Il-Musbieħ

MALTA NURSING AND MIDWIFERY JOURNAL

Malta Union of Midwives and Nurses

Numru 79 - Ġunju 2018

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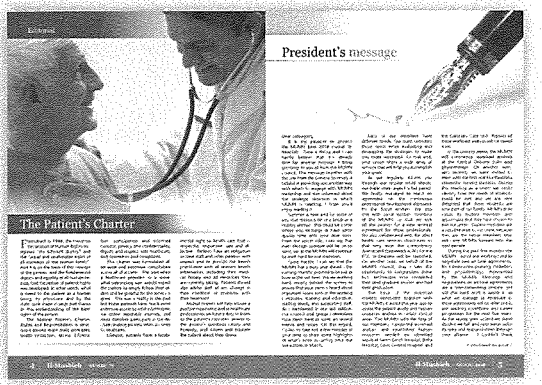
contents



- Editorial & President's message
pagni 4-5

- From our diary
pagni 20-21

- 11 vintage photos
pagni 28-29

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The Patient's Charter

Formalised in 1948, the Universal Declaration of Human Rights recognises "the inherent dignity" and the "equal and unalienable rights of all members of the human family". And it is on the basis of this concept of the person, and the fundamental dignity and equality of all human beings, that the notion of patient rights was developed. In other words, what is owed to the patient as a human being, by physicians and by the state, took shape in large part thanks to this understanding of the basic rights of the person.

The Maltese Patient's Charter, Rights and Responsibilities is structured around eight main principles: health protection; access; information; participation and informed consent; privacy and confidentiality; dignity and respect; safe healthcare; and comments and complaints.

This charter was formulated after wide and extensive consultation across all of society. The time when a healthcare provider, in a somewhat patronising way, would expect the patient to simply follow their orders and be grateful for the service is gone. This was a reality in the past but today patients have much more extensive access to solid information, via online reputable journals, and must therefore participate in the decision making process when it comes to treatment.

Likewise, patients have a fundamental right to health care that is respectful, responsive, safe and effective. Patients have an obligation to treat staff and other patients with respect and to provide the health practitioner with all relevant health information, including their medical history and all medicines they are currently taking. Patients should also advise staff of any change in their condition or problems with their treatment.

Mutual respect will help ensure a positive experience and as healthcare professionals we have a duty to listen to the patient's concerns, answer to the patient's questions clearly and honestly, and inform and educate the patient about their illness.

President's message

Dear colleagues,

It is my pleasure to present the MUMN June 2018 journal 'Il-Musbieh'. Time is flying and I can hardly believe that it's already time for another message. I bring greetings to you all from the MUMN council. This message together with the one from the General Secretary is helpful in providing you another way with which to engage with MUMN leadership and stay informed about the strategic direction in which MUMN is heading. I hope you'll enjoy reading it.

Summer is here and for some of you that means a bit of a break or a holiday abroad - this could be a time where you recharge or have some quality time with your dear ones. From the union side, I can say that even though summer will be on us soon, we at the MUMN will continue to work hard for our members.

Quite frankly, I can say that the MUMN has a busy year ahead – the coming months' promise to be just as busy as the last ones. We are working hard, mostly behind the scenes to ensure that your voice is heard about important issues such as the working conditions, training and education, staffing levels, and supporting staff. As I mentioned in our last edition, our council and group committees have been hard at work on several events and issues. On this regard, I'd like to take just a few minutes of your time to share some highlights of what's been occurring since our last edition in March.

Each of our members have different needs. Our team considers those needs when evaluating and developing the strategies to make you more successful. To that end, your union offers a wide array of services that will help you accomplish your goals.

As we regularly inform you through our regular email shoots, our trade union aspect is fast paced. We finally managed to reach an agreement on the continuous professional development allowance for the Social workers. We also met with social workers members of the MUMN, so that we kick off the process for a new sectoral agreement for these professionals. We also collaborated with the allied health care services directorate so that very soon the Competency Assessment Framework (CAF) for the ECG technicians will be launched. On another note, on behalf of the MUMN council, may I take the opportunity to congratulate those ECG technicians who completed their post-graduate studies and had their graduation.

The focus of the industrial relation committee together with the MUMN Council this year was to assess the patient acuity and human resources analysis in certain clinical areas. The MUMN with the help of our members, conducted workload analysis and established human resources needed on identified wards at Karen Grech Hospital, Boffa Hospital, Gozo General Hospital, and the Coronary Care Unit. Reports of these workload analysis will be issued soon.

In the coming weeks, the MUMN will commence workload analysis at the Central Delivery Suite and physiotherapy. On another note, very recently we were invited to meet with the first year Northumbria University nursing students. During this meeting as a union we could identify how the needs of students could be met and we are very delighted that these students are now part of our family. MUMN truly values its student members and appreciates that they have chosen to join our union. Student members are a valuable asset to our union because they are the future members who will carry MUMN forward into the next decade.

During the past few months the MUMN council was working hard to negotiate two sectoral agreements, for 3 professions (nursing, midwifery and physiotherapy) represented by the MUMN. Meetings and negotiations on sectoral agreements are a time-consuming process; yet still this hard work is worth it; as what we manage to negotiate in these agreements will be reflected in our working conditions and career progression for the next five years. As the saying goes 'united we stand divided we fall' and your union fulfils its roles and responsibilities through your alliance – I couldn't thank

• continued on page 7

Kelmtejn mis-Segretarju Ġenerali

Dħalna fix-xhur tas-Sajf u qed nantiċipaw li din is-sena dawn ix-xhur ser ikunu jaħarqu aktar mis-soltu! Dan ix-xahar ser inkunu qed nirċievu d-dokument sħiħ mingħand il-Gvern bħala reazzjoni għat-talbiet li għamilna dwar il-Ftehim Settorali tan-nurses u l-midwives.

Il-Ftehim kollu ġie diskuss u nnegozjat, però issa nkunu nafu eżatt f'hiex qegħdin. Jumejn wara li d-dokument ikun għandna, ser jiltaqa' l-Kunsill tal-Union b'urġenza biex janalizza kemm qegħdin il-bogħod jew viċin, kemm it-triq se tkun għat-tlajja jew għall-wita. Sussegwentament issir laqgħa oħra mal-Gvern biex inkunu eżawrejna l-possibilitajiet kollha li jintlaħaq ftehim madwar il-mejda. Fin-nuqqas ta' dan ikollna nirrikoru għalik sabiex flimkien nibdew sensiela ta' Direttivi Industrijali sakemm jintlaħaq Ftehim li jkun viċin it-talbiet tal-MUMN.

Nixtieq ngħid ukoll żewġ kelmiet dwar il-Ftehim Settorali li hemm inkluża fih il-Physiotherapists. Wara ħafna taqtih ta' qalb, fl-aħħar bdejna niddiskutu b'mod tanġibbli l-proposti li ressaqna u diġà qed naraw il-frott. Jekk inkomplu mexjin b'dan ir-ritmu jista' jkun li sal-aħħar tas-sena nibdew nagħlqu.

Dwar il-Ftehim Settorali tas-Social Workers irrid ngħid li kont sodisfatt ħafna bil-ħeġġa li hemm fost dawn il-professjonisti fejn iffinalizzajna l-proposti tal-Union flimkien u fil-ġranet li ġejjin se nressquh quddiem il-Gvern sabiex nibdew niddiskutuh ukoll.

Bħal ma tafu qegħdin fl-aħħar sena ta' dan il-Kunsill tal-Union. F'Marzu li ġej inti jkollok l-opportunità sabiex teleġġi lill-persuni ta' fiduċja tiegħek. Fl-istess xahar ser tiġi organizzata hawn Malta l-konferenza tal-Commonwealth, eżatt, se tkun fit-8 u d-9 ta' Marzu. Jista' jkun li d-data tal-elezzjoni tiġi mċaqalqa bi ftit ġimgħat biex b'hekk kollox jiġi organizzat kif suppost. Dettalji oħra jitħabbru aktar tard però tagħmel tajjeb li tħalli dawn id-dati vojta u tibda taħseb biex tlesti *abstract*.

In-nuqqas ta' *nurses* għadu pjaga nazzjonali. Kull fejn immorru u ma' min niltaqgħu kulħadd isemmi d-diffikultajiet li għaddejjin minnhom minħabba n-nuqqas. Konxji li ż-żewġ Ministeri qed jippruvaw jattiraw *nurses* barranin ta' stoffa però mhux daqshekk faċli. L-MUMN mhux se tieqaf tagħmel pressjoni.

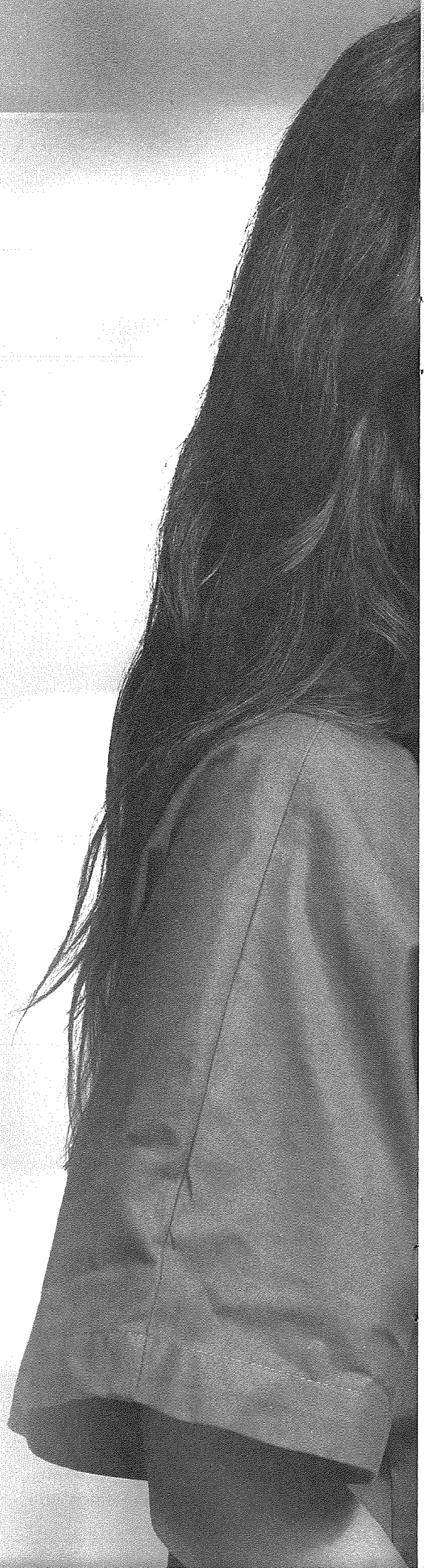
Ftit tal-ġranet ilu tlabna laqgħa mal-Università ta' Malta u dik ta' Northumbria dwar il-ħlas tal-*mentorship* biex jibdew minn issa jippreparaw il-ħlas ta' dawk in-*nurses* li ssottomettew ruħhom biex joffru *mentorship* lill-istudenti taż-żewġ universitajiet.

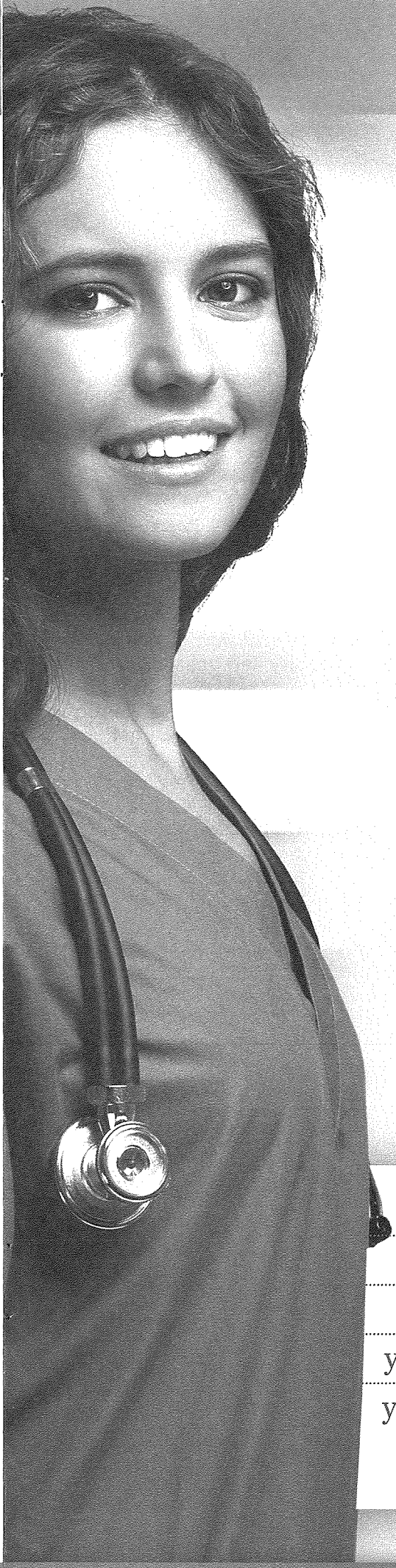
Il-Ftehim jipprovdi li l-ħlas isir flaħħar tas-sena però ma ridniex inħallu sal-aħħar għaliex nafu s-sistemi kif jaħdmu u għalhekk tlabna din il-laqgħa sabiex inkunu ċerti li l-ħlas ser isir fil-ħin.

Din il-ġimgħa ġejna nfurmati kemm qed jagħmel ġid il-Florence Nightingale Benevolent Fund fost il-membri tagħna, f'għajnuna differenti skond l-għawġ kif jinqala'. Dan huwa Fund li tixtieq li qatt ma tiġi bżonnu però fl-istess waqt nafu li jekk tinqala' l-ħtieġa qiegħed hemm ta' spalla. Inħeġġeġ lil kull min għadu ma daħalx membru fih biex jibgħatilna *email* u nibagħtulu l-benefiċċji ta' dan il-Fund. Żgur li kull min jaqrahom se jiddeċiedi li jissieħeb.

Għall-llum se nieqaf hawn. Ħafna mill-membri jagħżlu dan iż-żmien biex iqattgħu vaganza ma' dawk viċin tagħhom. Għaldaqstant nixtieq nieħu l-opportunità biex nawguralkom li tieħdu pjaċir kemm tistgħu f'dawn il-ġranet tas-Sajf.

Colin Galea
Segretarju Ġenerali





• continued from page 5

you enough for the support and collaboration from your end when we ask you to do so. In most cases we manage to reach agreements through effective negotiation skills, social dialogue and collective bargaining. But at times, dispute arises, and industrial action will be backed up by your effort, support and collaboration. Once again on behalf of the MUMN Council and group committees, thanks for your continuous collaboration

As you are aware, the MUMN has always considered Continuous Professional Development an important factor for advancing the healthcare profession for its members. As a union we are delighted to inform you that the Institute for Healthcare Professionals (IHCP) within the MUMN has reached an agreement with the World Continuing Education Alliance (WCEA) in collaboration with the International Council of Nurses (ICN), to provide you as a member of the MUMN with an e-learning platform. With this agreement, you will be able to access this worldwide platform to further enhance your knowledge on your profession and will also have access to over 1,500 accredited courses which will be readily available online. Most of these courses are Free. During the past few weeks you received an email as an invite to register. We hope that through this agreement you will take advantage of this opportunity to enhance your knowledge and advance in your profession.

May I also take the opportunity to inform you that on the 26th October the IHCP will be organising another conference – the theme is indeed interesting, and I look forward to seeing you there! May I also inform you that next March 2019, the MUMN will be hosting the regional Commonwealth Nurses and Midwives Federation Conference. This is a two-day conference and a call for abstract will be issued soon. This conference is a great opportunity, whereby members of the MUMN will have the opportunity to present their research findings; while others attended as delegates. We can all agree that in some way or another these events maximize our learning opportunities.

As always, we encourage as much feedback as possible from our membership as we want to ensure that our union continue to add value to your already busy lives.

I look forward to continuing to work with you over the coming months. Till we met again, I wish you all a fun-filled summer! Stay safe and enjoy!

Maria Cutajar
MUMN President

Being a nurse means...

you will never be bored;

you will always be frustrated;

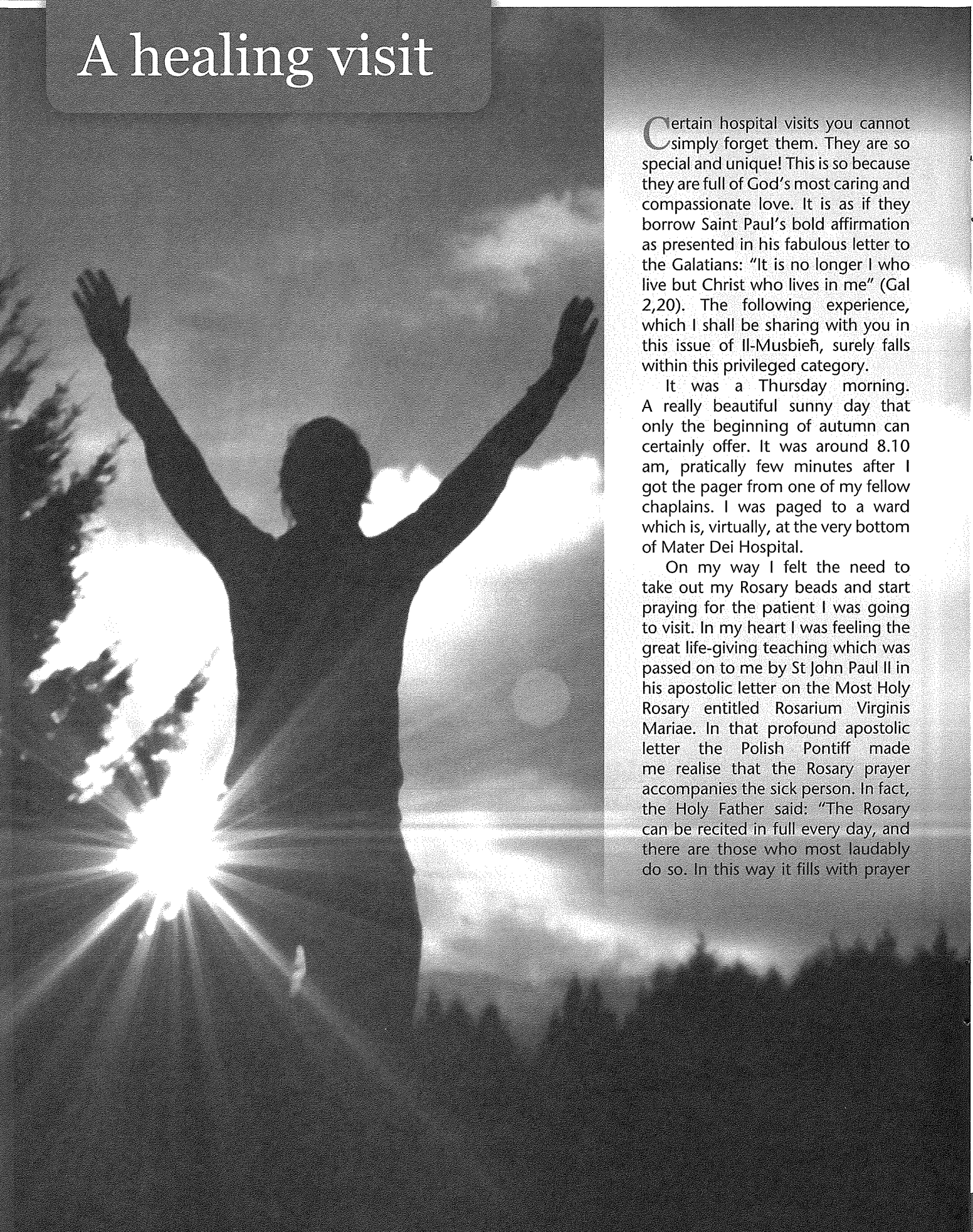
you will be surrounded by challenges;

you will carry immense responsibility and little authority;

you will step into people's lives and...

you will make a difference!

A healing visit



Certain hospital visits you cannot simply forget them. They are so special and unique! This is so because they are full of God's most caring and compassionate love. It is as if they borrow Saint Paul's bold affirmation as presented in his fabulous letter to the Galatians: "It is no longer I who live but Christ who lives in me" (Gal 2,20). The following experience, which I shall be sharing with you in this issue of Il-Musbieħ, surely falls within this privileged category.

It was a Thursday morning. A really beautiful sunny day that only the beginning of autumn can certainly offer. It was around 8.10 am, pratically few minutes after I got the pager from one of my fellow chaplains. I was paged to a ward which is, virtually, at the very bottom of Mater Dei Hospital.

On my way I felt the need to take out my Rosary beads and start praying for the patient I was going to visit. In my heart I was feeling the great life-giving teaching which was passed on to me by St John Paul II in his apostolic letter on the Most Holy Rosary entitled Rosarium Virginis Mariae. In that profound apostolic letter the Polish Pontiff made me realise that the Rosary prayer accompanies the sick person. In fact, the Holy Father said: "The Rosary can be recited in full every day, and there are those who most laudably do so. In this way it fills with prayer

the days of many a contemplative, or keeps company with the sick and the elderly who have abundant time at their disposal" (no. 38).

This powerful Marian prayer is not just repetitive but, particularly, illuminative! It magnificienty puts our lives under God's everlasting light! That is why St John Paul II's appeal of resorting back to the Rosary is mostly urgent! First and foremost for the sick people themselves. Thus he exhorted them with the following words: "I look to all of you, brothers and sisters of every state of life, to you, Christian families, to you, the sick and elderly, and to you, young people: confidently take up the Rosary once again. Rediscover the Rosary in the light of Scripture, in harmony with the Liturgy, and in the context of your daily lives" (no. 43). I don't know why but, precisely at that moment, I felt responsible to keep company to this patient by taking up the Rosary and start interceding with Mary for her.

As I arrived in the ward I sneaked in the cubicle where the patient was. Not knowing how I found myself just next to the patient's head. I have to admit that I was really impressed by what I have found. I am not talking about the gasping of this poor old lady. Time and experience have constantly showed me that patients who are in this situation are, in effect, approaching the end of their lives. But what mostly made me feel comforted about this distressing circumstance was the compassionate behaviour of the doctor. I certainly liked the way this doctor behaved with this suffering patient. She placed her hand on the patient's forehead as if to say: "Dear lady, do not be afraid! I am with you!" For me this outstanding humane gesture spoke volumes. It indubitably conveyed the message to the patient that she was with her all along her difficult journey.

This situation made me recall that famous address which Pope Francis delivered to the Medical Associations of Spain and Latin America on Thursday morning of June 9 2016. "The doctor's identity and commitment not only leans on his knowledge and technical competence, but primarily on his compassionate (he suffers-with) and merciful attitude to those suffering in body and spirit. Compassion is in some way the very soul of medicine. Compassion is not pity, but to suffer-with".

Further down his speech the Pope detailed that mercy is what gives the medical profession its real dignity.

"Compassion, this suffering-with, is the appropriate answer to the immense value of the sick person, an answer made of respect, understanding and tenderness, because the sacred value of the sick person's life never disappears or is obscured, but it shines with more splendor precisely in his suffering and helplessness. This is what is understood when St. Camillo de Lellis says with respect to treating patients: 'Put more heart in those hands.' Fragility, pain and disease are a tough test for everyone, including medical staff; they are a call to patience, to suffer-with; therefore one cannot yield to the temptation to apply quick, merely functional and drastic solutions driven by false compassion or by criteria of efficiency or cost savings. At stake is the dignity of human life; at stake is the dignity of the medical vocation".

After I administered the Sacrament of the Anointing of the Sick to this patient I felt the need of transferring myself just at the other end of the patient's bedside. I did so in order to pray the Divine Mercy Chaplet. Fully mindful of Jesus' promise to Saint Faustina as it is found in her Diary entry number 1541.

"My daughter, encourage souls to say the chaplet which I have given to you. It pleases Me to grant everything they ask of Me by saying the chaplet. ... Write that when they say this chaplet in the presence of the dying, I will stand between My Father and the dying person, not as the just Judge but as the merciful Savior".

... Continued on page 10

"I look to all of you, brothers and sisters of every state of life, to you, Christian families, to you, the sick and elderly, and to you, young people: confidently take up the Rosary once again. Rediscover the Rosary in the light of Scripture, in harmony with the Liturgy, and in the context of your daily lives"

◦ continued from page 9

Another thing that really impressed me was the caring way with which the nurse was holding the lady's left hand. Even here the noble gesture of the nurse was so reassuring for the dying woman. In an interesting article written by Fiona Macrae, the science correspondent for the newspaper Daily Mail, entitled How the best anaesthetic is a nurse's soothing chat: conversation found to be better at easing pain then listening to music or watching a film, published on 30 January 2015, stated that "the University of Surrey researchers said that having a nurse chat to a patient while holding their hand could be a 'simple and inexpensive' way of making operations done without a general anaesthetic more pleasant". In other words, verbal and nonverbal communication of a caring nurse means the whole world for the suffering patient to such an extent that it can have the power to ease his/her pain.

In another article, this time written by Fiona Dziopa, titled What Makes a Quality Therapeutic Relationship in Psychiatric/Mental Health Nursing: A Review of the Research Literature, held that "support in the research literature also encompasses physical support. Physical support is manifested through the use of touch. For example Shattell et al. found patients described feelings of connection when the psychiatric/mental health nurse hugged them or put a hand on their shoulder. Similarly a psychiatric/mental health nurse in Berg and Hallberg's study described an element of a working relationship as comforting through holding a patient's hand. Moyle also identified that patients with depression described relief when the psychiatric/mental health nurse embraced them. Importantly, the literature suggested that therapeutic touch is a skill dependent on different clinical situations and practitioners. For instance, physical touch to provide support was often elicited in studies for depressed and vulnerable patients".

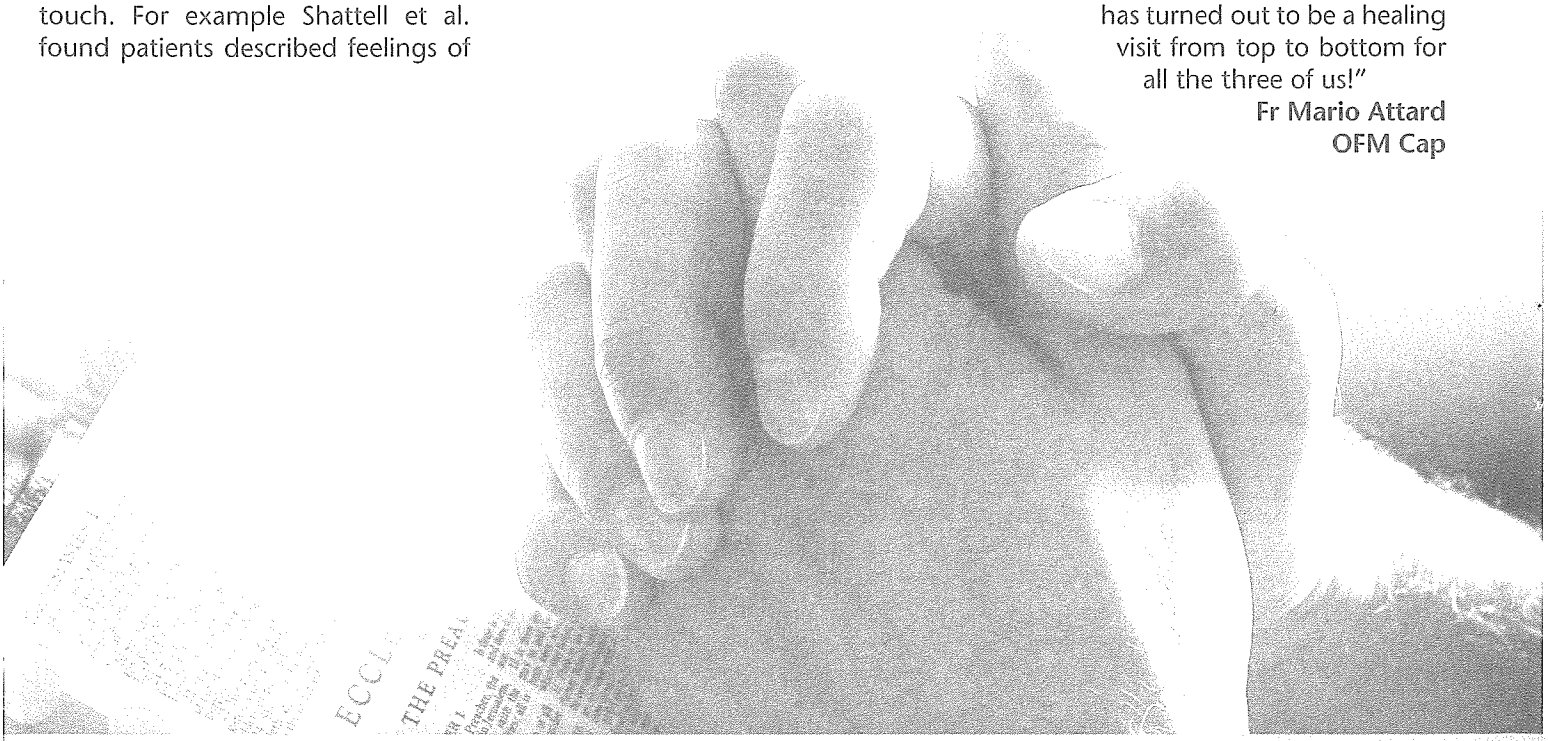
"It is no longer I who live but Christ who lives in me" (Gal 2,20).

While that woman was passing away the doctor told me with a sweet voice: "Father, this patient was so nice!" Her caring reminded me of what Saint Joseph Moscati, the great Napolitan physician as well as a medical school professor, once wrote to a young doctor, who happened to be one of his former students: "Remember that you must treat not only bodies, but also souls, with counsel that appeals to their minds and hearts rather than with cold prescriptions to be sent in to the pharmacist. Not science, but charity has transformed the world." In this situation the closeness of the doctor counselled this dying woman that even doctors can be excellent spiritual carers to their patients provided they are open to it.

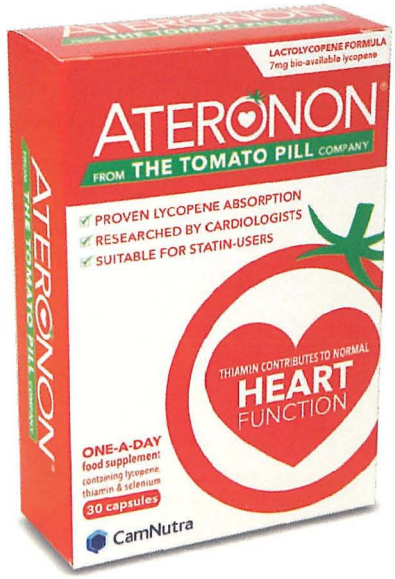
On my way out I gave a spiritual vitamin, that is a scroll containing the Word of God, to both the doctor and the nurse who were accompanying this patient at her final departure from this world. If our bodies need substances to help them grow and develop as they should how much more our spirit needs God's Word to develop the way it was designed to evolve? After all, as Pope Benedict XVI's apostolic exhortation, Verbum Domini, rightly says, is not "the Word of God ... the true light which men and women need?" (Verbum Domini, 12).

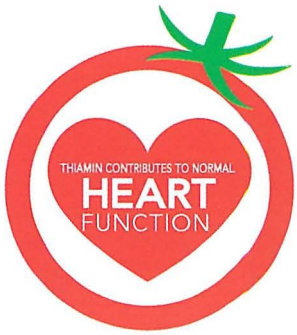
My conclusion for this reflection and this special pastoral visit I made is frankly the subsequent: "This visit has been the most beautiful visit I ever did in these past 13 years of hospital ministry as a chaplain working with the sick. It is so simply because, for its intents and purposes, it has turned out to be a healing visit from top to bottom for all the three of us!"

Fr Mario Attard
OFM Cap



Help hearts run smoothly





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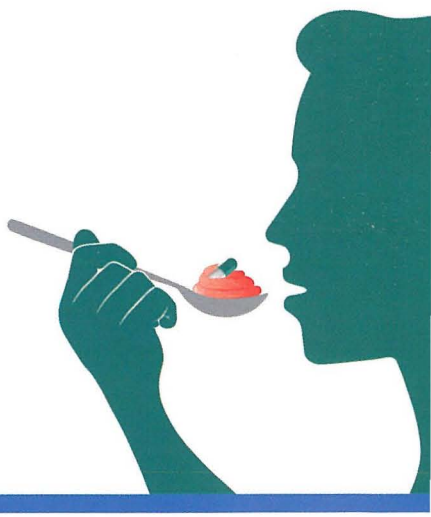

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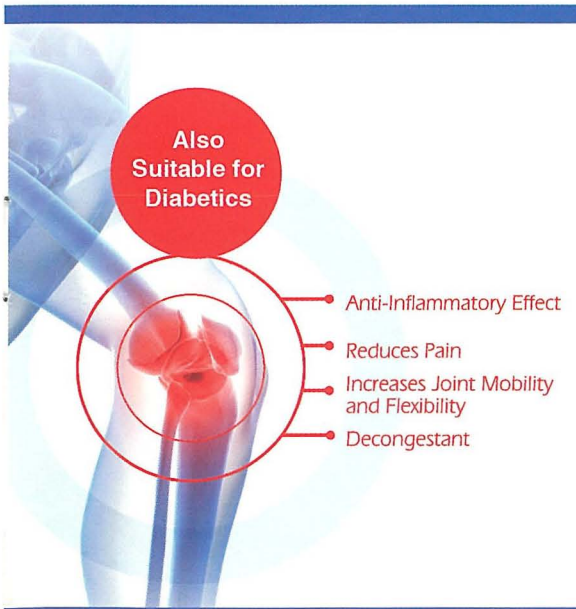

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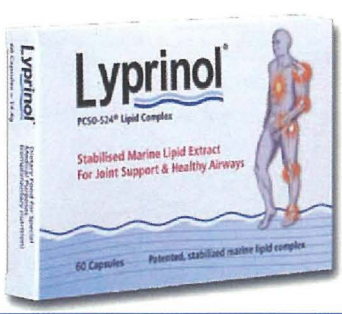

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The aging process is frequently characterized by an involuntary loss of muscle (sarcopenia) and bone (osteoporosis) mass. This loss of bone and muscle results in significant morbidity and a decreased quality of life for the individual. Preventing and attenuating osteoporosis and sarcopenia is an important public health goal and evidence suggests that protein plays a role in this process since dietary protein is crucial for development of bone and muscle. Most population-based observational studies suggest that greater dietary protein intake is associated with higher bone mineral density values in middle-aged and older adults. Dietary protein affects bone and muscle mass in several ways and there is evidence demonstrating that increased essential amino acid or protein availability can enhance muscle protein synthesis and anabolism, as well as improve bone homeostasis in older subjects. Furthermore, protein also increases circulating insulin-like growth factor, which has anabolic effects on muscle and bone.

A healthy lifestyle together with exercise intervention are known to exert positive effects on overall health. To promote and maintain health, adults need moderate intensity exercise for about half an hour several times a week. The balance between exercise and nutrition plays a pivotal role in the regulation of skeletal and muscle mass. Muscle protein metabolism is dependent on the adequate intake of dietary-derived nutrients and a protein rich in glycine, proline, arginine, and hydroxyproline is known to help the body to build and maintain protein structures. A protein compound rich in these amino acids is collagen. 'Hydrolyzed collagen' is a specially-processed form that creates shortened peptide structures which are more easily absorbed by the body. In fact, collagen peptides are absorbed into the bloodstream almost immediately after ingestion, making them ideal for nutritional replenishment. An innovative product by Nestle health science was recently launched locally offering collagen in its Hydrolysed form. Meritene Mobilis meets protein demands for active adults that want to maintain or prevent loss of bone and muscle mass. This product provides protein, contributing to the maintenance of muscle mass, as well as Magnesium and Potassium for normal muscle function. Meritene Mobilis also provides 1.2g of Hydrolyzed Collagen, a critical structural protein as well as 54mg Hyaluronic Acid which forms part of the synovial fluid lubricating the joints. Normal bone development is also targeted through the addition of Calcium, Vitamin D, Phosphorus and Zinc.

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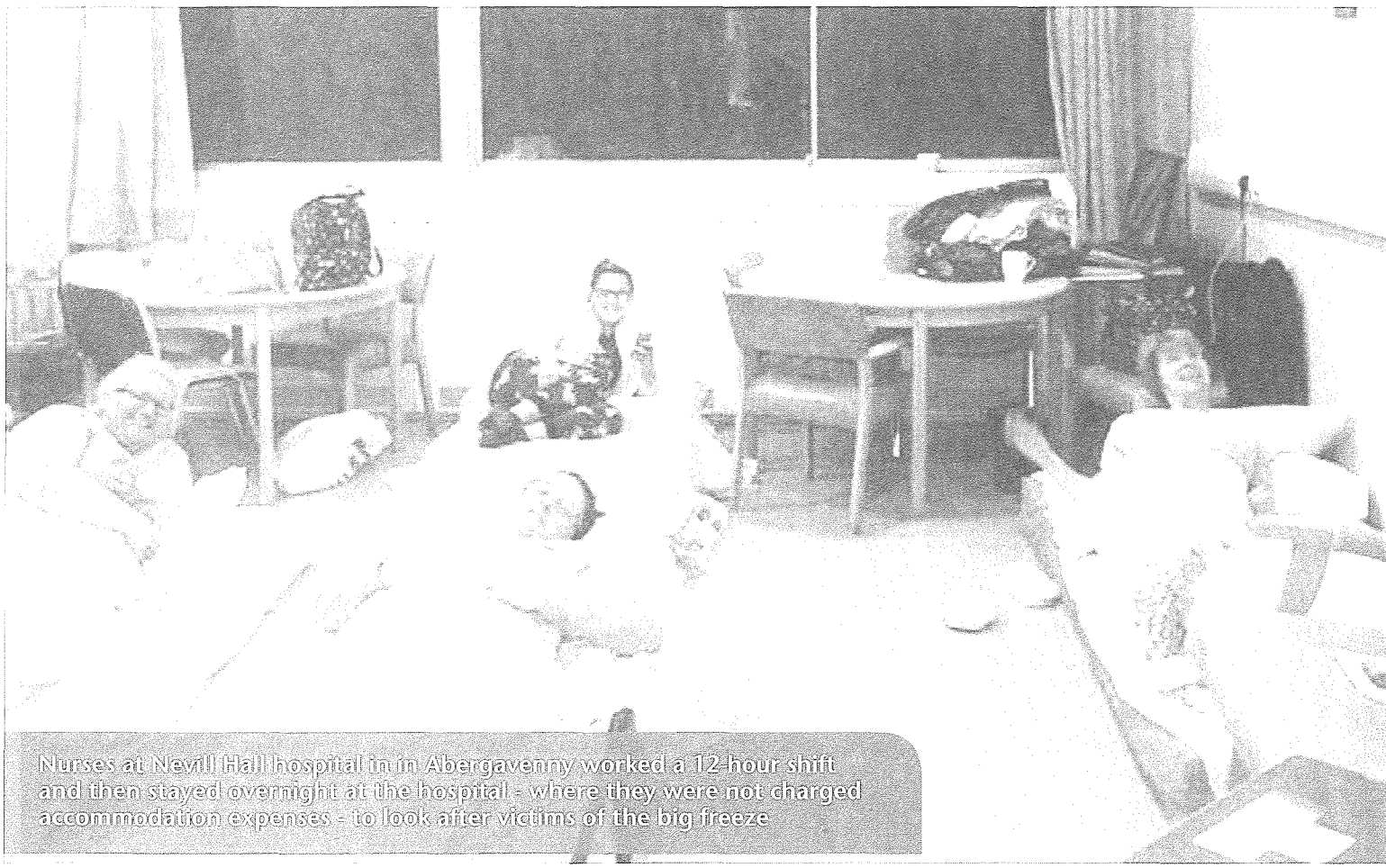
Wales runs out of nurses

Hospitals appeal for any qualified staff to help out in bad weather – despite outcry over £30-a-night accommodation charge those who did keep working through the big freeze



Nurses at Nevill Hall hospital in in Abergavenny worked a 12-hour shift and then stayed overnight at the hospital - where they were not charged accommodation expenses - to look after victims of the big freeze

Nurses and healthcare staff are urgently needed to help out at two Welsh hospitals because of the bad weather.

Cardiff and Vale University Health Board has appealed for any qualified nurses and healthcare staff who can help as other struggle to get to work in the snow.

Meanwhile a claim has been made that stranded nurses in Wales were charged up to £30 to stay overnight in hospital student accommodation during Storm Emma.

It comes as yellow weather warnings remain in place across England, Wales and Northern Ireland, threatening to leave 'death trap' patches of ice on roads up and down the country.

Total of 53 flood alerts have been issued nationwide, with 14 out of 15 located in the south west of England as Devon and Cornwall prepare for excess rain, melting snow and high winds.

Around 2,000 families in Devon and Cornwall are without power, with hundreds of others suffering power cuts in mid Wales and East Yorkshire.

Now, health chiefs are investigating the allegations against an unnamed Welsh Health Board after they were revealed by an outraged business chief.

The NHS is devolved and run by the Welsh assembly government.

Welsh health boards on Saturday said the claims that nurses were charged to stay in student accommodation during Storm Emma were not true.

A total of four Welsh health boards - Abertawe Bro Morgannwg, Cardiff and Vale, Cwm Taf and Hywel Dda - have all responded to the allegations on social media, rejecting the claim, a Wales Online report said.

In a statement Cwm Taf University said: 'Overnight there have been some claims that some NHS staff are being charged for accommodation if they need to stay overnight because of severe weather.

◦ continued on page 24

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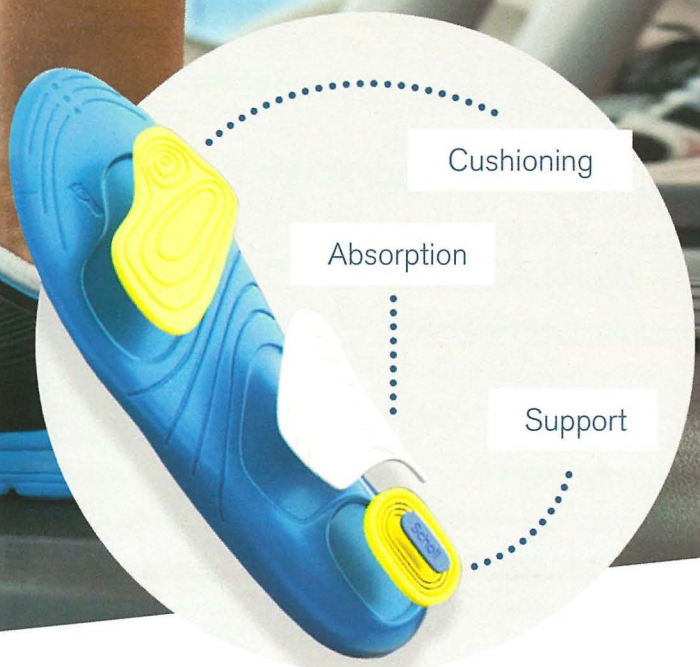

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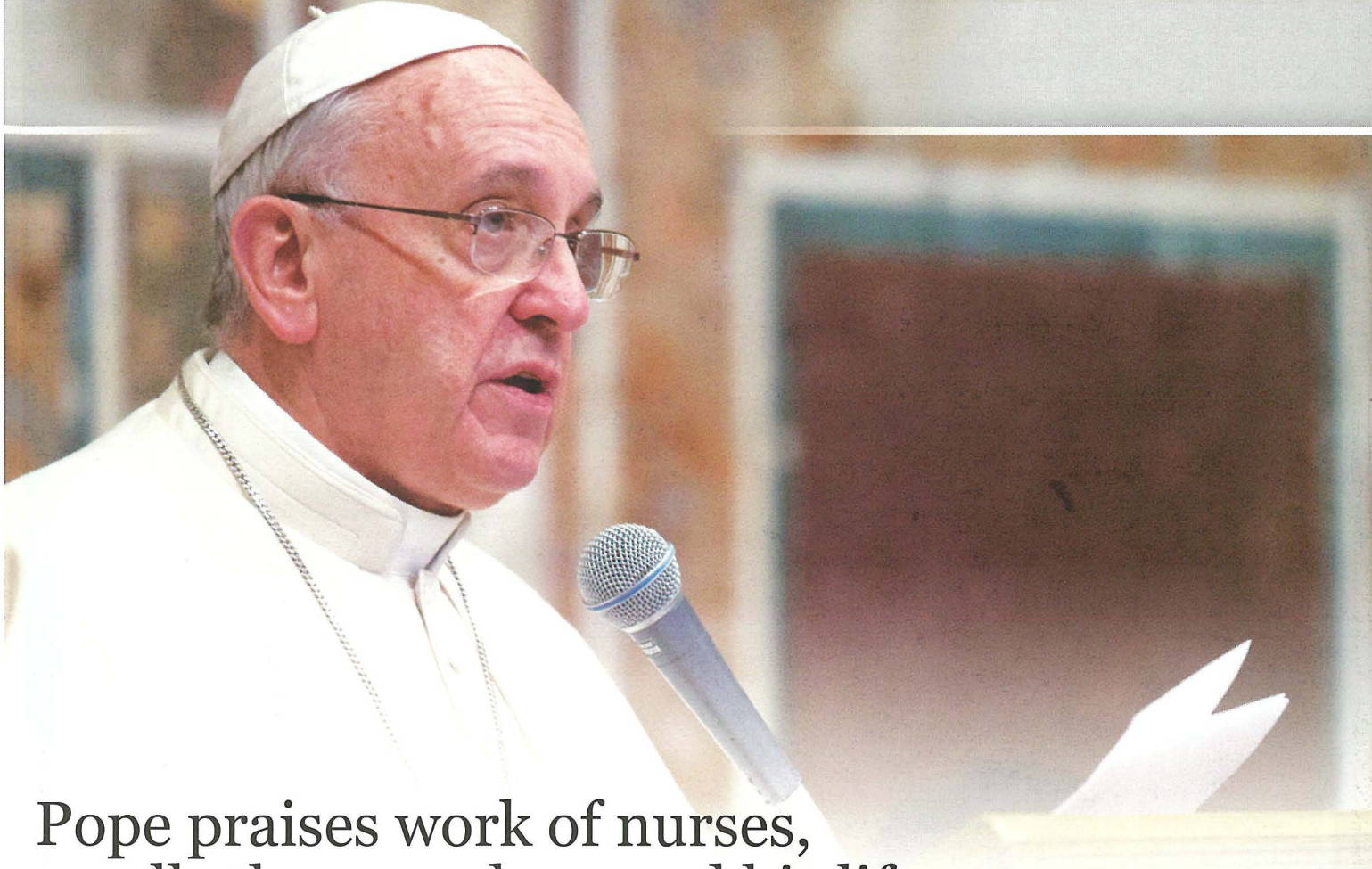

Pope praises work of nurses, recalls the one who saved his life

by Hannah Brockhaus, Vatican City, Mar 3, 2018

Speaking to a group of nurses on Saturday, Pope Francis thanked them for their valuable work and paid a tribute to the Dominican nun who saved his life when he was a young man.

"[She was] a good woman, even brave, to the point of arguing with the doctors. Humble, but sure of what she was doing," he said March 3.

Francis told a brief story from when he was just 20 years old in Argentina. He was ill and close to dying, he said, when Sr. Cornelia Caraglio, who was a nurse from Italy working in Argentina, argued with the doctors about his treatment, "and thanks to those things [she suggested], I survived."

The pope told the story to help illustrate the importance of the profession of nursing, saying "many lives, so many lives are saved thanks to you!"

"The role of nurses in assisting the patient is truly irreplaceable," the pope said. "Like no other, the nurse has a direct and continuous relationship with patients, takes care of them every day, listens to their needs and comes into contact with their very body, that he tends to."

Pope Francis spoke to members of the Federation of Professional Nursing Colleges, Health Assistants, and Child Wardens in the Pope Paul VI hall at the Vatican.

"[She was] a good woman, even brave, to the point of arguing with the doctors. Humble, but sure of what she was doing," he said March 3

Nurses, he said, are constantly engaged in the act of listening, in order to understand the needs of their patient, no matter what he or she is going through.

He reminded them that it isn't enough to merely rely on protocol, but that their job requires "a continuous – and tiring! – effort of discernment and attention to the individual person."

This makes the profession "a real mission," and nurses "experts in humanity," he said. This is particularly important in a society which often leaves weaker people on the margins, only giving worth to people who meet certain criteria or level of wealth, he noted.

The pope also told them that the sensitivity they acquire through their daily contact with patients makes them "promoters of the life and dignity of people."

"Be attentive," he continued, "to the desire, sometimes unexpressed, of spirituality and religious assistance, which represents for many patients an essential element of sense and serenity of life, even more urgent in the fragility due to illness."

He also acknowledged the difficulty of the profession with its risks and tiring shifts. Because of the demands on nurses, he encouraged patients to have patience with them, making requests without demanding, and also offering a smile.

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from our diary

MUMN 1996
Malta Union of Midwives and Nurses

MUMN's Learning Institute for Health Care Professionals kept on organising visits at schools as part of the nursing marketing campaign

MUMN Administration Committee together with the Deputy Prime Minister organised a press conference to launch this year's Nursing Marketing Campaign

Mons. Alfred Xuereb, Archbishop of Amanthea paid a visit to GGH to mark one of his activities before his new mission kicks off as the Apostolic Nuncio of Korea and Mongolia. This was even his first mass that he concelebrated in GGH at the Male Elderly Ward as one of the residents was his school mate

The SVP Group Committee organised again with the support of MUMN Council and SVP Management a Blood Donation Day where nearly 80 donors volunteered for this noble act

This ceremony started by MUMN reminding all those present with the loss of our colleagues who passed away recently, by a one minute silence in their honour

New elected Forum Unions Maltin National Council from two of which are MUMN Officials

Another outing another success by the Pensioners Group Committee who even paid a visit to Hon. Minister for Gozo

MUMN supported Mr. William Grech Staff Nurse to launch his book. During the ceremony Mr. Grech presented his book to MUMN President and Health Minister

MUMN Administration Committee met with Steward Healthcare President and Health Minister

MUMN Administration Committee together with the Deputy Prime Minister organised a press conference to launch this year's Nursing Marketing Campaign

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MUMN Administration Committee met with Steward Healthcare President and Health Minister

Interventions in Mental Health Care

Historically, mental illness was treated with the most intriguing and mind-boggling ways. Up until the mid-century, the management of mental illness was focused on restraint and segregation, which was the only know-how of dealing with people who were disturbed, due to psychiatric symptoms. These un-treated conditions and the peculiar methods used in psychiatric asylums were the cause of the stigma surrounding anything mental health, which unfortunately still lingers till today.

Fortunately, mental health care has evolved in its treatment and management of mental illness and psychiatric conditions. Primarily, pharmacological treatment has made huge leaps when it comes to psychiatric medication, with newer, more effective and modern drugs with less daunting side-effects being introduced regularly for a variety of conditions, including depression, OCD and schizophrenia. In psychiatry, medication is sometimes seen as a necessary evil.

Taking medication is never a coveted activity, more so when the medication is psychotropic. Patients might not be easily convinced that the difficulties they are experiencing are symptoms of mental health problems. And I'm not referring to just psychotic symptoms. I met the most depressed of patients who still reckon that they can overcome their depression by just their will power, or OCD sufferers who continue to justify their unfounded rituals and disabling ruminations as strategies to deal with life's uncertainties. However, the results and improvement noted when people take the medication can be remarkable.

Most of the reluctance in taking psychiatric medication comes from misinformation and lack of knowledge about it. People have understandable fears of becoming dependent on the medication, that the medication is going to change their personality, or that it is going to cause some irreversible damage to their brain. Most of these fears are unsubstantiated. Medication will treat the symptoms and not the personality; most medication is not addictive (when taken as prescribed) and side-effects are not as devastating as people might think they are. Also, the benefits of medication most of the time outweighs the detriment of the side-effects and if not, it is sensible to discuss this with the doctor to find an alternative treatment to the symptoms.

> What might work for one patient might not work with others, and what a patient might have found unpleasant, others might benefit from.

However, psychiatric treatments are not all about pills and chemicals. Actually, most of the interventions in the national mental health care focus on the psychological, social and occupational aspects of the illness. Nowadays, practitioners use an array of evidence based practices which target the behavioural, emotional, social and psychological factors with the aim of improving health functioning and well-being. Therapeutic interventions are supported by empirical evidence, with one of the most prevalent and established approach being cognitive behavioural therapy (CBT). CBT deals with negative thoughts that people experience automatically, which are most often the source of psychological distress and unhelpful behaviours. Through therapeutic interventions, cognitive restructuring and behavioural assignments the patient will learn how to deal with these negative thoughts with the aim of changing core beliefs they have about themselves, others and life.

Psycho-social interventions (PSI) is a spin-off from CBT for psychosis, and is focused primarily with people who suffer from long term conditions like schizophrenia or bipolar disorders. It involves the use of structured assessment tools, psycho-education techniques, medication management and family work. PSI notes that there is a complex interplay between biological, environmental and sociological factors which when combined with certain stressful life events can trigger an onset of psychosis or a relapse.

This works part and parcel with Early Intervention in Psychosis (EIP), which is a systematic approach to support people experiencing their first episode of psychosis. A psychotic episode can be a frightening experience which if not tackled well can have long lasting effects on the individual and the family. Although psychotic experiences are part of the symptomatology of schizophrenia, not all psychotic episodes are part of it. Psychosis can be related to severe

stress in one's life, substance misuse and organic disorders.

Moreover, research showed that when psychosis is dealt with immediately and at an early stage in the individual's life, it results in better prognosis and outcome for the patient and the family. Other interventions in psychosis include the Hearing Voices approach, which is a group intervention for people who experience auditory hallucinations. Hearing voices is an interesting phenomenon which is viewed as meaningful for the patient and has the potential to be understood in different ways. The Hearing Voices approach uses a support group system, interviews and techniques to assist individuals to cope with these symptoms and facilitate recovery.

Assessment is part and parcel of mental health interventions. It is the first step in any practitioner – patient encounter and it is the basis for further action and treatment. Similar to having a blood test or an x-ray to identify medical disorders, the psychiatric assessment helps the practitioner in joining the pieces of information together to create an understanding which results in psychiatric diagnosis and formulation of a plan of care. In mental health, risk assessment and mental state examinations are a continuous strategy in helping the patient to make sense of the experience, the clinician in creating a formulation of the problem and identify areas of risk which the patient and practitioner should focus on to establish a relapse prevention and harm reduction plan.

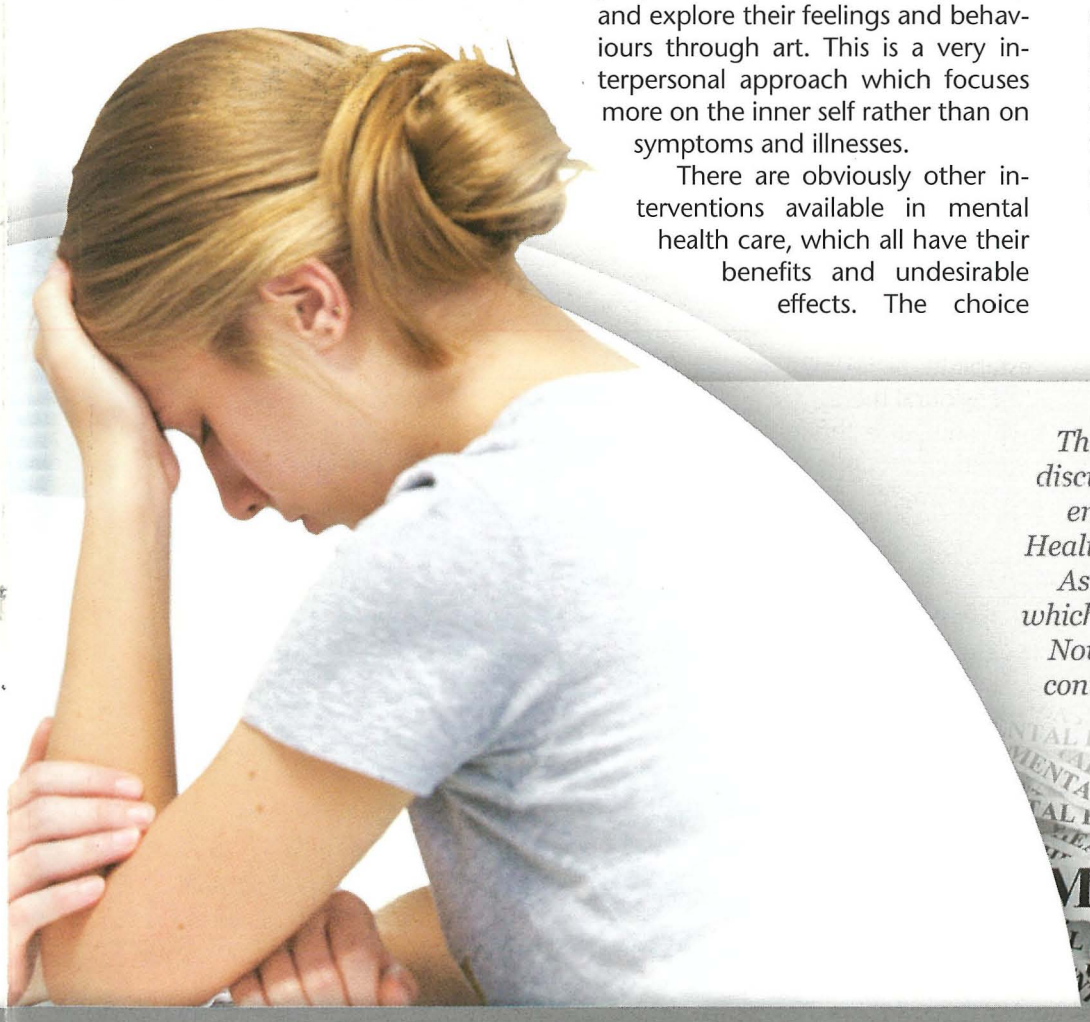
Other interventions can be of a more creative and expressive nature. The use of art therapy in mental health care is a well established approach and it involves more artistic work like drawing, painting, creative writing, pottery and sculpture, dance movement and drama which help people to express their individuality and explore their feelings and behaviours through art. This is a very interpersonal approach which focuses more on the inner self rather than on symptoms and illnesses.

There are obviously other interventions available in mental health care, which all have their benefits and undesirable effects. The choice of intervention always lies with the practitioner but ultimately with the patient or client.

> These un-treated conditions and the peculiar methods used in psychiatric asylums were the cause of the stigma surrounding anything mental health, which unfortunately still lingers till today.

In mental health care, there is no one size fits all. What might work for one patient might not work with others, and what a patient might have found unpleasant, others might benefit from. There is also no miracle cure, and the management of psychiatric and mental ill health requires a combination of biological, psychological, social and spiritual approaches. It is a blend of art and science, understanding the most basic of human emotions, using empathy to understand the experience of others and communication to help other make sense of that experience.

Pierre Galea – President
Maltese Association of Psychiatric Nurses



These interventions will be further discussed in the upcoming conference entitled "Interventions in Mental Health Care" organized by The Maltese Association of Psychiatric Nurses, which will take place on the 8th and 9th November 2018. For further details contact mapsychnurses@gmail.com

Health chiefs are examining the claim against an unnamed Welsh health board

A Welsh CBI representative said that nurses were being charged £30 a night

The Welsh government aid that it was wrong to charge 'excellent' NHS staff

Shop fronts blocked by snow drifts in Brynmawr, South Wales, illustrated just how badly the big freeze affected Wales

• continued from page 16

'We are immensely grateful to all our staff for their dedication to patients in this weather and we would like to make it clear that we are NOT charging any of our staff for accommodation.

'If they have been asked for any payment this is totally unacceptable and they should contact their site manager immediately. In the event any staff has had to pay they will be reimbursed in full.'

The Aneurin Bevan University Health Board also posted a message online that read: 'Just to be clear, we are NOT charging any of our staff for accommodation.

'We are also providing meal vouchers for our staff who have needed to stay in work. If anyone has been asked to make any payment they are asked to contact their site manager immediately.

'We are grateful to all our dedicated staff who are going the extra mile to provide first class care.'

Around 2,000 families in Devon and Cornwall are without power, with hundreds of others suffering power cuts in mid Wales and East Yorkshire.

Tina Donnelly, head of the Royal College of Nursing in Wales, said any storm charge was 'abhorrent' - after staff walked up to 10 miles to reach hospital.

The claim was made against an unnamed Welsh health board on social media.

Leighton Jenkins, head of policy for the Wales CBI (Confederation of British Industry), exposed the alleged charge on his Twitter account as thousands were stranded by heavy snow.

Mr Jenkins wrote: 'Some Welsh hospitals are charging those nurses who volunteer to not go home the cost of sleeping in on-site student accommodation (£20-30 a night).

'This is despite the fact they are saving the NHS the cost of sending a 4x4 to collect and return them to their homes.'

Welsh Government Health Secretary Vaughan Gething pledged to investigate - and praised the battling NHS staff.

He said: 'NHS staff who have

stayed overnight to try and make sure that their employer - the National Health Service - can continue to function the next day, I just don't think that should result in a charge to any of our staff who are doing that.

'There is extraordinary public sympathy and support for our national health service as people have seen the extraordinary efforts being made to maintain a service for our most vulnerable citizens.'

The names of the hospital accused of charging nurses were not revealed but Mr Gethin said his staff were investigating.

'I'm expecting that situation to be resolved, and for every part of the service to understand very clearly my expectation and to act in accordance with it.' he said.

Welsh health boards on Saturday said the claims that nurses were charged to stay in student accommodation during Storm Emma were not true.

A statement made by Cardiff and Vale University Health Board in relation to the nurses shortage on Saturday morning said: 'We are appealing for nurses, in particular critical care nurses, to attend for duty at the University Hospital of Wales and University Hospital Llandough.

It is asking staff to undertake extra shifts at the University Hospital of Wales in Cardiff and University Hospital Llandough in the Vale of Glamorgan.

Heavy snow has caused widespread disruption across parts of Wales, but people have been helping healthcare workers across the country get to work.

There have been lots of examples of people using 4x4s to take dozens of NHS workers to and from hospitals and doctors and nurses have been staying overnight and hospitals to make sure they don't get stranded at home and are there for their shifts.

'If they have been asked for any payment this is totally unacceptable and they should contact their site manager immediately.

Speaking about the overnight accommodation charges, Vanessa Young, the director of the Welsh NHS Confederation, which represents all the Welsh health boards, said the claims needed to be examined.

'We would want to ensure that if staff are coming in to help with the situation that we are facing at the moment, that they wouldn't be incurring additional cost,' she said.

'It may be to do with the fact that they need to pay in advance and then claim it back from their health board. 'But as I say, we need to look at the detail and deal with that.'

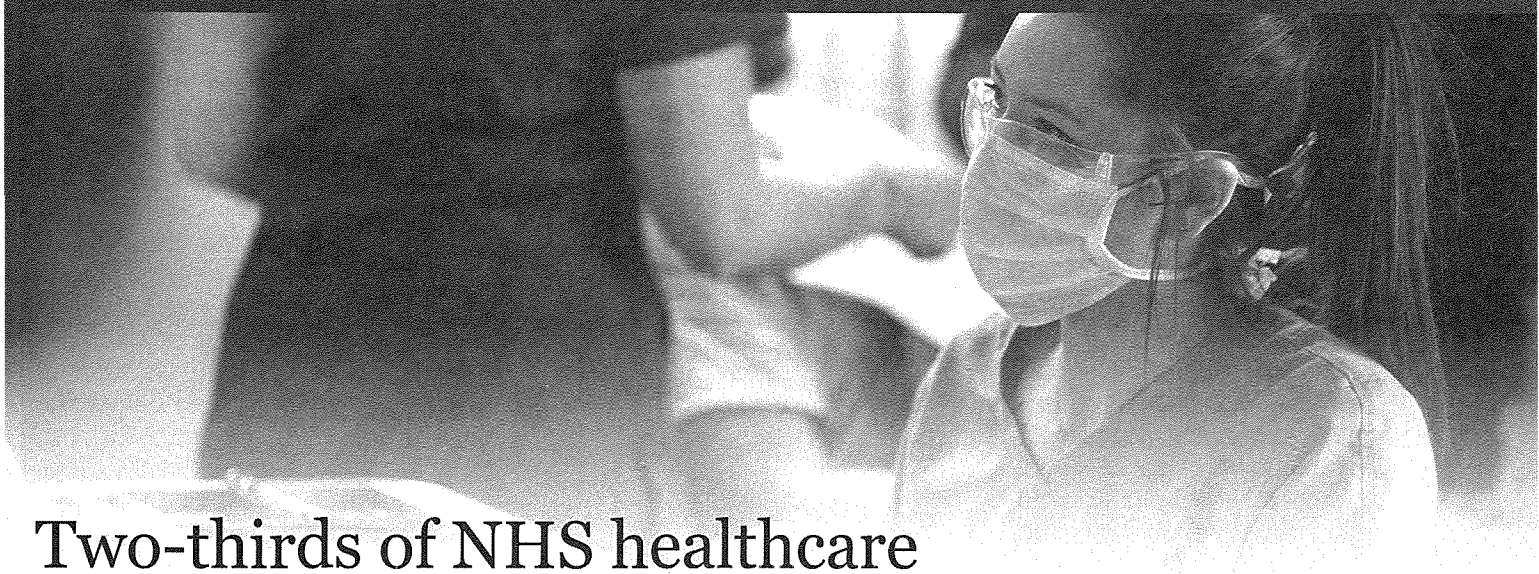
She praised the work of Welsh staff over the last few days, adding: 'They really have pulled out all the stops.'

The director of the Royal College of Nursing in Wales, Tina Donnelly, said she wanted to hear from anyone affected by the allegations.

'I would be keen to speak with them to address this issue - this is abhorrent,' she said.

By ALASTAIR TANCRED and STEWART PATERSON for MAILONLINE

Denis Campbell, The Guardian - Health Policy Editor



Two-thirds of NHS healthcare assistants doing nurses' duties, union finds

Unison survey finds HCAs give out medication, dress wounds and take blood pressures

Almost two-thirds of healthcare assistants (HCAs) are performing roles usually undertaken by nurses, such as giving patients drugs and dressing their wounds, in the latest illustration of the NHS's staffing crisis.

The apparently growing trend of assistants acting as "nurse substitutes" has sparked concern that patients may receive inferior or potentially unsafe care because they do not have the same skills.

Of the 376,000 assistants in the NHS in England, 74% are taking on extra tasks, according to findings by the union Unison.

In a survey of almost 2,000 mainly hospital-based HCAs across the UK, 63% said they were providing patient care with worryingly little help from doctors and nurses, and 39% said they were not confident the patients they look after were receiving safe care.

"On my first day I was shown how to do tasks like taking pulses and blood pressures by another HCA," said Nicole, an HCA in Greater Manchester and Unison member.

One healthcare worker who asked to remain anonymous said: "They said they'd never been trained properly how to do it and weren't really sure if they were doing it properly. HCAs are doing electrocardiograms and taking bloods. That's a lot of responsibility."

In the survey, 51% of HCAs said they had not been properly trained to dress wounds, give out medication or change stoma bags.

"Healthcare assistants are being left to fill staffing gaps and do vital tasks without recognition or reward. It's bad for them and bad for patients", said Unison's head of health, Sara Gorton. "It's clear the pressures on them to act as nurse substitutes have increased over the winter."

A majority of respondents (57%) said they had to perform extra tasks last winter as the NHS came under its most intense pressure ever, and 41% said they were asked to act beyond the usual limits of their roles, and without proper training more often than the previous winter.

> Support workers should supplement the work of nurses not replace them, says the Royal College of Nursing

The creeping expansion of HCAs' roles, linked to the NHS in England's shortfall of 40,000 nurses, risks leading to "nursing on the cheap", the Royal College of Nursing said in response to the findings.

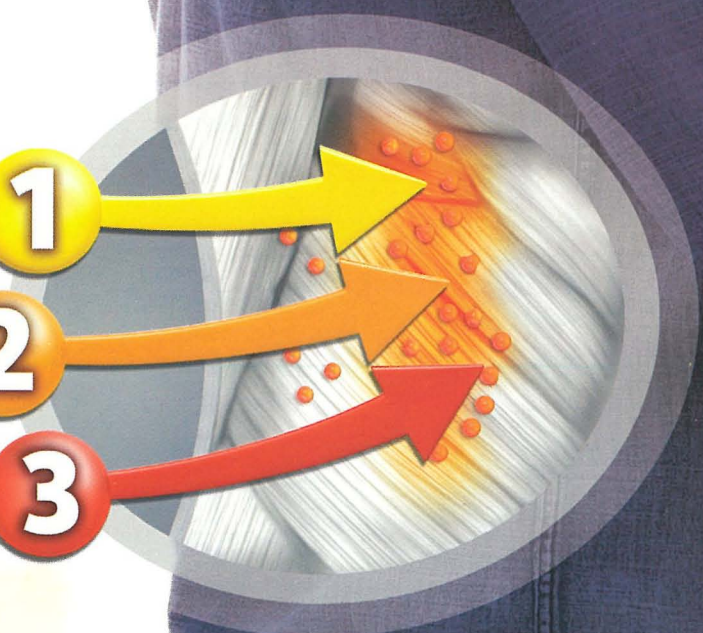
"As the shortage of nurses continues to bite, shifts are increasingly filled with more unregistered care staff," said the RCN's general secretary, Janet Davies. "Support workers play an extremely important role, but they should supplement the work of nurses, not replace them.

"It's unfair on HCAs to expect them to deliver care they have not been trained for. It's also unfair on patients," she added. "Health outcomes improve with more registered nurses on duty. The government must not allow nursing on the cheap, and increasing the supply of registered nurses must be a priority."

Jonathan Ashworth, the shadow health secretary, said: "The situation is getting worse year by year, putting patient safety at risk. It's totally unacceptable to expect healthcare assistants to fill in, effectively acting up while denying them the training and support they deserve for taking on extra responsibilities."

The policy director at the Nuffield Trust health think tank, Candace Imison, said the findings were worrying. She said: "We know that across the NHS, staff – from healthcare assistants to clinicians – are being stretched beyond their capacity daily as the health service grapples with staff shortages and growing numbers of sick and frail patients."

Penetrates deep to relieve pain



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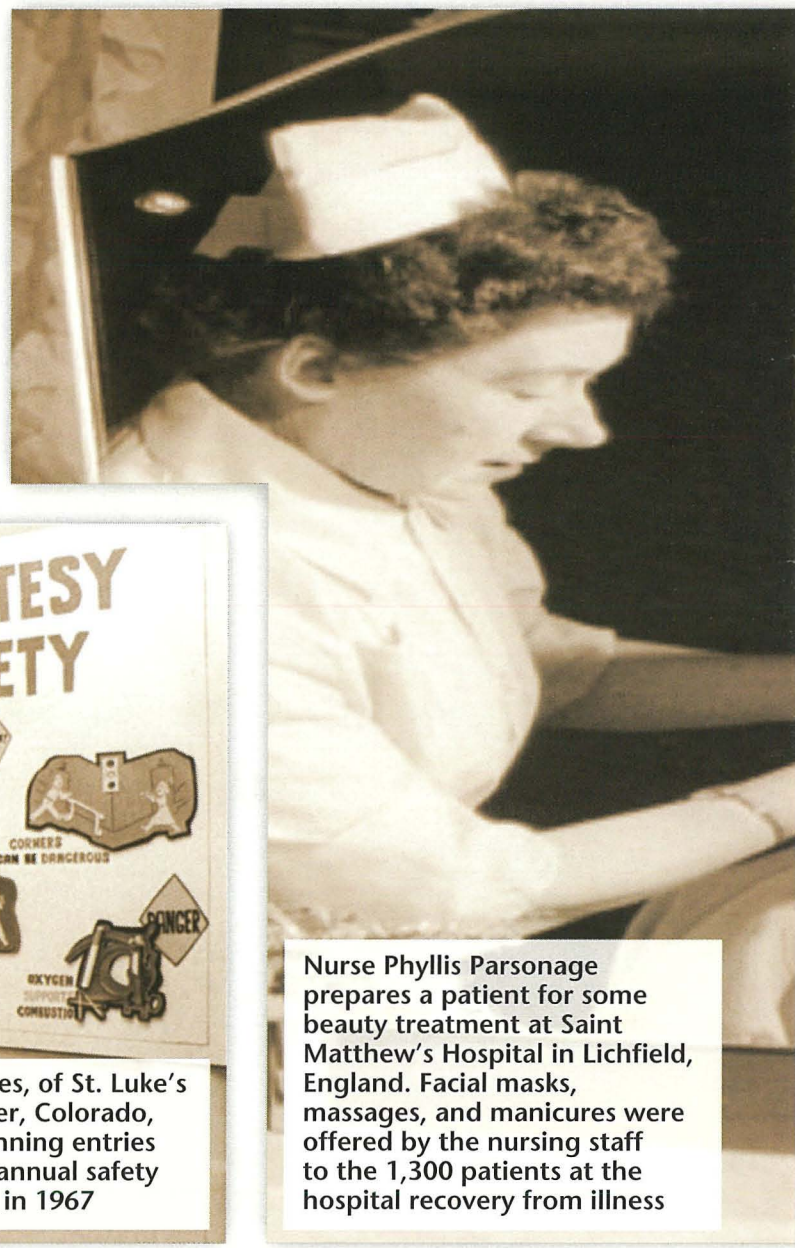
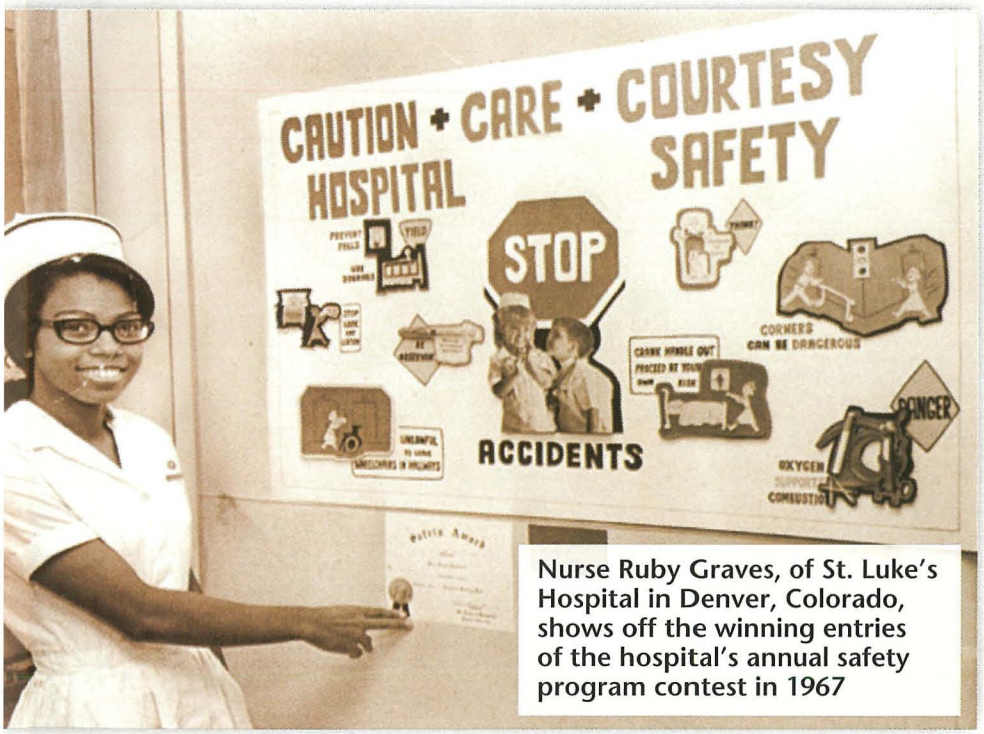
11 VINTAGE PHOTOS
showing the Aura of Nurses

A nurse feeds a young baby in 1965 at the newly built U.S. Air Force Hospital in Suffolk, England

A little girl shows her tongue to a nurse in 1952

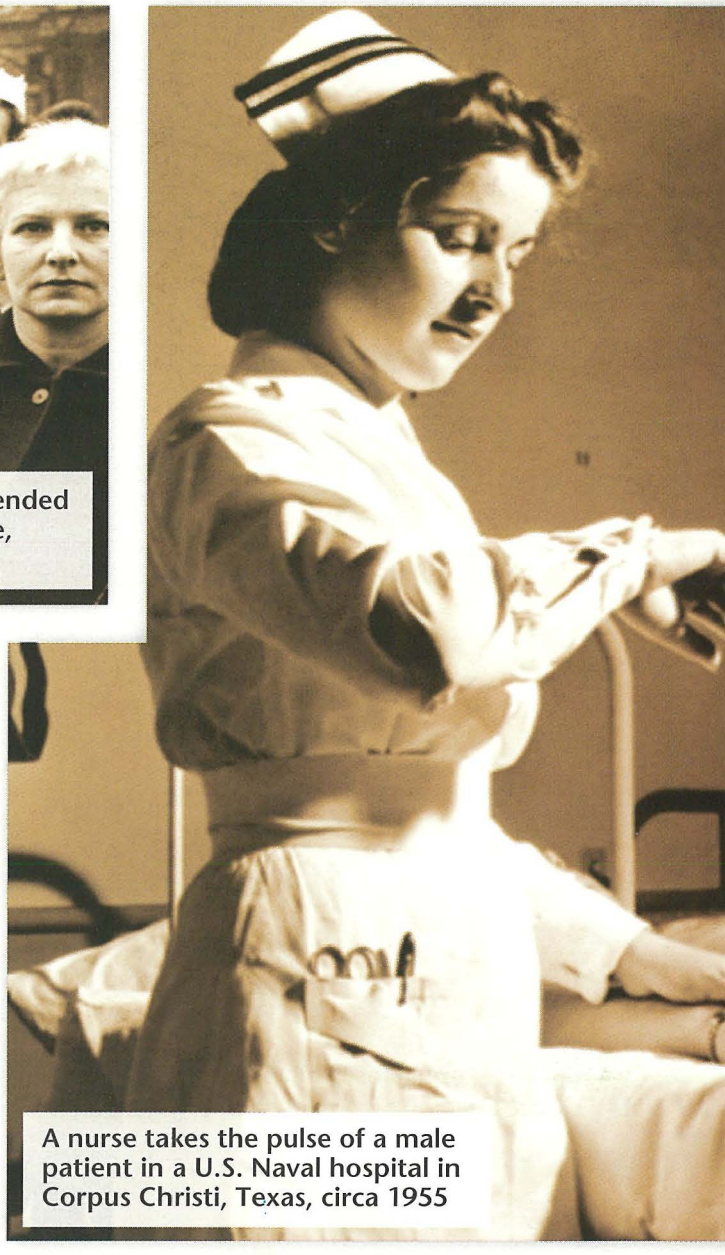


Nurse Phyllis Parsonage prepares a patient for some beauty treatment at Saint Matthew's Hospital in Lichfield, England. Facial masks, massages, and manicures were offered by the nursing staff to the 1,300 patients at the hospital recovery from illness

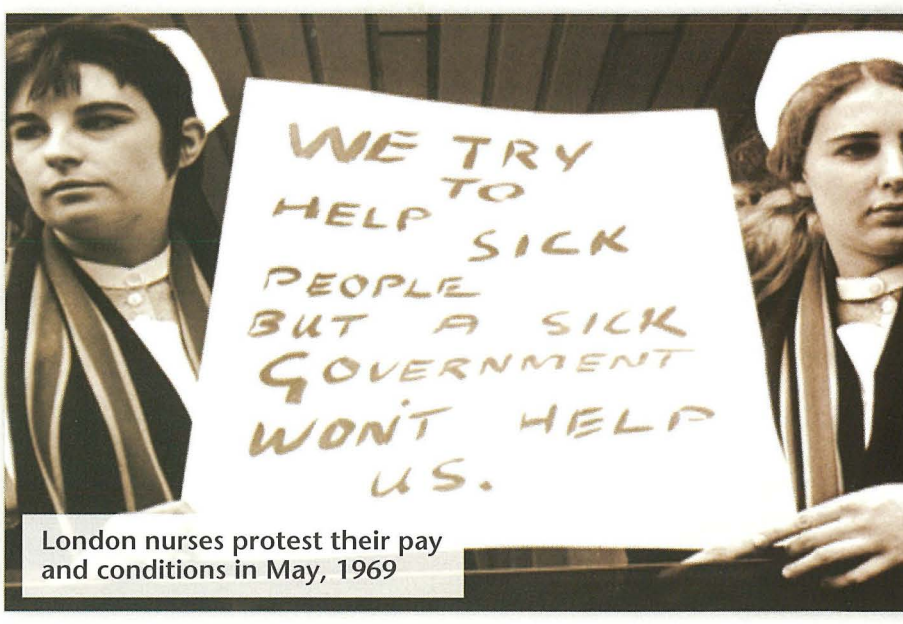


Nurse Ruby Graves, of St. Luke's Hospital in Denver, Colorado, shows off the winning entries of the hospital's annual safety program contest in 1967

In April, 1962, some 8,000 nurses attended a protest meeting at Trafalgar Square, London, in support of fair wages



A nurse takes the pulse of a male patient in a U.S. Naval hospital in Corpus Christi, Texas, circa 1955



London nurses protest their pay and conditions in May, 1969

by Carmel Saliba P. G. Dip Ger; ex Deputy Charge Nurse - 20.02.2018

When there is a beginning there will be the end

43 years as a qualified nurse and two-year course

I started the Enrolled Nurse course in February 1971. At that time calls for such posts were issued mostly for female students only. I qualified in May 1973 as an Enrolled Nurse and started my employment on 1st April 1975. I, together with my other group members, was left for 23 months without employment in the nursing section. Since April 1975 I worked four months at St Vincent De Paule Hospital. Later, as I requested, was transferred to Craig Hospital in Gozo (later named Gozo General Hospital).

My work in Gozo started as a reliever for three months. Once, when I was still in the relieving pool, I was night duty and I was ordered to go to the Paediatric Ward alone. At first I refused but I was ordered to go because there was no female nurse to cover that night. During that night I received a call from the casualty department that a child is being admitted and I had to be substituted by a female nurse from the casualty department and not to show that I was working at the Paediatric Ward. During my first working years no male nurses were allocated at the Paediatrics. Later male nurses were sent as a compliment with other female staff.

My first placement was at the Male General Ward where I worked there for twenty years. During my first years at the Male General Ward only two nurses were in each shift. There were no nursing aids or health assistants. All work was done by nurses from preparing for major operations to delivering coffee and tea. All male over 14 cases were admitted to the Male General Ward.

My plan since the beginning of my nursing career was that if I work 40 years as a nurse, I work the first 20 at the Male General Ward and the rest at the Male Geriatric Ward. In 1995 I was transferred, at my request, to the Male Geriatric Ward.

Till 1997 all opportunities to upgrade the Enrolled Nurse status were closed. In 1997, after there were discussions as from 1992, there was the introduction of the Enrolled Nurse to Staff Nurse Conversion course. I applied for this course and I placed with the first intake out of 850 candidates/Enrolled Nurses.

After I succeeded as a State Register Nurse, later known as Staff Nurse, I had difficulties to work at this grade at the Gozo General Hospital. I was asked by the Health Administration to start in my new grade in Malta. Six months after my Maltese colleagues I received my appointment with a backdated date and was allowed to work in the new grade at the Gozo General Hospital. A change that opened the door for the next new enrolled nurse who followed the Conversion Course.

When I finished this course I followed the Postgraduate Diploma in Gerontology and Geriatrics at the University of Malta. As part of this course I had to submit a dissertation. My dissertation was titled Physical Dependency of the Older Adult in a local institution. I am very pleased to note that when looking for titles that include 'physical dependency' in the University of Malta library there is only my contribution.

This study was done in the Male Geriatric Ward. This is still the only study done at the Gozo General Hospital to assess clients for their physical dependency. I am pleased to note that most of the recommendations that I proposed were included at our area of work and even in the planning of Sant' Anna Residence.

I followed several other courses related with my area of work to enhance my nursing abilities. As from 2002 I was delegated by the Manager Nursing Services to work day duties only because of my speciality in the elderly section.

Since then I followed three interviews for the Deputy N.O.

The first being in 2003 issued by the Gozo Ministry where I placed 16th out of 34. After my complaints my placement was changed twice, that is, to 13th and to 11th placement. Although I complained that my Postgraduate Diploma merits more qualification marks than a first degree my case was closed by the Ombudsman. Then in 2011 I was officially informed that my Postgraduate Diploma was in line with Master's Degree and hence higher than a First Degree.

The second time was in 2008 in a call issued by the Health Division where I placed 40th out of 450 candidates. The Health Administrators, including the Gozo Ministry, informed me that if I accept the promotion I had to work in Malta and if I ask for transfer to Gozo I had to abdicate the DNO grade and continue working at the Gozo General Hospital as a Staff Nurse. This was because, they stated, that the Health Division and the Gozo Ministry have the rights to do their own interviews for Deputy NO and higher. I had to resign under protest. Later I found that the Gozo Ministry with other Ministries were granted the right to do their own interviews in 2012 by the LN 246 of 2012.

The third time was in 2012 in a call issued by the Gozo Ministry where I place 2nd out of 35. I was asked by the Manager Nursing Services, to cover the Short Stay Ward. I had other options to choose but I accepted this challenge.

When I reached the retirement age at 62 I had to abdicate the Deputy NO grade. Regards this forced abdication I have my queries. This is happening in the health sector only. My believe is that one day this will be contested and who contest it will win it. It is not fair especially for the Deputy Charge Nurse, as they are known today,and higher. I accept it because most of my working years were in the nursing

level.

In 1973 my mother-in-law who had followed the State Registered Nurse in the early 1950's was reemployed as a nurse at Victoria Hospital, the one before the Gozo General Hospital. She was one of the first married women in Gozo who was reemployed as a nurse. At that time this change brought different reactions from the staff saying 'my father never sent my mother working' and even that she took the place of work of another Gozitan who is still working in Malta'.

Today if one assesses the state of the female staff within the Gozo General Hospital finds thatnobody quits from work when they get married. Most of the female nurses are married.

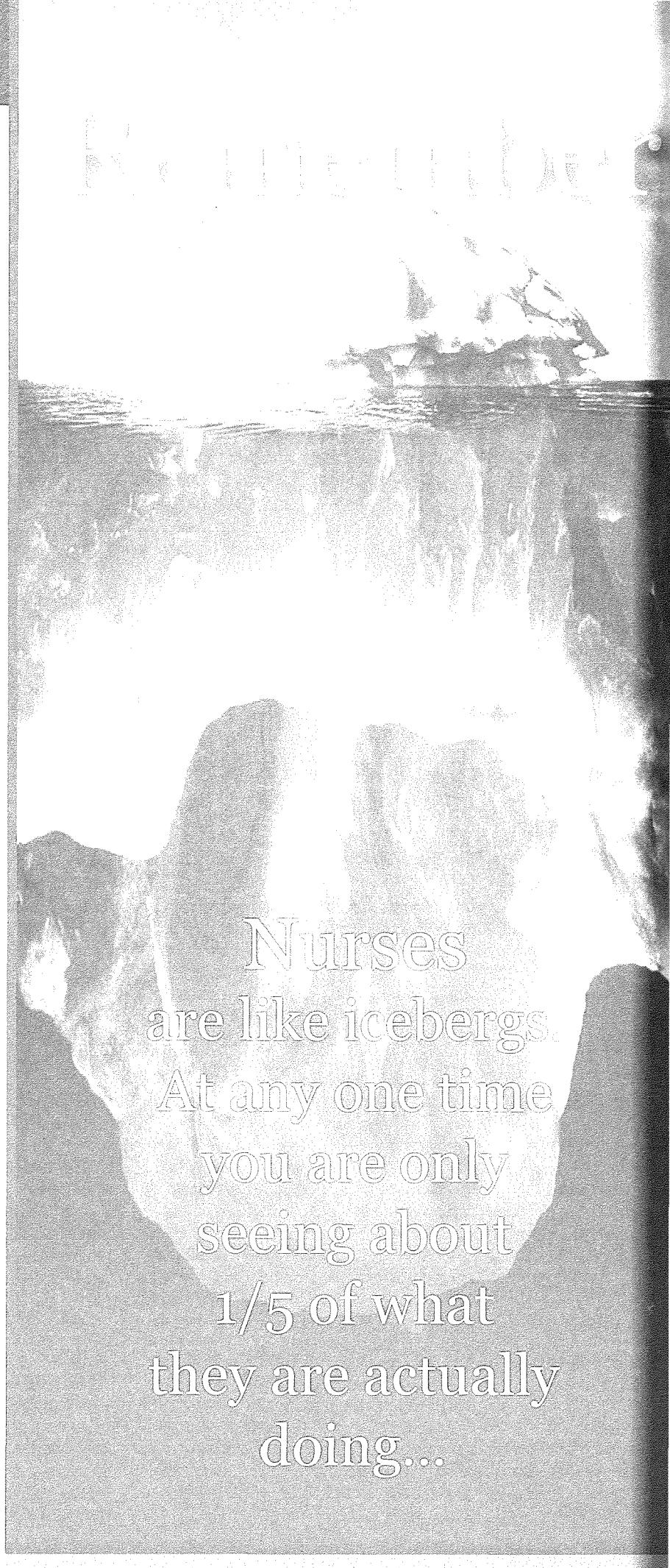
The same is happening today. I, as others, continued working after my retirement age. May I hope that those who are saying that they will not do as I am doing will keep their own believe and retire on their retirement date.After all today the retirement age will soon be for all 65. And even when such age is reached there will be nurses who apply to work over 65. This is what I believe.

I believe also that when the retirement agreement between the government and the MUMN is agreed, maybe the 30 years of service, will have a very low percentage of nurses who leave their work.

These were some of my episodes of my nursing career. There were others. I can confirm that the Gozo General Hospital has drastically changed during my 43 years working in it. For sure our hospital needs an extension.

I remember the time when the hospital had one surgeon and one physician and the mental clients were still at Chambray Hospital. Now there are many different professionals.

May I hope that our hospital will continue to expand so that one day Gozo will have a State of Art Hospital as that in Malta – Mater Dei Hospital. And not to forget those clients who I have worked with during my last six years..... those with mental health problems.



Compression bandaging in Venous Leg Ulcer Treatment

Compression Therapy is a strong therapy which can promote venous leg ulcer healing, and enhance a person's quality of life[1, 2]. Persons suffering from chronic venous insufficiency are predisposed to develop venous leg ulcers, due to impairment of the blood return circulation system, to the heart[3]. The squeezing effect of compression onto the leg, results in reduced oedema and improved venous blood flow towards the heart[1].

The amount of compression required during treatment, is generally based on the patient's morbidities and ability to tolerate treatment. Treatment of venous leg ulcers generally involves application of sub-bandage pressures >40mmHg. Sub-bandage pressures, vary according to posture, movement of patient and also bandage application techniques[2]. The **resting pressure** is the pressure exerted by a bandage or stocking, onto the treated leg, while the patient is resting. This tends to be lower than the **working pressure**, which during exercise, results from expansion of the calf muscle against the stiff resistance created by the bandage[2]. This effect, improves the actions of the calf muscle pump, to pump blood back, from the leg towards the heart[4].

Advantages in the use of Compression Bandages: Although hosiery or intermittent pneumatic compression devices are available to induce compression, bandages are most often used to achieve this effect[1]. The European Wound Management Association Position Document 2003 promotes the use of compression bandages, as treatment of choice, over the use of compression stockings since the use of bandages results in a significant effect on deep venous blood return, when compared with elastic compression stockings. Such hosiery exert their primary effect on the superficial vein system. Inelastic bandages may therefore be more effective in patients with extensive deep vein reflux[4]. During the use of compression devices, it is very important to avoid further damage to the wound bed and the surrounding skin, and to ensure that the pressure applied is evenly distributed. Hence, the use of compression stockings is also impractical in patients at high risk of pressure damage and those with large ulcers or high exudate levels, since no padding can be applied underneath. Self application of compression stockings is also often difficult, even if an application device is used[1].

Bandage Materials and features: The pressure created by a bandage mainly depends on the tension of the material, the number of layers applied and the shape of the leg. Tension is dependant on the amount of stretching of the bandage during application. Sustainability of this tension depends on the elasticity of the bandage material; which is the ability of the material to return to its original length on decreasing applied tension. Elasticity directly depends on the composition of the threads and the method of construction of the bandage. High compression bandages are usually classified according to their amount of extensibility, or their ability to stretch. Although non-stretch materials, such as those used in Zinc Paste bandages are available; the most common materials used are short-stretch, for minimally elastic or extensible bandages; and long-stretch, for highly elastic, extensible bandages[2].

Long-Stretch bandages are able to accommodate expansion or contraction of the leg circumference during exercise or due to reduced oedema, with minimal changes in sub-bandage pressures[2, 5]. Long-stretch bandages, sustain high pressure for long periods of time, even whilst the patient is resting[5]. However, high resting pressures may not be suitable for such patients[1]. A high resting pressure might interfere with the supply of blood to the extremities in patients with arterial problems.

Short-Stretch cotton bandages are able to create high working pressures during exercise, and low resting pressures[2]. They are less able to accommodate changes in leg circumference and retain their rigidity against the calf muscle, thus improving the action of the calf muscle pump. During rest, the sub-bandage resting pressure is quite low, and hence short-stretch bandages are also considered safer in patients with moderately impaired arterial circulation[5].

Multi-layer compression systems have been found to be more effective than single layer compression systems. The concept of multi-layering is that compression is applied in layers, thus achieving an accumulation of pressure[5]. Such systems may be simple, using only 2 layers of the same type of bandage; or complex including both short and long stretch bandages[2].

Hypo-allergenic bandage materials: Contact sensitivity is very common in patients with venous insufficiency[8,9]. It affects 40–82.5% of patients and has major implications on patient management[7,8]. Allergic contact dermatitis to rubber or synthetic rubber components in compression stockings or bandages, is frequently seen[8,10] and occurs in 11–15.6% of patients with chronic venous leg ulcers[7,8]. Besides the effect on skin integrity, allergy greatly affects patient compliance to treatment; as on application, itching, skin redness and a burning sensation is often considered as an allergy to the stocking/bandage, and usually leads to discontinuation of treatment[11]. Hence, it is of utmost importance that materials used for compression devices are hypo-allergenic.

Patient Compliance makes an integral part of any treatment. It can be enhanced by encouraging patients to take an active role in their treatment. It often depends on patient motivation, which can be affected by issues originating from the health condition itself, such as social isolation; or treatment discomfort, which might range from pain or inhibition of regular activities such as work or entertainment. Education of patients and relatives is very important, to gain their compliance[5].

Patients should be advised about the importance of:

- Wearing flat comfortable shoes that allow flexing of ankle joint
- Exercise such as walking, if possible participate in a rehabilitation programme
- Adequate skin care
- Proper care of compression bandages[1]

Contra-indications and precautions: Compression therapy should be used with caution, since incorrect application of compression can lead to serious consequences. Strong compression in patients with arterial insufficiency, neuropathy, cardiac disease, or intolerance to compression material may be unsafe or painful[1, 5]. Prior to treatment, a Doppler test should be carried out to calculate the ankle brachial pressure index (ABPI), in order to evaluate arterial perfusion. In patients with cardiac failure, compression may be dangerous, as it induces rapid shifts of body fluids, which increase the pre-load of the heart. In patients with neuropathy, the risk of pressure damage underneath the bandages increases, since the protective response to pain is absent[5].

Cost-effectiveness ensures that scarce resources available for health-care; are used in the best possible way to achieve the greatest improvement in the health-related quality of life of patients[6]. Budgetary constrains, stress the importance of presenting evidence of cost-effectiveness[6]. Evidence shows that treatment of patients with venous leg ulcers, with a multi-layer compression system in combination with normal wound-care, incurs less weekly costs. It is estimated to be 44% less expensive than usual wound-care alone. It is also more cost-effective than usual wound-care, since the majority of venous leg ulcers heal prior to 52 weeks of treatment with compression[6].

An ideal cost-effective compression system should:

- Be clinically effective to provide evidence based treatment
- Provide sustained clinically effective levels of compression for about a week
- Enhance and support the function of the calf muscle pump
- Use bandaging materials which are non-allergenic, in order to avoid risk of allergy
- Be easy to apply and easy to train patient or carer to apply
- Conformable and comfortable, to aid patient compliance
- Long-lasting, in order to enhance cost-minimisation due to re-use of bandages[5]

Innovative 2 layer compression bandage system, using 2 bi-elastic 100% cotton short-stretch bandages has been recently developed. Bi-elasticity of the bandage is achieved through the weave structure of the bandage. Such a system is as effective as complex multi-layer systems in achieving high working pressures and low resting pressures. Additional advantages of this system include:

- the use of normal shoes, since it is not as bulky as 3 or 4 layer systems, the circumference of the bandaged foot will not increase much, thus fitting the shoes that the patient regularly uses
- more comfortable for patients to wear during warm weather due to lighter, air permeable, skin-friendly cotton material enhancing better quality of life and also compliance
- Due to the bi-elastic properties of bandages, these conform better to leg contours to distribute the pressure more evenly, hence providing also easier application
- These bandages are able to regain their full elasticity after washing, resulting in a cost-minimisation impact on healthcare institutions due to their re-usability

In the treatment of leg ulcers, compression therapy has been used since the time of Hippocrates[5]. Compression can dramatically reduce the amount of oedema and pain and promote healing of venous leg ulcers. Success directly depends on the use of the right materials and application technique[4]. Preventive measures include the long-term use of compression bandaging, since sustained compression prevents recurrence of oedema and results in a lower incidence of ulcer recurrence. A high level of compression is associated with a lower incidence of ulcer recurrence. Medical professionals involved in the care of such patients, should be capable of choosing and applying the appropriate compression system according to individual patient needs[1]. A high healing rate of up to 70% of ulcers within 12 weeks can be reached, and if complimented with an ulcer recurrence preventive programme, it can greatly improve the quality of life of such patients and decrease the burden of venous leg ulcer disease on healthcare systems[5].

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Il-lingwa Maltija użata fid-dinja Medika

minn Joe Camilleri, Charge Nurse - L-Ewwel Parti

L-użu tal-lingwa Maltija fid-dinja medika u li allura tintuża fix-xogħol tagħna tan-Nursing jista' jagħti impressjoni li huwa kemmxejn limitat u dan minħabba t-teknikalità tax-xogħol tagħna, l-użu ta' kotba b'lingwi differenti (speċjalment bl-Ingliż) u l-fatt li aħna poplu bilingwali. L-użu tal-kliem bl-Ingliż huwa wkoll attribwit mal-fatt li aħna konna kolonja tal-Gran Brittanja u anke għall-fatt li l-kelma Ingliża hija aktar komda jew faċli biex tippronunzjha. Il-fatt li aħna Maltin u saħansitra mill-bidunett tal-istruzzjonijiet għall-Infermieri kienu bil-lingwa Maltija, għandna però ħafna kliem, idjomi, jargon u espressjonijiet bil-lingwa tagħna jew meħudin mill-Isqalli/t-Taljan, mill-Ingliż u xi naqra mill-influwenza Semitika.

Il-kelma 'Nurse' jew 'Midwife' ilha tintuża ħafna fl-isptarijiet anke minħabba l-fatt li t-tmexxija tal-isptarijiet f'Malta kienet mill-barranin u speċjalment mill-Ingliżi. Il-kelma 'Infermier' jew 'Infermier Reġistrat', għalkemm aċċettati, mhumiex daqshekk popolari daqs 'l-S.R.N' biex tingħad u fi żminijiet riċenti anke ddaħħlet il-kelma 'Infermeristiċi' speċjalment biex nispjegaw is-servizz tad-'Direttorat' tal-Infermieri.

Mill-kelma 'infermier' joħorgu wkoll il-kliem 'inferm' (infirm) u 'infermerija' (infirmary). 'Infermier Iskritt fl-Elenku' kienet u għada tirreferi għal dak li konna nirreferu għalih/a bħala State Enrolled Nurse (S.E.N. jew E.N.). Kliem ieħor antik li qajla għadhom jintużaw huma 'servjenti' li ġejja mill-kelma 'servitrichi', 'attendenti' li kienet tirreferi aktar għall-Hospital Attendants u l-'gwardjani' kienu aktar jużawha f'dak li kien jissejjaħ 'Ta' Frankuni' jew 'Ta' Franconi' ('Il-Manikomju' jew 'Il-Mentali' li wara ssemma' L-Isptar Monte Carmeli). Il-kelma 'l-Imgħallem', għalkemm ma tintużax biss fid-dinja tan-Nursing, kienet u għada tirreferi għal min imexxi u allura għan-Nursing Officer, Ward Sister, Charge Nurse u dari għall-Ward Master.

'Il-kbir/a tas-sala' u 'dak/dik tal-blu' jirreferu għall-istess ħaġa waqt li l-'kbir/a ta' l-isptar' jirreferi għall-Matron fi sptar ġenerali u 'l-Maġġur' f'Monte Carmeli. Illum insibu wkoll 'id-Direttur' għal meta nirreferu għal-Director. 'Tal-post' tfisser li l-istaff ikun reġistrat u jaħdem uffiċjalment mal-istituzzjoni (u mhux aktar student). Min-naħa l-oħra bħala referenza għat-tabib mill-pazjenti anzjani, dawn jindirizzawh bħala 'Sinjur', anke minħabba r-rispett, waqt li l-istaff, ħafna drabi, jirreferu għalih bħala 'Id-Dottore', kelma li anke tintuża fl-avukatura.

'Il-Profs' jew 'Il-Professur' kien u għadu dak li llum ngħidulu l-'Konsulent'/'Speċjalista' u miegħu jkollu 'it-tabib ta' warajh/ta' taħtu' jew 'it-tabib iż-żgħir'. Is-'supretendent' fil-qosor insibuh 'is-super'. It-tobba 'jduru l-pazjenti' meta jagħmlu ward round u fil-privat issib 'it-tabib kuranti' jew 'ipoġġu' f'xi klinika. Il-kirurgu (surgeons) li dari kienu jirreferu għalihom bħala barberotti (barber-surgeons) huma dawk li 'joperaw' fit-'teatri' (operating theatres jew

'sala tal-operazzjonijiet') u jkunu fil-qasam tal-'Kirurġija'. Interessanti li għalkemm bl-Ingliż jissejħu Mr. Jew Ms. (Mister jew Miss) bil-Malti ma nindirizzawhomx bħala Sur, Sinjur jew Sinjorina. Lit-tobba fl-isptarijiet 'nippejġjawhom' jew 'intuhom pager' (to page) meta għandna bżonnhom.

Fl-antik kienu jirreferu għall-'Kontrullur'/Kuntrullur' meta jirreferu għall-Comptroller of Charitable Institutions. Kelma għal tutor kienet tintuża 'surmastru' u kelma għall-lecturer għandna 'lettur'. Kull min hu professjonista ta' xi dixxiplina partikolari fl-isptar inżidu is-suffiss 'ista' per eżempju 'podologista' (tad-dwiefer), xjentista (scientist) u 'flebotomista' (phlebotomist).

Rigward is-shifts li jaħdmu fihom in-Nurses, meta wieħed kien ikun 'tal-għassa' kien jaħdem sat-8 ta' fl-għaxija; jekk 'tas-sitta' ovvjament sas-6 ta' fl-għaxija; jekk 'tas-C' kien ikun nofstanahar u jekk 'bil-frank' kont u għadek tkun off duty. Dawn il-kliem kienu u għadhom jintużaw komunament minn kull min kien jaħdem bix-shift f'Malta. In-nurse li 'jissupplixxi' kien dak li jaħdem bħala reliever.

In-Nurse raġel kien jilbes il-'ġagaga'/'bluża' (lab coat) u li saħansitra sat-tmeninijiet kien għad hemm min jilbes l-'ispalletti' (epaulettes) mal-ispallejn. F'Monte Carmeli in-nurse raġel kien jilbes il-'ġakketta' l-bajda b'ħames buttuni tar-ramm. In-Nurse mara kienet ixxid (tilbes) 'il-kappun'. Interessanti li 'kappun' kien ukoll jintuża f'Monte Carmeli biex ilibbsuh f'ras il-pazjenti (bħall-elmu) biex ma jweġġgħux meta jkunu fil-kabinetti u bl-istraight jacket.

Fil-għodu, mar-radd tas-Salib in-Nurses jibdew 'jagħmlu l-pazjenti' frażi li tista' tfisser ħafna affarijiet bħal jaħslu; inaddfu, ibiddlu, iniżżlu fuq pultruna, ikeffnu, iqaxxru x-xagħar (shaving), jagħmlu pompa u anke jimmedikaw. L-użu tal-kelma 'patients' jew 'pazjent' illum hija aktar popolari biex tintuża minn nurses però nurses antiki kienu jirreferu għalihom bħala 'il-marid' jew 'il-morda' (the sick). Dak iż-żmien kont naraha stramba din il-kelma imma llum napprezzaha ferm aktar. Kienet ukoll tintuża l-espressjoni 'nattendi pazjent' jew 'nattendi patella' (bedpan) li ovvjament ġejja minn 'attendere' jew 'to attend to'. Il-pazjent ikun 'konvalezzenti' f'xi sptar għall-mistrieħ jew f'daru.

Frażi oħra hija 'ejja ħa nduruhom' jew 'nagħmluhom' li ħafna drabi jirreferi għal meta ntellgħu l-pazjenti fis-sodda, innaddfuhom u nbidlulhom waranofsinhar u 'f'ta' bil-lejl' (night duty). Il pazjenti 'indawruhom' meta nibdlulhom il-pożizzjoni fis-sodda kull sagħtejn (2-hourly turning). Il-frażi 'fih ix-xogħol' u 'nagħmlu waħdi/ma tnejn' jirreferu għall-workload fix-xogħol tagħna. 'Nagħmlu/jgħamlu/għamlulu/għamluhielu' tfisser ħafna affarijiet fosthom kull tip ta' proċedura/operazzjoni, inkluż 'suppositorji'/'tapp/tappijiet' (suppositories).

Ngħidu 'l pazjent biex 'jogħla mill-patata' jew 'jogħla 'l fuq' biex nagħmlulu l-ħarqa

Ngħidu wkoll 'nagħmlu manwal' jiġifieri manual evacuation jew rectal clear meta jkun hemm faecal impaction. 'Nagħmlu s-sodda' tfisser 'nifirxu/nippreparaw is-sodda'. Il-frażi 'naqra ta' malajr' jew 'naqra wiċċek u hemm isfel' jirreferu għal-meta bl-Ingliż nużaw 'tops and tails', shortcut konvenjenti għal xi wħud biex jiffrankaw ix-xogħol jew meta jinħaslut-trabi. Dan sakemm il-pazjent ma jkunx 'inkallat' (grossly unclean) u fejn dari konna ngħorkuhom bl-'etere' biex inneħħulhom 'il-kallu'; Waqt li qed insemmu l-frażi 'hemm isfel', suġġett delikat ħafna, fost ir-referenzi għall-partijiet ġenitali tal-pazjenti insibu: 'il-parti privata', 'il-parti tiegħu/tagħha', 'is-sigrieti', 'minn wara', 'hemmhekk', 'hemm taħt' u oħrajn li mhux xieraq insemmuhom f'dan l-artiklu għax jew joffendu jew jirredikolaw. 'Fih qantar' ngħidu għal meta l-pazjenti huma tqal ħafna ('barjatriku', bariatric) u biex intellgħuhom 'irridu parank' (winch). Forsi b'ċajta, imma dejjem bqajt niftakarha, kien hemm uħud li jgħidu 'tlaqna naqalgħu l-patata', frażi li għalkemm tirreferi għall-biedja, tfisser ukoll li x-xogħol tagħna mhux wieħed faċli.

'Tlaqna bir-ring' jew 'bil-lant' jirreferu wkoll għal meta l-ħasil tal-pazjenti jsir b'mod kollettiv u mhux allokat (jew strutturat), għalhekk jibda' minn tarf u jispiċċa f'tarf ieħor. 'Intik tefa' ma tintużax biss fin-Nursing u tirreferi għal meta ngħinu lil xi ħadd. 'Qed nammetti pazjent' (to admit a patient) tfisser qed 'nirreġistra pazjent u nurih jew indaħħlu fis-sodda' waqt li meta l-pazjent jiġi 'illiċenzjat' (discharged) ikun 'rilaxxat' mill-isptar jew ikunu 'baghtuh'.

Lill-pazjent insaqsuh ukoll jekk 'tawhx il-karti' (discharge letter) meta jiġi lliċenzjat waqt li 'l-karti' huma kull tip ta' dokument. 'Għamillu karta' kienet frażi li tintuża u sa ċertu punt għada wkoll u tirreferi għal meta pazjent irridu nammettuh jew 'jinġabar' f'xi istituzzjoni (bħall-Imgieret). Il-pazjent ikollu 'l-biljett il-blu' (appointment ticket) għall-Outpatients u 'nirreġistrawh'. Il-'kartuna l-bajda/safra'/'roża'/ 'permessi' jintużaw biex wieħed iġib il-mediċina b'xejn.

Nirreferu għall-'istejjer' meta nitkellmu fuq patient notes. Il-pazjent 'jirkadi' (relapse) meta jerġa' jimrad. Il-pazjent 'jintefa'/ 'jinxteħet f'sodda' mhux biss biex jidħol fis-sodda imma meta jkun dikjarat bedridden jew ma 'jiflaħx'. Ngħidu wkoll 'sodda tal-marid' meta nitkellmu fuq 'sodda'. Pazjent ikun 'rikoverat' meta jkun l-isptar. 'Ngħabbu l-pazjent' meta nitrasportawh bis-'siġġu tar-roti' (wheelchair), sodda jew bl-istretcher u ngħidulu 'jarbula għall-ġemb' meta rriduh 'jiġġenneb'.

Dari l-pazjent kien jinġieb l-isptar bil-'katalett', illum ngħabbuh f'ambulanza'.

• ikompli f'paġna 36

• ikompli minn paġna 35

IL-KATALETT

Ngħidu 'l pazjent biex 'jogħla mill-patata' jew 'jogħla 'l fuq' biex nagħmlulu l-ħarqa. Ngħidu 'ngħaddu' jew 'indaħlulu pajp' jew 'tubu' jew 'nikkatiterizzawh' (pass/ introduce a tube/catheter) bħal fil-każ tal-catheter/katiter tal-pipi, nasogastric tube jew chest drain tube u ngħidu 'taħt is-sikkina' meta l-pazjent ikun qed jiġi operat u 'fuq il-mejda' meta jkun fuq il-mejda ta' l-operazzjoni.

Ngħidu 'amputazzjoni' (amputation) meta xi riġel, driegħ, id jew sebgħa jkun 'għall-qtugħ'. 'Il-borża tal-awrina' tirreferi għall-urine bag waqt li 'l-bużżieqa tal-awrina' tirreferi għall-urinary bladder. Ngħidu wkoll 'inbattlu l-borża' meta nbattlu l-borża tal-awrina/pipi.

'Inqattru' meta napplikaw il-qtar fl-għajnejn u 'nidilku' meta napplikaw kremi (creams/ointments). Il-pazjent ikun 'sajjem' (fasted) qabel operazzjoni jew proċedura u 'rieqed' meta jkun anestetizzat (anaesthetised). Il-pazjent 'jitqaxxar' qabel xi 'operazzjoni maġġura' (major operation).

Espressjonijiet oħra li nsibu fid-dinja tan-Nursing huma 'inqassmu d-dieta' u dari konna ngħidu 'ngħoddu l-lożor/ il-laundry'. Kliem li sselifnih mill-Ingliż insibu 'nintubaw' (to intubate) meta nkunu ser 'inraqqdu'/ 'nillupjaw' (namministraw l-anestesija jew 'nagħtu l-loppju'), 'nimmonitorjaw' meta l-pazjent ikun fuq monitor, 'nixxukjaw' jew 'niddifibrillaw' meta nużaw id-defibrillator, 'nistentjawh'/ 'nagħmlulu molla' meta ssir stent, 'nifflaxxjaw' meta nagħtu 'flush' f'xi pipe jew cannula u 'nagħtu l-mediċina/trattament' meta nqassmu t-treatment.

'Tnaddaf' ma tfissirx biss 'taħsel il-pazjent' imma tfisser ukoll li tneħħi l-ħmieġ, timsaħ jew tibdel ħarqa. Meta 'tqaxxar' pazjent ma tkunx biss qed tkaxxarlu l-leħja jew ix-xagħar, suf jew pil, imma wkoll iġġibu nadif tazza. 'Intellgħu' l-pazjenti meta jkunu fuq pultruna u 'ntellgħuhom lura fis-sodda' meta intellgħuhom aktar propped up sew fis-sodda. Qabel konna 'intellgħu' l-pazjenti għas-swali tal-operazzjonijiet, illum 'inniżluhom'.

'Inniżluhom' ukoll meta meta npoġġuhom fuq pultruna u 'nambulawhom' meta 'mmexxuhom'. 'Għatini tefgħa' ngħidu lil xulxin meta għandna bżonn ngħinu lil xulxin biex intellgħu, imbiddlu, inniżlu l-pazjent eċċ. Meta l-pazjent ikun 'imħawwad'/ 'konfuz'/ (confused) intuh 'rabta tajba'/ 'norbtuh' (restrained) u meta jkun constant watch inkunu 'għassa miegħu' jew level one.

Il-pazjent jista' jkun ukoll 'imgerfex' jew 'imgerfex ħelu'. F'Monte Carmeli kienet tintuża t-terminolġija 'jużaw il-forza' meta 'd-delirju jkun furjuż' u kien għalhekk jitlibbes 'il-ġlekk tal-forzi' (straight jacket) u japplikaw 'il-liżar' (restrainer). Il-pazjent 'taħrablu' (incontinent) meta 'jagħmel taħtu', u 'jixxarrab' (soiled) meta jxarrab ħwejġu u l-friex.

Il-pazjent ikollu jew niċċekjawlu 'l-pressjoni' (blood pressure) bil-'magna' (BP monitor) jew bl-'isfigmomanometru' (sphygmomanometer) u jista' jkollu 'pressjoni għolja' jew ' pressjoni baxxa'.

IL-'ĠLEKK TAL-FORZI'

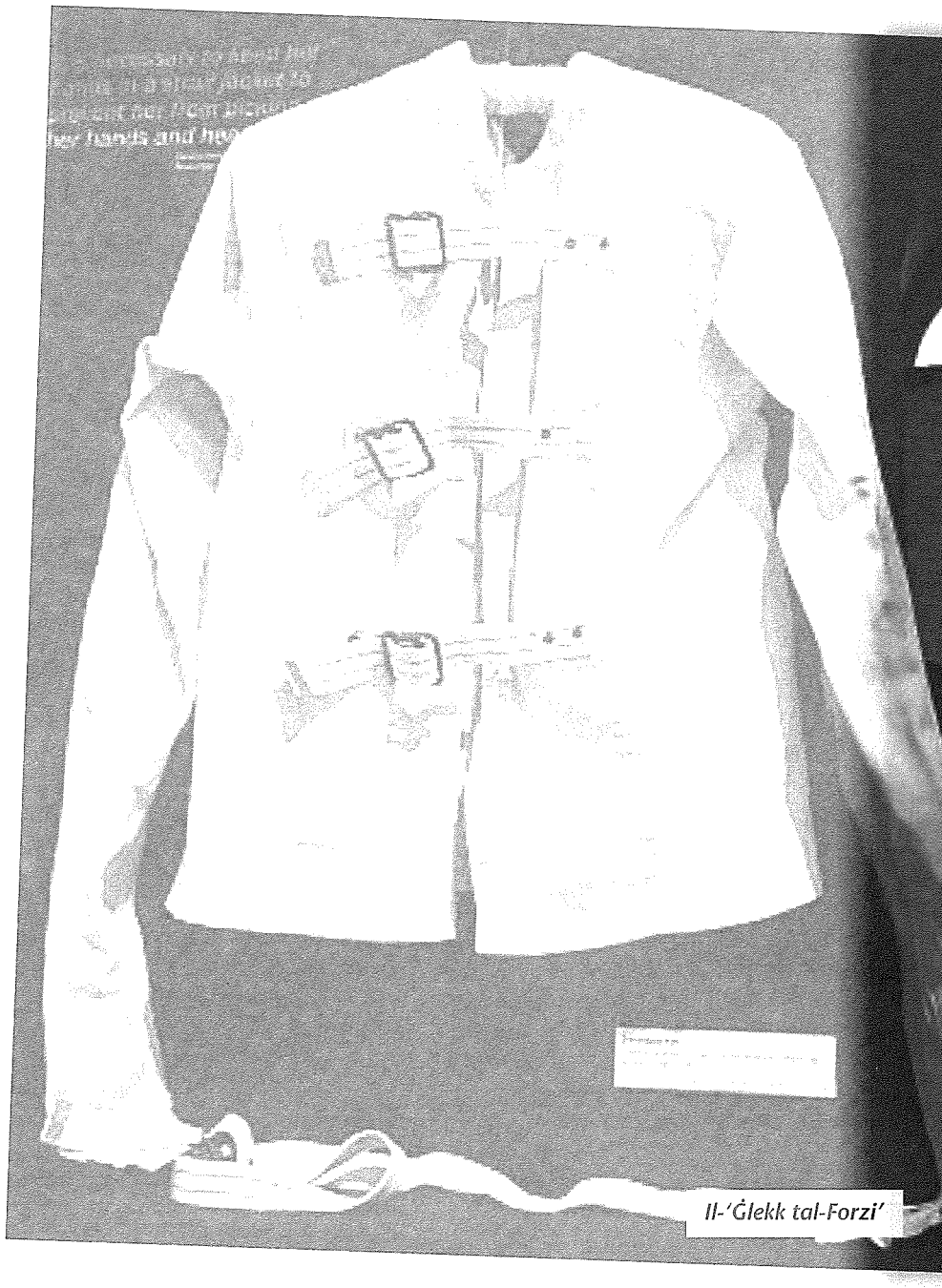
Interessanti li meta l-pazjent 'itellgħuh hemm fuq' inkunu qed nirreferu għall-admission fl-Isptar Monte Carmeli.

Minħabba li llum mhux politically correct li nittimbraw pazjenti fil-qasam tal-kura tas-saħħa mentali, kliem bħall-'miġnun', 'mard tal-ġenn/moħħ', 'moħħu ħfief', 'bliegħ', 'belgħani', 'iblaħ', 'ħass moħħu', 'għamillu karta', 'maqful', 'm'aħniex' (li tfisser ukoll li 'mhux f'sikktu', 'mhux f'tiegħu' jew not all there), 'żmagat' jew 'żmanġat' (ġejja mit-Taljan smangiato, mentally unstable), 'spissjat', 'spejsjat', 'sempliċi', 'monglu', 'kuku', 'imħerwel' (crazy/daft), 'moħħu bye-bye' jew 'moħħu ċaw ċaw', 'imtektek' u 'intamat' m'huma wżati qatt (suppost).

'Mard tal-qamar' jew 'tal-qamar' jirreferu għall-'epilessija' (epilepsy jew fits). Is-soċjetà għandha t-taboos tagħha li huma assoċjati mal-biza', superstizzjoni, sess, prudenza eċċ u dawn għandhom jiġu rispettati.

> Forsi b'ċajta, imma dejjem bqajt niftakarha, kien hemm uħud li jgħidu "tlaqna naqalgħu l-patata", fraži li għalkemm tirreferi għall-biedja, tfisser ukoll li x-xogħol tagħna mhux wieħed faċli.

Għalhekk ċertu kliem għandhom jiġu evitati jew talanqas jintuża kliem li jweġġa' anqas. Kliem tekniku fil-psikjatrija bħal-'psikopatiku', 'skizofreniku', 'manijaku', 'allucinazzjoni' jew 'thewdin' ('tisma' l-ilhna'), 'dipressjoni' ('dwejjaq'), 'anzjetà, 'delirju/dellirju/dillirju/deliranti' (delirium), 'ferneżija' u 'psikożi' huma wżati mill-professjonisti. 'Isteriżmu' jew 'sterka' (hysteria) tfisser 'konvulsjonijiet isterići'.



Il-'Ġlekk tal-Forzi'

Espressjoni antika li ltqajt magħha hija 'jagħtuhom it-tazza' jew 'it-tazza' ('trankwilizzant'/tranquillising draught) fejn din kienet tirreferi għall-mistura li kienet tingħata lill-pazjent li kien ikun f'dillirju minħabba l-mard tal-pesta meta kienu jkunu 'kwarantina' (quarantine) ġewwa Lazzarett f'Manoel Island, Il-Gżira.

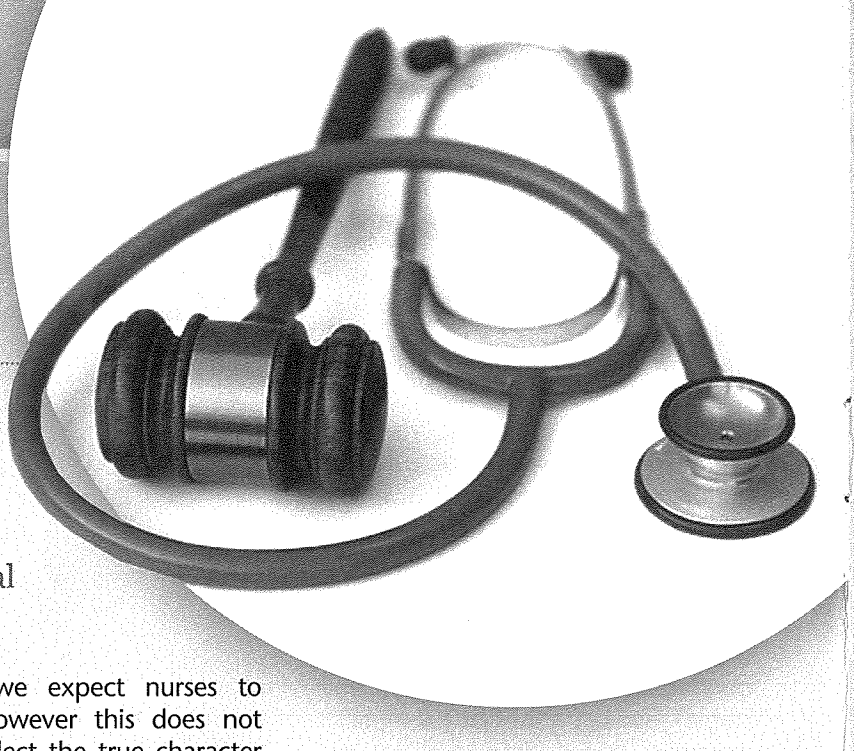
Kliem ieħor li llum mhux aċċettat fil-konfront ta' persuni b''diżabilità'/'diżabbiltà' huma 'immankat', 'ċonga', jew 'inkapaċitat'. Jeżisti wkoll kliem (jew tgħajjir) għaldak kollu li għandu x'jaqsam mal-orjentazzjoni sesswali li wkoll mhux xieraq inġibuhom f'dan l-artiklu.

Dawn l-aħħar 50 sena **daħal** ukoll kliem użat fid-dinja tat-'teħid tad-droga' jew 'sustanzi' u 'alkoħol' (tingħad 'alkol' ukoll) bħal-'jittaqqab', 'ifaqqa', 'jieħu l-labra', 'jieħu linja', 'linja kowk (cocaine)', 'jieħu/mgħadux jieħu', 'jaqa' sick' (withdrawals), 'taħt l-effett' (under the effect); 'xammiema' (glue sniffing), 'jisniffja', 'ħaxixa'/'kannabis', 'eroina', 'kokaina', 'sustanza', 'narkotiċi', 'patata', 'żibel', 'ħara' u 'il-mistura' (Methadone).

◦ **Ikompli f'ħarġa oħra**

Għar-riferenzi kkuntattjaw lil: Joe Camilleri

Understanding Beneficence



Deontology is a normative position in the subject of ethics, that is often referred to that area in ethics that is duty or obligation-based. In health care, this can be understood as the expectation for the healthcare professional to be bound to their duty as a care provider.

With this in mind, deontology may be seen as the ethical position that governs the principle of beneficence, as nurses and healthcare professionals are expected to serve to achieve medical and health beneficence when providing care. Focusing on this deontological approach Beauchamp (1994) explains that 'the principle of beneficence expresses an obligation to help others further their important and legitimate interests by preventing and removing harms; no less important is the obligation to weigh and balance possible goods against the possible harms of an act'.

There are however other approaches or positions that can influence beneficence. For example, a utilitarian approach to beneficence can be understood by Frankena (1973) who stated that 'we ought to do the act or follow the practice or rule that will or probably will bring about the greatest possible balance of good over evil'. Other possible positions of beneficence are libertarian and virtue-based. Virtue-based beneficence, which includes kindness, creates an awareness of the importance in making a distinction between moral ideals and moral rules.

As explained earlier, while rules are based on the deontological approach to beneficence, moral ideals are concerned with virtue-based beneficence. Irrespective of the position taken, it must be clear that the moral foundation of nursing (and healthcare professionals) is the obligation of beneficence. However, obligation is a social construct and as a result we expect nurses to be dutiful, however this does not necessarily reflect the true character of the nurse as their motive may be purely deontological.

It has been noted that the value of the action may be missing from actions that are not virtue-based. This is because the approach and understanding of each professional can be distinct according to the position they adopt in their practice. When adopting an obligations-based approach, it is quite possible that feelings and kind thoughts are not taken into consideration.

This may be for several reasons, including the need to fulfil moral and legal obligations as well as rights and responsibilities. These aspects may eschew or make it harder for health care professionals to also consider the virtuous aspect of beneficence. This is why it is important to acknowledge the influence of a deontological approach to beneficence in health care but to keep in mind that as explained by Armstrong (2007) it may lead to the neglect of the moral character of the healthcare professionals and patients; it is heavily focused on actions and consequence; it does not give due importance to the emotional aspect in the lives of healthcare professionals and patients; and a solely obligations-based approach is not compatible with the provision of holistic and person-centred care.

Based on this, the inclusion of virtue-based decision-making in health care is essential. Nurses and healthcare professionals need to be aware of the virtues and vices that can affect the helping the relationship, as well as how compassion and patience encourage positive interpersonal responses.

When adopting a virtue-based approach in the helping relationship moral virtues are used to respond to patients' interests and needs in beneficent ways. Moral virtues include compassion, tolerance, patience, respect, justice, trustworthiness, honesty and kindness amongst others.

A virtue-based approach in health care requires going back to the roots of the nursing profession as established by Florence Nightingale and giving this a contemporary dimension for todays society. In practical terms this requires that healthcare professionals use the language of virtues in clinical practice; the role of emotions in the lives of healthcare professionals and patients is taken seriously; patient-centred care and empowerment are promoted; and moral wisdom is acknowledged as being important (Armstrong, 2007).

Caring and justice are the basis of benevolence, where caring is benevolence expressed through the emotions and justice is benevolence expressed through reason. In order to act on the principle of beneficence, healthcare professionals should strive to achieve an appropriate balance between these two.

Marisa Vella

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