of the MAPN*

References:

• Bushell, H. D., Crome, I., & Williams, R. (2002). How can risk be related to interventions for young people who misuse substances? *Current Opinion in Psychiatry, 15*(4), 355-360.

• Hayward, P. & Bright, J. (1997) Stigma and mental illness: a review and critique. *Journal of Mental Health*, 6, 345 -354.

• Kessler, R. C., Crum, R. M., Warner, L. A., Nelson, C. B., Schulenberg, J., & Anthony, J. C. (1997). Lifetime co-occurrence of dsm-iii-r alcohol abuse and dependence with other psychiatric disorders in the national comorbidity survey. *Archive of General Psychiatry, 54*(4), 313-321

World Health Organisation. (2011). *Mental Health: Adcocacy.* Retrieved February 24, 2011, from http://www.who.int/mental_health/advocacy/en/

• World Health Organisation. (2008). *Management of substance abuse: Lexicon of alcohol and drug terms published by the world health organization.* Retrieved October 26, 2008, from http://www.who.int/substance_abuse/terminology/who_lexicon/en/ http://www.who.int/mental_health/advocacy/en/

EFN BRIEFING NOTE

On Patient's Rights in Cross-Border Healthcare Directive

Yesterday, 19 January 2011, the European Parliament - meeting in Strasbourg - voted in favour of the EU Directive on patients' rights in cross-border healthcare, which marks an important step forward for all patients in Europe. With these clearly identified rules on their rights to access safe and good quality healthcare across EU borders (Citizens will benefit from accessible, clear and precise information thanks to single national contact points), the EU patients travelling to another EU country for healthcare will enjoy equal treatment as the citizens of the country in which they are treated.

The Directive will also benefit patients in several other ways as: it will help patients who need specialised treatment (e.g.: rare diseases); it will bring about closer and improved health cooperation, including the recognition of prescriptions, between Member States; and health experts across Europe will be able to exchange best practices and mutually benefit from innovations in health technology assessment (HTA) and eHealth.

In terms of reimbursement, and also as a mean to discourage "health tourism", it has been approved that the patients will be entitled to get reimbursement (Representing today only around 1% of the EU Member States public spending on healthcare) for the treatment they have received in another Member State in the same basis as under their home country healthcare system. Therefore, in case of higher costs' hospitalisation or treatment the patient will have to pay the difference. Nonetheless, citizens needing care (including emergency care) when temporarily abroad will continue to benefit from the existing Regulations scheme and be provided with the care they need. Also, in cases of hospitalisation or treatments under high costs, on a voluntary basis for Member States, patients would be able to not pay upfront for the treatment they will receive.

Furthermore, the EU Member States will have the possibility of introducing a system of prior authorisation for patients seeking cross-border healthcare. This will apply to healthcare involving overnight(s) hospital stay, highly specialised and cost-intensive healthcare. In order to safeguard patients free movement rights, this authorisation could only be refused if the treatment could present a risk for the patient or if appropriate healthcare can be provided at home country in good time. Nevertheless, this refusal has to be explained by the Member State.

The EFN welcomes this 2nd reading approval of the Directive which will now need to be formally adopted by the Council of Ministers, meeting on 7 March 2011. Once approved, the Directive should become effective in 2013.

Finally, the EFN would like to take this opportunity to congratulate the European Patients' Forum (EPF) for their hard lobby work and outcomes.

For further information:

• Directive Legislative Proposal
http://ec.europa.eu/health/archive/ph_overview/co_operation/healthcare/docs/com_en.pdf
• Questions & Answers on the Directive:
http://europa.eu/rapid/pressReleasesAction.do?reference=MEMO/11/32&format=HTML&aged=0&language=EN&guiLanguage=en
• European Commission Website on Cross-Border Healthcare
http://ec.europa.eu/health/cross_border_care/policy/index_en.htm
• EFN Briefing Note - 22 December 2010
http://www.efnweb.eu/version1/en/documents/EFNBriefingNoteonCross-borderHealthcareDirective-22122010_000.pdf

EFN Briefing Note – 20 January 2011

The European Federation of Nurses Associations (EFN)
Registration Number 476.356.013
Clos du Parnasse 11A, 1050 Brussels, Belgium
Tel: +32 2 512 74 19 Fax: +32 2 512 35 50
Email: efn@efn.be Website: www.efnweb.eu

Absorbing chlorinated water 'a cancer risk'

Swimming too much - or even taking too many baths or showers - could increase the risk of developing bladder cancer, warn environmental health experts.

Carcinogenic chemicals called trihalomethanes (THMs), created as a byproduct of chlorinating water, can be absorbed through the skin, they say.

People who regularly swim in chlorinated pools or take lots of showers or baths could therefore be putting themselves at risk. Dr Gemma Castaño-Vinyals, of the Centre for Research in Environmental Epidemiology [CREAL] in Castilla La Mancha, Spain, said the effects negated the 'purity' benefits of drinking unchlorinated, TCM-free bottled mineral water.

She said: "People with more money and more education may think that they're reducing their risk of exposure to water contaminants by drinking bottled water.

"However, despite being apparently cleaner and taking more exercise, as a result of taking more frequent and longer baths, and using swimming pools more often, they are actually increasing their risk of THM exposure."

However, she said the additional risk of developing bladder cancer from absorbing THMs was "small".

She and colleagues were looking at exposure to THMs in 1,270 people in Spain.

By Stephen Adams

Source: http://www.telegraph.co.uk/health/healthnews/8383696/Absorbing-chlorinated-water-a-cancer-risk.html

Over 60s 'shouldn't walk and talk while crossing the road'

If you are over 60 you should not cross the road and speak on your mobile at the same time, say psychologists.

Older people find multi-tasking more difficult than younger ones, researchers have found, so those who "walk and talk" across a road could be putting themselves at greater risk.

Psychologists at the University of Illinois's Beckman Institute in the US found it took people aged 59 to 81 "significantly longer than college students to cross a simulated street while talking on a mobile".

In a series of tests which looked at a range of distractions while crossing the road, including listening to music and talking on a mobile phone using a hands-free kit, the older volunteers were "significantly impaired" when it came to getting across a busy road safely.

By comparison, the student "showed no impairment on dual-task performance", the researchers said.

Mark Neider, a postdoctoral researcher who conducted the study with Prof Art Kramer of the institute, said: "Combined with our previous work, the current findings suggest that while all pedestrians should exercise caution when attempting to cross a street while conversing on a cell phone, older adults should be particularly careful." However, he added that young people were not immune from the dangers of listening to music or talking on the phone while crossing the road.

"It should be noted that we have previously found that younger adults show similar performance decrements, but under much more challenging crossing conditions," he said.

The results of the study are published in the journal Psychology and Aging.

By Stephen Adams

Source:http://www.telegraph.co.uk/health/healthnews/8383371/Over-60s-shouldnt-walk-and-talk-while-crossing-the-road.html

How a simple sugar pill from the doctor may not be a thing of the past

The placebo effect is so powerful that doctors want to make more use of our ability to 'trick ourselves better', says Liz Bestic

Not so long ago, it wasn't unusual for your friendly GP to have at hand a bottle of sugar pills for patients' minor aches and pains. While sugar pills are no longer on offer, a report out last week revealed that half of all German doctors are happily dishing out placebos to their patients for ailments such as stomach upset and low mood.

The study, published by the German Medical Association, said that placebos – here defined as sham treatments without any active constituents – from vitamin pills to homeopathic remedies and even surgery, can prove effective as treatments for minor problems and are completely without side effects.

So if placebo treatments are such a good thing, should UK patients be getting them?

The power of the placebo first came to light during the Second World War. Morphine was in short supply in military field hospitals and an American anaesthetist called Henry Beecher, who was preparing to treat a soldier with terrible injuries, feared that without the drug the operation could induce a fatal heart attack. In desperation, one of the nurses injected the man with a harmless solution of saline. To Beecher's surprise the patient settled down as if he had been given morphine and felt little pain during the operation. Dr Beecher had witnessed the placebo effect.

Wind forward 70-odd years and the story of the placebo continues to fascinate, even though in the UK placebo treatments are usually confined to clinical

trials, as a comparison with "real" treatments. Recent research suggests the placebo effect is not confined to subjective areas such as pain but may bring about physical changes. In one (albeit small) trial, published in the journal Science, people with Parkinson's disease given placebo injections showed significantly higher dopamine levels in the brain, similar to the effects of medication.

Interestingly, the German study found that the efficacy of a placebo can depend on the size and colour of a pill and on its cost (with more expensive placebos being more effective) and that injections work better as placebos than tablets.

What causes the placebo effect? No one really knows; but the idea of the healing power of the mind is nothing new. The discovery in the 1980s of the rich supply of nerves linking the brain with the immune system, which led to a new branch of medical research known as psychoneuroimmunology, clearly goes some way to explain it.

Nor does the placebo have to be a pill or injection: just seeing your doctor can work wonders. Edzard Ernst, professor of complementary medicine at the University of Exeter, believes that the key is the relationship between the patient and the doctor or therapist.

"Trust can generate a placebo response. People are already anticipating getting better when they come to the surgery. If the doctor then gives that patient an aspirin for a headache and does it in an empathic manner, the aspirin will have a pharmacological effect and the therapeutic relationship will generate the placebo effect," explains Prof Ernst.

One widely publicised analysis of clinical trial data on modern antidepressants from the University of Hull found that leading brands of antidepressants worked little better than placebos. Subsequent reporting by the press concluded that antidepressants were useless. However, this failed to mention that the patients' response to placebos was "exceptionally large". In other words, it wasn't that antidepressants didn't work – but that placebos worked very well. "If the drugs are no better than a placebo, then why not give a placebo which has none of the nasty side-effects?" argues Irving Kirsch, professor of psychology at Hull and lead researcher.

But others say using placebo treatments other than in clinical trials poses an ethical dilemma. While it is not illegal for a doctor to prescribe a placebo if they believe it is in the best interests of the patient, Dr Tony Calland, chair of the BMA's Medical Ethics Committee, says: "Long ago doctors would give people medication that was scientifically of no value. These days, we believe patients should have an informed choice. Giving a patient a placebo without telling them is regarded as unethical and deceptive."

But if deception is the problem, could patients be informed they were getting a placebo? A recent study of 80 patients with irritable bowel syndrome at Harvard Medical School in Boston showed that, even though patients were told, their symptoms still improved, compared to those who had no treatment. Dr Calland points out there is a bigger problem with the placebo response. "In one patient it may be very strong while in another it may be virtually non-existent," he says. And placebos do not work for everything: they cannot alter blood sugar levels in diabetics, mend a broken leg or cure cancer.

"To hope you will get a placebo effect would simply be not very good medicine," Dr Calland argues. "Why not just give a treatment that actually works?"

By Liz Bestic

Source:http://www.telegraph.co.uk/health/8376919/How-a-simple-sugar-pill-from-the-doctor-may-not-be-a-thing-of-the-past.html#

Child, 3, treated for alcoholism at British hospital

A three-year-old has become the youngest child in Britain to be treated for alcoholism, it emerged today.

The child has been treated in hospital after being given alcohol regularly for six months.

The unnamed youngster, from the West Midlands, was one of 13 children who were diagnosed alcoholic by the Heart of England NHS Trust between 2008 and 2010.

In the same period, 106 teenagers aged 13 to 16 were also treated for their addiction to alcohol.

Nicolay Sorensen, a spokesman for Alcohol Concern, said: "To be diagnosed alcoholic, it's possible this child would have shown a physical dependency. They would have had to ingest enough to cause withdrawal symptoms.

"Whatever the circumstances, it is a truly horrifying case and raises very serious child protection issues."

Sarah Matthews, spokeswoman for the British Liver Trust, said: "This is an extreme case and definitely one of the youngest cases of alcoholism we have heard of. "However, it does raise the issue of the accessibility of alcohol and how normal it has become. The power of cheap alcohol, availability and promotion makes it very difficult for people to consider their health when making decisions about if they drink and how much." The statistics emerged just weeks after Brighton and Sussex University Hospitals NHS Trust revealed that hundreds of children were admitted to hospital every year, often after their parents have bought them alcohol.

Their research found four five-year-olds among 165 under-17s they treated in the past five years for drink and drug problems.

By Victoria Ward

Source: http://www.telegraph.co.uk/health/healthnews/8380005/Child-3-treated-for-alcoholism-at-British-hospital.html#

Il-Warrant

Kważi l-i*staff nurses* kollha ħadu jew sejrin jieħdu dan iċ-ċertifikat li juri li l-persuna konċernata għandha l-kwalifiki meħtieġa biex tiffunzjona b'responsabiltà, il-kwalità ta' kapaċità rigward il-professjoni tiegħu jew tagħha. Qiegħed nirreferi għal xogħol meħtieġ u tant important li huwa n-*nursing*.

Però nistaqsi lili inifsi: saritx xi bidla minn meta ma kellniex il-*warrant* għal issa li għandna dan iċ-ċertifikat? Għax fuq il-postijiet tax-xogħol sew sptarijiet jew *health centers* inħoss li kollox baqa kif kien. Stima minn naħħa ta' l-*administration* lejn dawn l-impjegati baqgħet li kienet jew bidla ftit li xejn. B'detriment li anke l-impjegati l-oħra li jaqgħu taħthom ma jgħatux l-importanza kif meħtieġa lil din il katergorija tant importanti.

Inħoss li wasal iż-żmien li jerġa jiġi rivedut *protocol* tax-xogħol għal l-impjegati u b'hekk kullħadd jieħu l-istima li jixraqlu skond il-professjoni tiegħu. Qiegħed ngħid hekk, għax mhux darba jew tnejn, tmur f'xi dipartiment tas-saħħa u ċerti mpjegati jiddegradaw lil individwi li għalkemm għandhom il-*warrant* ħadd ma jgħati kashom. Kulħadd jaf li issa hawn ħafna tipi ta' impjegati privati bħal *ward clerks, securities, carers* u oħrajn.

Għalhekk, naħseb li wara l-MUMN għamlet akkwist meħtieġ permezz tal-*warrant*, tkompli taħdem biex dan iċ-ċertifikat ta' siewi jieħu l-importanza meħtieġa u b'hekk kullħadd jaħdem f'ordni u dixxiplina. B'hekk ikun hawn aktar kordinament u kuntentizza li f'aħħar mill-aħħar jgawdi kullħadd inkluż il-pazjent.

Thomas Agius
Part time u penzjonant

Somewhere right now, a NURSE is getting yelled at for being late with pain meds, while holding her bladder because she doesn't have time to pee, starving because she missed her break, being pooped/peed/bled on, and is missing her family while taking care of yours. In the minute you took to read this, NURSES all over the world are saving lives..... You cannot teach a person to be a nurse. No book can teach you how to cry with a patient, no class can teach you how to cry with a patient, no class can teach you how to tell a daughter that her mum has passed away and no professor can teach you how to find dignity when giving a bed bath. A nurse is not about pills and injections it's about being able to Love people at their weakest most vulnerable moments. No one makes you a nurse....you just are.

LETS BE GOOD FRIENDS

- Friendship is sharing with laugher & happiness!
- Friendship is helping each other when it seems there's no hope!
- Friendship is taking time to encourage one another!
- In Friendship you and I can learn from each other also offer good advice to our selves especially in some circumstances that is beyond our control.
- There's a miracle called "Friendship." Oh what a miracle in just keeping it real! The "Friendship" dwells way down deep in the heart and soul of a person or individuals.
- You don't know how this "Friendship" happens. It just happens so soulfully. It is a light from the "Friendship" that provides sunlight to the soul whenever it happens. But you know and you have to recognize the gift from above.

Position Statement

Socio-economic welfare of nurses

ICN Position:

The International Council of Nurses (ICN) and national nurses associations (NNAs) advocate for a workplace that is safe and encourage excellence in nursing practice. Nurses have a right to practice in an environment that is conducive to quality care with competitive wages/benefits and to work in a family-friendly environment that promotes the occupational safety and health of its employees.

ICN upholds nurses' right to freedom of association: they may belong and participate in a union, association or organisation of their choice without discrimination or victimisation.

The work of nursing personnel and its importance for the life, personal safety and health of persons in their care, demand measures that encourage and promote the full development and implementation of negotiating mechanisms between employers, nurses and their representatives. A formal procedure for the hearing of grievances should be available to nurses and their employers in the health services.

The principles of equal pay for work of comparable value and pay equity should be applied. These principles should be supported by gender-neutral job classification and performance evaluation tools, and non-discriminatory access to education and promotion opportunities. Salary relativities between and among professionals must reflect the education, expertise, competencies, responsibility, risks and hardships associated with the working conditions, roles and tasks assigned (e.g. unsocial hours, shift work). Nurses' salaries and conditions of work must be determined in consultation and agreement with nurses and/or their appointed representatives.

Nurses associations have a responsibility to:

- Establish, promote and maintain programmes to enable nurses to achieve a level of economic and social recognition commensurate with their contribution to society.
- Promote sustainable opportunities for the development and support of nursing career options, including entrepreneurship.
- Define nursing work and participate in the development of appropriate evaluation tools.
- Ensure commensurate recognition and reward for continuing education, post-basic education and qualifications.
- Advocate for a positive practice environment in the health sector that supports and rewards excellence.

International Council of Nurses

3, place Jean-Marteau
CH -1201 Geneva • Switzerland
Telephone +41 (22) 908 0100
Fax +41 (22) 908 0101
e-Mail : icn@icn.ch
Website : www.icn.ch

/over...

- Encourage nurses to recognise, value and explain their work, articulating the value of their profession's contributions to the wellbeing of individuals, families, communities and society.
- Develop and maintain mechanisms that support the negotiating rights of nurses, provide protection from exploitation, and balance equity and employment issues.
- Support the creation of opportunities for nurses to assume leadership roles within health systems.
- Create an effective network to share information on professional and industrial relations issues.
- Develop training programmes which adequately prepare association representatives, nursing leadership and nurse employees in the practice of the various negotiation methods for resolving employment concerns as appropriate in each country.
- Promote mechanisms or protocols that ensure nurses are appropriately remunerated and guaranteed a realistic retirement pension, taking into account their working conditions, including unsocial hours.
- Initiate and support studies to identify possible wage discrepancies and promote salary reviews.
- Lobby for legislation and public education supporting pay equity.
- Encourage their respective governments to ratify relevant ILO conventions, review and update them regularly, and monitor that the principles are put into practice.
- Support other NNAs seeking government ratification of relevant ILO conventions.

Background

The vitality of a nation is dependent upon the health of its citizens in general and its work force in particular.

The right of access to health care has been internationally recognised and is substantially dependent on the availability of adequate numbers of sufficiently educated and trained health personnel and effective workplace retention strategies.

Freedom of association and negotiation of employment and conditions of work are internationally recognised by the International Labour Organisation (ILO) Declaration of Philadelphia and ILO Conventions (e.g. 100, 111) and in particular Convention 149 on Nursing Personnel.

Current compensation structures are often based on gender and not on the value of the job to society. The undervaluing of the crucial role nurses play in the delivery of health care, coupled with a generalised discrimination against women has resulted in inappropriately low economic and social conditions for many nurses. There are an increasing number of substantiated reports of discrimination within the nursing profession itself. Nurses, however, are →

assuming key roles and responsibilities in the political arena thus widening the profession's scope of influence. With the increased data available and raised awareness, equal opportunity policies and practices are starting to be introduced.

ILO research indicates that 75% of all classifications/grades are sex-segregated. The study concluded that approximately half of all the world's workers are in gender-stereotyped occupations wherein males or females predominate to such an extent (representing at least 80 per cent of all the workers) that the occupations themselves can be considered as "male" or "female" [1] Men in female dominated professions will suffer from the same gender-stereotyped discrimination as their female colleagues (e.g. male nurses).

«Even countries with strong track records for promoting gender equality still have strong degrees of occupational segregation. Compounding the problem, so-called women's jobs are often assigned a lower market value. Even in women-dominated fields, such as in health and education, men usually occupy the "more skilled", "responsible" and better-paid positions. Developments in job evaluation methodologies, however, have demonstrated that many jobs occupied by women in fact require levels of skills, responsibilities and complexity similar to the higher paid jobs held by men."[2]

ILO has acknowledged that the relative value and degree of remuneration attributed to a certain occupation still seems to be influenced by the predominance of women in that occupation. In fact, comparable worth studies have shown that, on average, female dominated jobs are paid 15% less than male dominated jobs which require comparable levels of skills, effort and responsibility[3].

Once established, relationships between wages paid to different jobs (i.e. relativities) change very little over time, so historical inequities tend to remain unless deliberately changed. Pay differentials persist in all countries ranging from 10 to 30 percentage points[4]. Pay equity must be encouraged world-wide.

Many job evaluation systems are gender-biased and fail to capture or value the work of nurses and other women workers, thus perpetuating existing wage inequities. Analyses confirm that many nurses continue to be underpaid because skills and competencies used in the practice of nursing were not

[1] Breaking through the Glass Ceiling: Women in Management. Report for discussion at the Tripartite Meeting on Breaking through the Glass Ceiling: Women in Management. International labour Office. Geneva, 1997.
[2] Wirth, L (2002) Breaking through the Glass Ceiling: Women in Management. Geneva: International Labour Office.
[3] International Labour Organization, equality of opportunity and treatment between men and women in health and medical services, Geneva, ILO, 1992, pp 12, 22-29-33
[4] (Wirth, L (2002) Breaking through the Glass Ceiling: Women in Management. Geneva: International Labour Office)

→

regarded as job-related skills but as *qualities intrinsic to being a woman*[5,6]. It is important that the nursing profession continues to define the nature of its work and assist in the development of relevant evaluation tools.

Adopted in 1999
Reviewed and revised in 2004 and 2009

Related ICN Positions:

- Abuse and violence against nursing personnel
- Career development in nursing
- Nurse retention and migration
- Occupational health and safety for nurses
- Part-time employment
- Nurses and shift work
- Strike policy

The International Council of Nurses is a federation of more than 130 national nurses associations representing the millions of nurses worldwide. Operated by nurses and leading nursing internationally, ICN works to ensure quality nursing care for all and sound health policies globally

[5] American Journal of Nursing, How Women's Work is made "invisible", findings of the Pay Equity Commission, Ontario, September, 1991.
[6] American Journal of Nursing, How Women's Work is made "invisible", findings of the Pay Equity Commission, Ontario, September, 1991.

DIRECTIVES TO ALL NURSING AND MIDWIFERY STAFF including NURSING OFFICERS AND DEPUTY NURSING OFFICERS working at Mater Dei Hospital, Boffa Hospital, Karen Grech Hospital and Mount Carmel Hospital

Open Letter

Dear Hon. Health Minister Dr. J. Cassar,

An issue which nurses and midwives have always contested was the responsibilities imposed on them as Nursing Officers and Deputy Nursing Officers in the process of the General Elections and/or Local Council elections and/or in the imminent case of a Referendum on the introduction of the Divorce issue.

Although several emails were sent, these were conveniently ignored by the Health Division and thus the Health Division did not bring forward the difficulties of the Nurses and Midwives to the Electoral Committee to find a solution on this issue. Nurses and Midwives find themselves signing for voting documents of the patients or have added responsibilities regarding the voting documents, not to mention additional paper work. MUMN will no longer allow Nurses & Midwives to handle any work on the electoral process in their respective wards.

Therefore MUMN is issuing directives to all Nurses and Midwives, Nursing/Midwifery Officers and Deputy Nursing/Midwifery Officers at Mater Dei Hospital, Karen Grech Hospital, Boffa Hospital and Mount Carmel Hospital not to attend to any meetings, handling of voting documents or to do any paper work so as not to be directly or indirectly involved in the electoral process for any type of election.

Till now the only process which MUMN will allow regarding the electoral process is accompanying severely sick patients to the voting booths. Again a directive on accompanying patients can be issued in the future since the voting box can be taken to the sick patient and not vice versa.

Regards, **Paul Pace,** MUMN President - 19/02/11

19th February 2011

Dr. Godwin Grima
Principal Permanent Secretary Office of the Prime Minister
Auberge de Castille, Valletta

Dear Dr. Grima,

An issue regarding our salary scale for the new appointed degree nurses and midwives has risen these last two years which can be taken as being discriminate with us nurses/midwives. As you are aware we have two tiers in nursing, one being the diploma nurse and the other being the degree nurse.

The Diploma nurse starts with a scale 12 then advances to scale 10 after five years. The Degree nurse/midwife starts at scale 10 then advances to scale 9 after two years.

Recently the nurses/midwives who have just graduated from the university with a degree instead of starting with scale 10 are being posted in scale 12 on a temporal basis awaiting appointment. When appointment is given (which could be a period from 3 months to two years) then such degree nurses are posted in scale 10. In the meantime these last two years someone decided to place such degree nurses in scale 12 as the nurses of the diploma.

Such a measure is costing our degree nurses/midwives 200 euro per month. Also this is considered as discriminate since in none of the other professions employed by the government and who are in a possession of a degree are placed in a such inferior scale while awaiting for an appointment to materialize.

Can you please treat such an issue as urgent since every month which is passing, this is costing hundreds of euro to the newly appointment degree nurses/midwives. I would like to point out that MUMN is trying to attract young people to the depleted degree course in both nursing and midwifery and therefore such a decision will have its impact felt on the such vital recruitment of nurses and midwives into the degree course.

As MUMN we are suggesting that such nurses/midwives who at first are employed as casual basis awaiting appointment, should have their salary adjusted to scale ten retroactive on their day of employment when they become in the possession of their appointment.

Or as MUMN we are suggesting that such nurses and midwives are employed directly to salary scale 10 since the University of Malta informs the Health Division that such new recruitment are in the possession of a degree.

Whilst I thank you for your consideration and action on this matter, as MUMN we are awaiting your feedback on this issue.

Regards,
Paul Pace, MUMN President

Dr. Godwin Grima
Permanent Principal Secretary Office of the Prime Minister
Auberge de Castille, Valletta

Dear Dr. Grima,

As President of the Malta Union of Midwives and Nurses, I am formally requesting to initiate the negotiations for a sectoral agreement for the nurses and midwives working in the public service.

This concept was also discussed with the Prime Minister four months ago who agreed that such an agreement could be started but stressed out that it should be finalized after the collective agreement for the public service is concluded.

MUMN's primary intentions in this sectoral agreement are to introduce a combination path for a career progression through the salary scales structure for nurses and midwives who either through years of experience and/or through specialization courses can benefit. Such a sectoral agreement is fundamental since highly experienced nurses/midwives or highly qualified nurses/midwives would not need to resort only into the management way stream but will continue to provide bed side nursing.

The only career progression in Malta for nurses and midwives is only through management and therefore such an agreement would be important since for the first time in Malta a specialization career ladder would be introduced for all those nurses/midwives who have accumulated either years of experience or invested to obtain a degree or a diploma in a nursing/midwifery specialty and could finally continue to give a service to our patients without the need to move into management and therefore the Government would be in a better position to make use of such nursing/midwifery staff with such a valuable asset.

Your confirmation will be highly appreciated.

Regards,
Paul Pace, MUMN President

cc. Dr. Lawrence Gonzi, Prime Minister

Hon. Dr. J. Cassar
Minister of Health, Elderly and Community Care

Dear Hon. Minister,
MUMN is concerned on the work practices at the maternity department of Mater Dei where against even EU directives, there is no midwifery input in ante natal care and post natal care service to the mother. Midwifery is a profession who not only posses a warrant to practice but is highly specialized due to the great working experience they posses but also to the high academic qualifications such as Bachelors degree and Master Degree level. Such midwives like their counterparts in all European countries can offer a holistic service to all pregnant mothers from pre conception to antenatal care then in the delivery stage leading to post natal care.

Such services can be provided to the mother and child in such a way that no other profession can be close to offer such a similar service. Midwives not only can examine the mother to see the well being of the mother and the well being of the unborn baby but also advise the mother on eating habits and exercise and other health habits which the mother should adopt to have a health pregnancy. Also the mother feels more confident to divulge all personal feelings and worries since there is a female to female bonding and therefore such intimate advise can take place. The midwife can detect also when such pregnancies are not within the normal and natural course and therefore redirect the mother to contact her doctor.

In fact today in Mater Dei Hospital, there is NO care for ante natal care for any mother, not even by doctors. The only visit the mother does is that when she becomes pregnant, her GP at some unknown stage during the pregnancy refers her to hospital to be booked at the ante natal clinic. She will be informed by the doctor at the ante natal clinic that the mother can either attend to her GP or any other doctor or to the health centre to be seen by the gynecologist at very long intervals. No midwifery input is done at the detriment of the mother and the baby. This is how the service is given at Mater Dei Hospital where after all mothers can still opt not to see any gynecologist provided by the Government.

Although most mothers where finding a better service by the midwives the team midwifery which was functional and giving excellent results was stopped. Mothers had a choice in the past of either attending to the midwifery led clinics at St. Lukes hospital or go to their GP. The service was so good by the midwives that through various "reasons" and "excuses" from the gynecologists (who have their private practice at heart) pressurized the health division to stop all midwifery led clinics that mothers opted more to the midwifery clinics at the hospital than at their GPs.

The role of the midwife is to assist the mother in all stages of labour as long as no complications have not developed. In fact midwives have a stringent protocol which regulates a healthy pregnancy. Once they detect the slightest abnormality this is sent to her gynecologist. They are also a profession with a warrant so even they are liable to be sued.

Regards,
Paul Pace, President

DH Circular No.46/2011
DH 1828/2006

21 February 2011

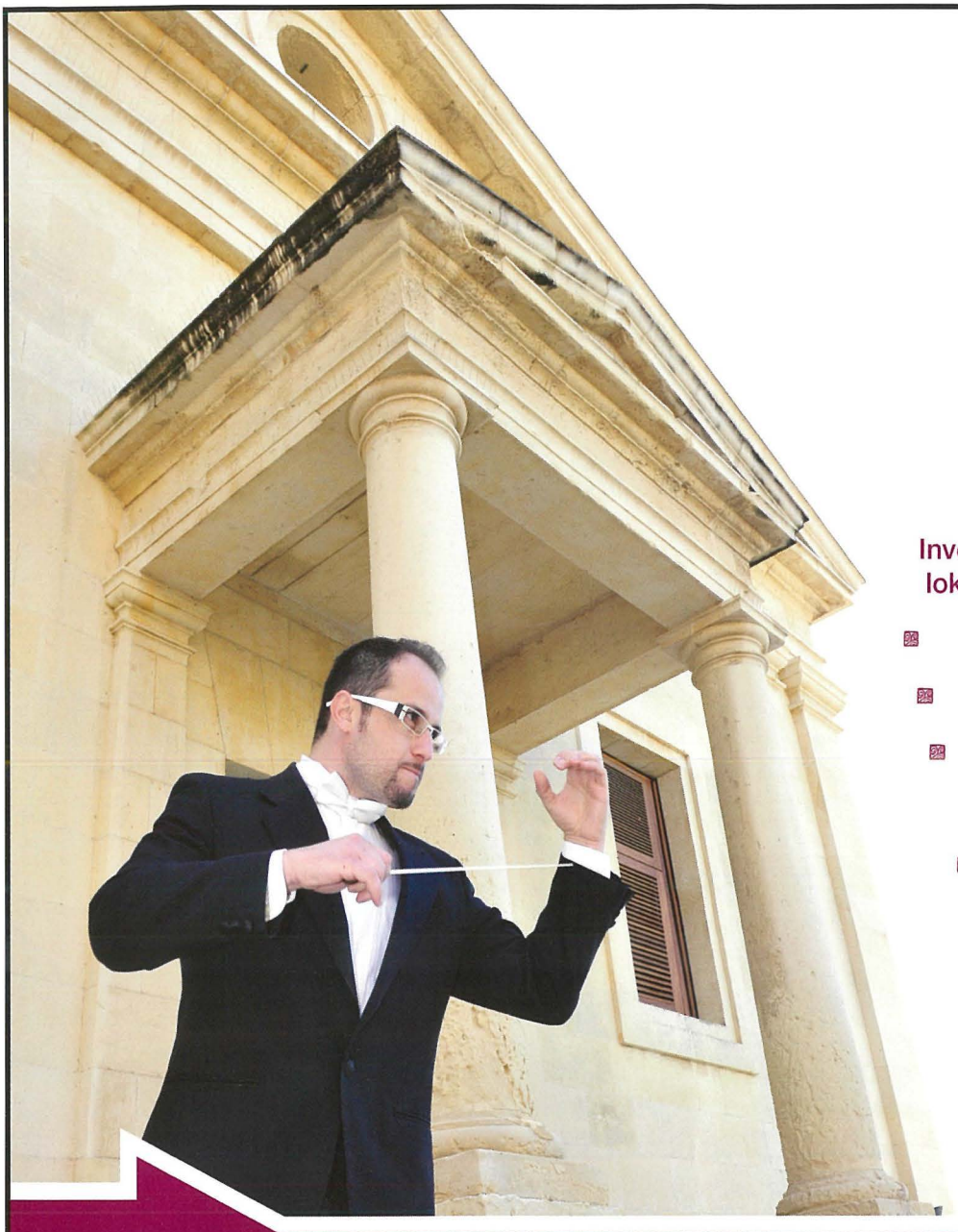
Medical Superintendents
Heads of Branches

CPD refund for employees in the nursing profession attending the 2011 International Council of Nurses (ICN) Conference

The Department of Health strongly encourages employees in the nursing profession to participate in the forthcoming ICN conference. For this reason, nurses who will submit receipts related to the participation of this event will on an exceptional basis be allowed to utilise their CPD entitlement for the year 2012 together with this year's entitlement and any remaining CPD funds from 2010.

Participants in the ICN will also be given precedence in the processing of their 2011 CPD applications and will be refunded within six months from the submission of their application.

Joseph Barbieri
Director HR and Administration



Investiment b'kompożizzjoni lokali li joffrielek

- Dħul* regolari
- Firxa ta' bonds u ishma
- Parteċipazzjoni fit-tkabbir potenzjali ta' kumpaniji lokali
- Portafoll imħaddem fuq parir tal-Bank of Valletta plc

direzzjoni lokali għal portafoll sinkronizzat

VALLETTA FUND MANAGEMENT

A Member of the BOV Bank of Valletta Group

VILHENA MALTA FUND

LA VALETTE MALTA FUND

WIGNACOURT MALTA FUND

8007 2344 | **vfm.com.mt**
Fergħat tal-BOV f'Malta u Għawdex
u Intermedjarji Finanzjarji Liċenzjati

*Id-dħul kif ukoll il-frekwenza li fiha l-fondi mistennija jħallsu jistgħu jvarjaw u m'humiex garantiti.

Il-Passat mhux garanzija tal-futur. Il-valur ta' l-investiment jista' jitla' kif ukoll jinżel u l-ispejjeż inizzjali jistgħu jbaxxu l-valur ta' l-investiment. L-investiment għandu jsir wara li jinqara l-Prospett li jista' jinkiseb mill-Valletta Fund Management Limited ('VFM'), mill-Fergħat tal-Bank of Valletta p.l.c. u mill-intermedjarji finanzjarji liċenzjati. Il-VFM hija liċenzjata biex tipprovdi Servizzi ta' Investiment f'Malta mill-MFSA. Il-fondi mħaddma mill-VFM huma liċenzjati mill-MFSA. Il-Vilhena Funds SICAV p.l.c. hija liċenzjata bħala skema ta' Investiment Kollettiv li tikkwalifika bħala UCITS mill-MFSA. Maħruġ minn VFM, TG Complex, Suite 2, Level 3, Triq il-Birerrija, Mrieħel BKR 3000. Sors: VFM

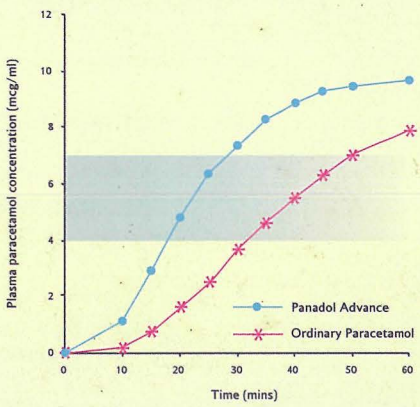
Paracetamol tablets Reinvented

Introducing New Panadol Advance 500 mg Tablets, the only paracetamol formulation to contain the unique Optizorb™ disintegration system.

This allows the tablets to disperse up to 5 times faster in the stomach than ordinary paracetamol.[1]

Panadol Advance reaches therapeutic levels faster than ordinary paracetamol[2]

Randomised, cross-over pharmacokinetic (PK) study in 75 subjects given a standard meal[2]



Therapeutic plasma paracetamol threshold is reached within the shaded area

From the above graph you can see Panadol Advance Tablets reach therapeutic levels faster than ordinary paracetamol.[2]

Recommend Panadol Advance to your patients to tackle everything from period pain to backache.

For relief from mild to moderate pain, help customers get their day back on track with Panadol Advance

paracetamol Disperses up to 5X Faster than ordinary paracetamol

Product Information. Panadol Advance 500mg film coated Tablets (paracetamol). Contains disintegrant system to accelarate dissolution. **Uses**: Mild analgesic and antipyretic. **Dosage and administration**: *Adults and children, 12 years and over*: Two tablets at ≥ 4 hour intervals. Max. 8 tablets in 24 hours. *Children 6-12 years*: Half to one tablet at ≥ 4 hour intervals. Max. 4 tablets in 24 hours. Do not use for >3days without doctors advice. *Children under 6 years*: Not recommended. **Contraindications**: Hypersensitivity. **Precautions**: Severe renal/hepatic impairment, non-cirrhotic alcholic liver disease. Concomitant use of warfarin/other coumarin anticoagulants, domperidone, metoclopramide, colestyramine. Refer to doctor if persistent headache or non-serious arthritis requiring daily analgesia. **Pregnancy/breastfeeding**: Pregnancy: Refer to doctor. Breastfeeding: not contraindicated. **Side effects**: Hypersensitivity including skin rash, blood dyscrasias. **Overdosage**: Immediate medical advice due to risk of delayed, serious liver damage. **Legal category**: OTC. **Product licence number**: AA460/00701. **Product licence holder**: GlaxoSmithKline Consumer Healthcare, Brentford, TW8 9GS, U.K. **Package quantity**: Compack 12's. Date of last revision: November 2008. **Panadol** is a trade mark of the GlaxoSmithKline group of companies.

gsk GlaxoSmithKline Consumer Healthcare