Il-Musbieħ

MALTA NURSING AND MIDWIFERY JOURNAL

Malta Union of Midwives and Nurses

Numru 81 - Diċembru 2018

A new sectoral Agreement for Nurses & Midwives

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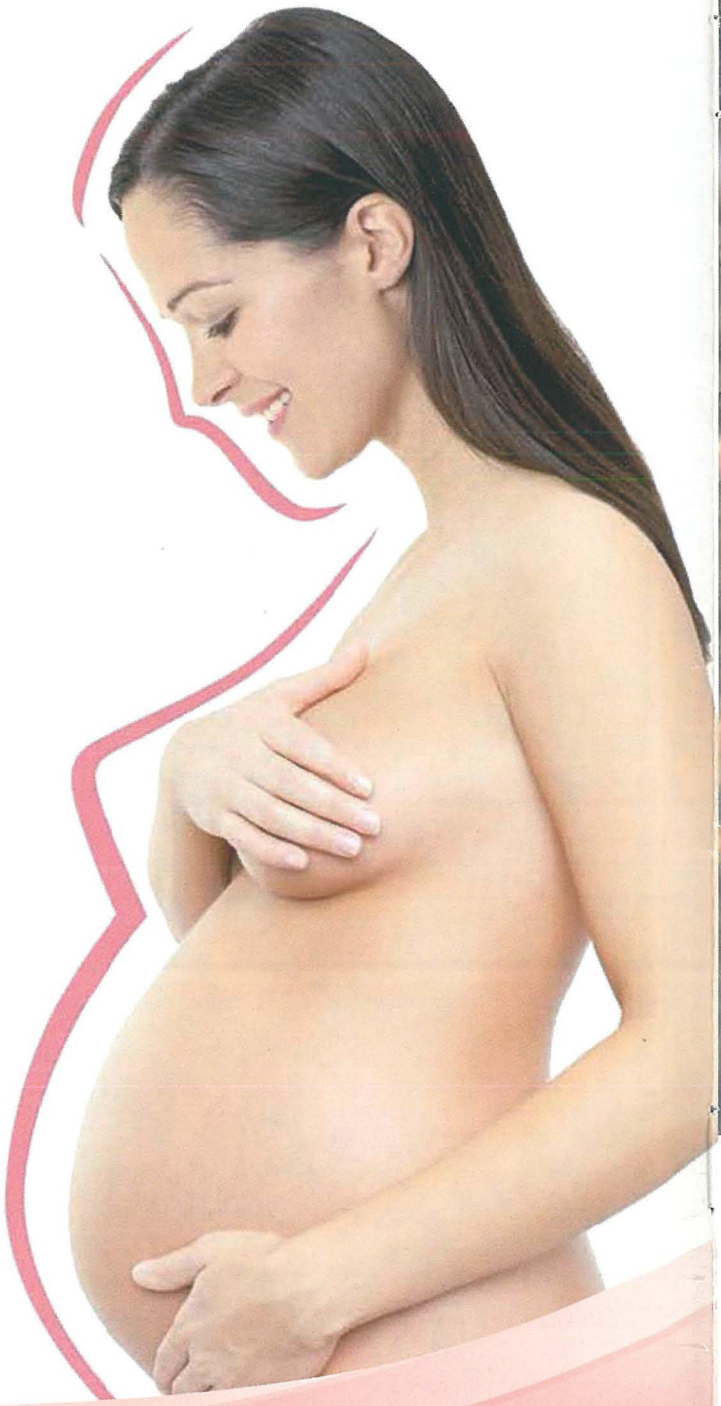

NUTRITIONAL SUPPLEMENTS CANNOT REPLACE A VARIED, BALANCED DIET AND A HEALTHY LIFESTYLE.

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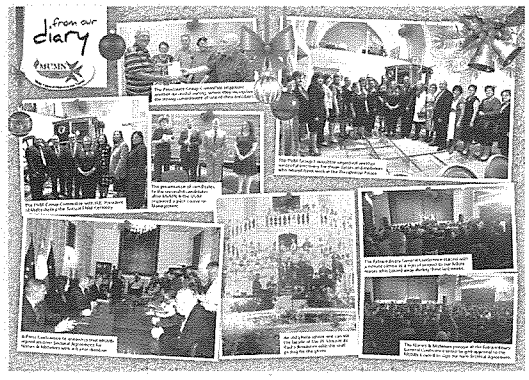

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Cultural Diversity

With Malta's population fast approaching the half-a-million mark that is approximately 10,000 people every year and the 'necessity' of the importation of foreign labour in the service industry, cultural diversity is a stark reality.

In Mater Dei for example, health professionals in several wards face the reality of the expansion of cultures. In fact they need to be equipped with a wider set of skills to interact with patients and colleague staff with different cultural backgrounds. The expansion of our economy with foreign help has therefore its effects across the board.

Migrants coming from different cultural backgrounds are often unfamiliar with the health care system of the host country and do not know how, when and where to seek help. Language barriers may also impede utilisation of health services.

Even in multicultural healthcare settings, difference in cultural values and belief is also known to cause disagreement even among healthcare workers. Known occurrences of such conflict and misunderstanding have transpired as a result of work-related issues involving differences in opinions and practices among cultures. When such conflict resulting from cultural differences among the healthcare workers is not resolved, the health care system will suffer thus affecting the delivery of healthcare to the general patient population. Training and seminars designed to all staff bridge the gap in order to cultivate understanding between cultural differences.

Everyday routines that the predominant culture takes for granted such as time orientation, eye contact, touch, decision-making, compliments, health-beliefs, health-care practices, personal space, modesty, and non-verbal communication can vary dramatically between cultures, sub-cultures, and religions.

The trend of today's healthcare leans toward being more inclusive of personal and cultural preferences. This demands a knowledgeable and open response from caregivers. One of the most important elements emphasised in pursuit of competent cultural care is identifying your own beliefs and culture before caring for others. Acceptance is also another powerful tool, but one that demands solidarity between the healthcare provider and patient. Finally, when in doubt, the best way to provide sensitive care to patients of diverse cultures is to ask.

The trend in health care is to allow for more liberty in patient choices and involvement, as well as the ability to carry out their normal practices as much as possible. The conscientious healthcare giver can affirm, respect, and nurture all patients through deliberate awareness, acceptance, and asking.

Professional healthcare providers take pride in fully dedicating themselves to the responsibility bestowed upon the profession which is devoted to providing reliable care for the well-being of the general patient population without discrimination of race, ethnicity or culture but with due regard to everyone's value in life as human beings.

President's message

Dear colleagues,

What a year it has been for me and everyone working so hard for MUMN. As we bring 2018 to a close, let us count the blessings and pray for peace and safety throughout the world. It was my pleasure to work with a team and represent MUMN to sign the sectoral agreement for the nurses and midwives. I can say that 2018 has been a significant year for the MUMN; and as the year comes to an end, it is a time not only to reflect and give thanks but also to recharge and prepare for 2019. We will celebrate this year's successes with a Christmas Dinner at the Xaghra Lodge. I look forward to seeing you and celebrate together.

Throughout this year, together we focused on the positive, worked together to lift each other up, while strengthening our union and the professions it represents. The MUMN continues to be a well-respected and recognized face both locally and Internationally. Thanks to all of you members of this union, who provide excellent care to our patients and clients. It is because of our culture of compassion, hard work and excellence in good quality care that the MUMN succeeds.

There has been a great deal of activity and work done since my last update in September. Throughout the months, the Council members together with the group committee members have been diligently working for all our members. Thanks goes to each one of these members representing the MUMN and the Council members for all their work this year. Special thanks to all of you members of the MUMN for your continuous support and collaboration. I know that we all strive to keep the best interests of MUMN in our minds and our hearts as we make decisions for the organisation.

In closing this message, I want to say that it has been a privilege and pleasure to have served as the MUMN President from 2015-2019. I wish to publicly thank all council and group committee members for their willingness to serve this union.

I appreciate you all very much and thank you for your open dialogue. MUMN will continue to grow as we work together to advance the professions it represents. For sure next year will be another busy year for the union. We will kick off with an International Conference hosted by the MUMN, followed by the election to elect a new MUMN council; and together with the day-to-day duties of the running of a union, there will be the negotiation processes of another two sectoral agreements; for the physiotherapists and social workers.

Before starting writing this message, I reflected on the report published last November by the medical journal The Lancet. The report established that Malta has ranked 9th worldwide in an annual health-related index. While reflecting on these results, I comprehend the importance of having a top-performing workforce.

As soon as I started my midwifery studies, I was immediately attracted by the top performers. But for me, it wasn't their performance that was the attraction...it was their thought process, the way they approached their clients/patients, a new service, their life. Top performers have special set of skills that allows them to see opportunities that others do not. As I furthered my career, I noticed that most top performers are direct, only spend time on what matters most, and they ignore anything and everything that detracts them from their primary goal.

During the years, I came across several top performers; individuals with exceptional leadership skills, connected to their people, patients and their people's needs. Through industrial relationships, on a regular basis I meet top performers; who with great sense of responsibility and confidentially talk about wanting something better than they currently have or do. Or more specifically,

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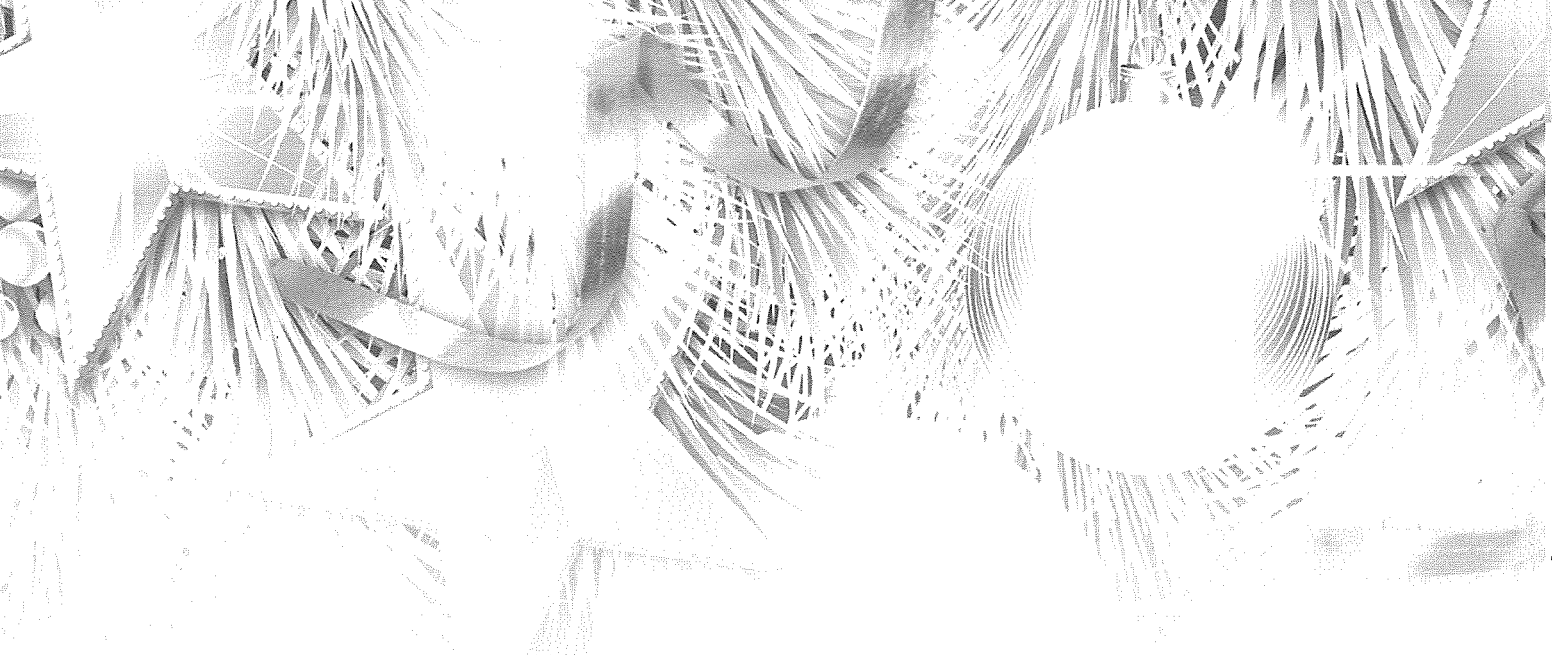

Kelmtejn mis-Segretarju Ġenerali

Għaddiet sena oħra però mhux biss. Għaddew ukoll erba' snin u wasal biex jintemm terminu ta' Kunsill ieħor, biex inkun eżatt is-sitt Kunsill tal-MUMN minn meta twaqqfet din il-union, f'Settembru tal-1996.

Kienu erba' snin ta' ħidma kontinwa fejn flimkien irnexxielna nakkwistaw kemm kundizzjonijiet ta' xogħol aħjar kif ukoll żieda fis-salarju. Irnexxielna wkoll noħolqu strutturi ġodda f'dak li għandu x'jaqsam ma' żvilupp professjonali fejn, fost l-oħrajn, ġie inawgurat l-Institute for Health Care Professionals. Għalkemm kultant mad-daqqa t'għajn, li żżomm dak li gżandek u tibni fuqu, tidher li tkun xi ħaġa faċli, nista' nassigurakom li m'hiex fejn kuljum, mingħajr ma tħares lejn l-arloġġ jew il-kalendarju, trid tirsisti biex tindokkra u ssaħħaħ l-istrutturi kollha tal-Union, il-persuni li jaħdmu fl-uffiċċju tal-Union u aktar u aktar.

Però s-sodisfazzjon huwa enormi. Meta bl-intervent tiegħek jirnexxielek ittejjeb il-ħajja ta' xi ħadd ieħor, hija sensazzjoni li terġa' tqajjmek minn mal-art u tagħmillek kuraġġ, speċjalment meta l-irwiefen ikunu qed jonfħu kontrik minn kull naħa. Però dan huwa parti mill-ħajja ta' trejdunjonista u rridu naċċettawha.

F'Marzu li ġej ser ikollna l-elezzjoni għall-Kunsill ieħor b'mandat ta' erba' snin. Nixtieq nieħu din l-opportunità sabiex nirringrazzja l-ewwel nett il-President tal-Union, l-Uffiċjali l-oħra li jiffurmaw l-Amministrazzjoni tal-Union, il-membri l-oħra tal-Kunsill, il-persuni li jaħdmu fl-uffiċċju tal-Union kif ukoll l-attivisti kollha li dejjem kienu ta' sostenn. Kienu erba' snin ta' fejda. Issa li ilni 22 sena naħdem fl-MUMN, qed naħsibha bis-serjetà jekk nerġax nikkontesta għal terminu ieħor. Ix-xogħol żdied bil-bosta li kemm kemm jibqgħalek ċans għall-affarjiet oħra anki dawk privati.

Il-Ftehim Settorali ffirmajnih. Kuntenti ħafna b'dak li akkwistajna. Kienu 13-il xahar iebsa għaliex ikollok il-pressjoni tal-membri fuq naħa biex tfittex tlesti però fl-istess waqt tkun konxju li jekk tasar il-kamin ftit ieħor, taf ikollok prodott aħjar f'idejk. Kuntenti għaliex dak li wegħdna ġibnieh. Minn dejjem għedna li l-proposti tagħna huma maqsuma f'erba' pilastri – skema ta' irtirar kmieni, żieda fl-iskali, żieda fl-*allowances* u affarjiet oħra mixxelarji. Dan kollu ġie rrispettat u minflok l-iskema ta' irtirar kmieni, akkwistajna skema oħra li tiggarantixxi sistema finanzjarja aktar stabbli għal min japplika. Barra minn hekk dan huwa Ftehim Settorali li 'l quddiem il-Union tista' tibni fuqu, pjattaforma għal aktar żvilupp u titjib fis-salarju.

Ix-xogħol tal-Union ma waqafx hemm kif iffirmajna għaliex dan ix-xahar stess kellna żewġ laqgħat ma' żewġ Ministri differenti biex jerġa' jiġi introdott il-*minimum wage* għall-istudenti kif ukoll l-ammont tas-*sick leave* fil-formola li jinħadem bih il-Pre-Retirement Leave jonqos peress li x-xogħol tagħna huwa fil-mard u għalhekk aħna aktar suġġetti li nimirdu mill-impjegati l-oħra kollha fis-servizz pubbliku. Issa, kif jgħaddu l-festi irridu naqbdu rankatura wkoll fuq it-tkomplija tan-negozjati fil-Ftehim Settorali fejn huma involuti il-Physiotherapists u nibdew ninnegozjaw dak tas-Social Workers.

F'Marzu li ġej ser inkunu qed norganizzaw konferenza importanti ħafna tal-Commonwealth. Se tkun konferenza interresanti immens b'*concurrent sessions* varji. Dalwaqt ser inkunu qed niftħu l-*applications* biex min hu interessat li jirreġistra jkun jista' filwaqt li qed inħejju l-programm sabiex inti tkun tista' tara l-*presentations* li ser ikunu qed isiru.

Għal-lum ħa nieqaf hawn għaliex jiġbduli widnejja li ħadt ħafna spazju. Minn qalbi nixtieq nawgura Milied Hieni u Sena Ġdida mimlija Risq u Saħħa lilek u lil dawk viċin tiegħek. Awguri.

Colin Galea

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wanting good governance, quality care, efficient and sustainable services. Through the insight gained during these encounters with top performers, I acknowledged that we need to embrace and include their talent, skills and insight; while giving them a platform to succeed. I truly believe that the successes achieved in the Maltese health-related index is due to the hard work and good quality care provided by top performing health care professionals. I look forward to seeing all of us finding all the avenues needed to motivate ourselves not only to keep excelling in what we are doing but in other areas too.

> But for me, it wasn't their performance that was the attraction...it was their thought process, the way they approached their clients/ patients, a new service, their life. Top performers have special set of skills that allows them to see opportunities that others do not.

On another note may I kindly remind you that the registrations for the Commonwealth Nurses and Midwives Federation Conference to be held in Malta on the 8-9th March 2019, are now open. On behalf of the Scientific Program Committee, I can say that there was a good number of abstracts for presentations received. This conference will provide a forum for discussion on a wide variety of topics; and it is an opportunity for us all to continue our education, to meet old friends and make new ones!

As I said earlier, next year there will be elections to elect a new MUMN Council, and as such this might be my last message to you as the MUMN President for this term of office. On this regard, allow me the opportunity to end my message, by saying that it has been a pleasure to have served as President of the MUMN over the last 4 years, and I am proud to have done so with dedicated council members with deep commitment to this Union. For this last message, I want to communicate my thoughts about my time as President and tell you about some important accomplishments during my tenure. Although, I have faced some challenges, but overall, I can say that the MUMN is heading into a very exciting and transformative period in its history. As a union, the MUMN has undergone tremendous growth during these past years. Our current membership gone up year after year, our Facebook page had increased its followers, an Institute for health care professionals was setup, while the industrial relationship aspect diversified and strengthened. As you might be aware, we have offered many new benefits for our members, including free professional development opportunities. We have expanded the content of our website with useful information. Perhaps one of our greatest milestones was adopting a clear mandate to reach out to and engage more with our members.

In closing this message, I want to say that it has been a privilege and pleasure to have served as the MUMN President from 2015-2019. I wish to publicly thank all council and group committee members for their willingness to serve this union. My appreciation goes to all the MUMN office administrators, whose enthusiasm and keen sense of humour brought a personalized meaning within the office. Finally, I want to thank all of you for supporting the MUMN and me during my term of office. I am proud of having worked with and served such a great community of professionals. I give you my best and wish you all tremendous success in whichever way you define it.

Best wishes for a Merry Christmas and a joyous New Year.

With warmest regards,

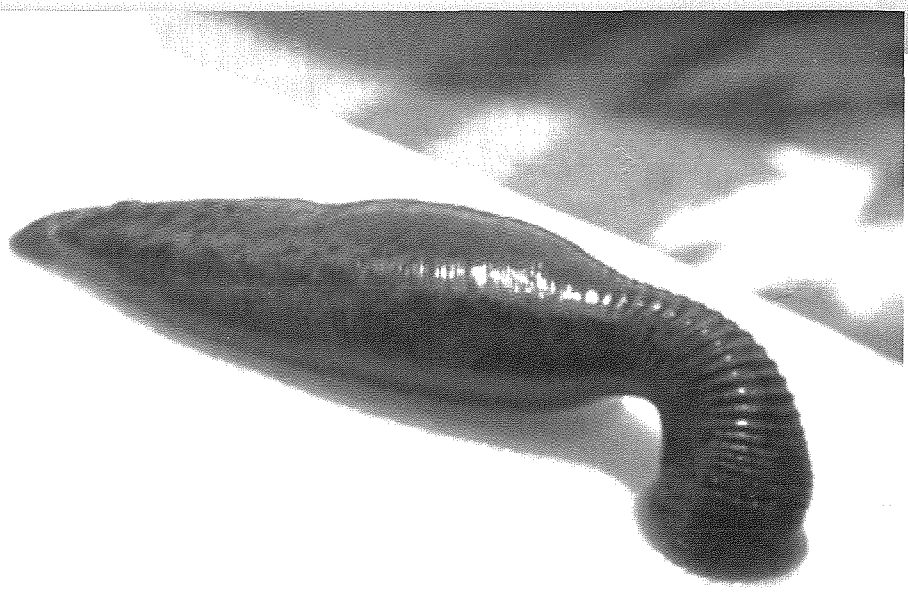
Maria Cutajar

Il-lingwa Maltija użata fid-dinja Medika

minn Joe Camilleri, Charge Nurse - It-Tielet Parti

Fl-ewwel u t-tieni parti ta' din is-sensiela ta' artikli ddiskutejna l-użu tal-kliem bil-Malti fid-dinja medika u allura wkoll fin-Nursing u f'dak kollu li għandu x'jaqsam ma' l-isptarijiet. Illum ħa nkomplu nagħtu aktar eżempji ta' dan.

Kliem ieħor li niltaqgħu miegħu huwa 'xgħir'/ 'xgħira'/ 'għajn tħammeġ' (*stye*); 'katarretta/i' (*cataracts*); 'żlieġa' fl-għajn; 'ħakk fl-għajnejn'/ 'għajn ħamra' (*conjunctivitis*); 'twerriċ' (*strabismus*); 'nefħa fil-kappell' tal-għajnejn; 'ċmajra' (riħ fuq riħ), 'flissjoni' (*runny nose*), 'konġestjoni fl-imnieħer'; 'riħ' jew 'influwenza' (*common cold* jew *flu*); ngħidu wkoll minflok 'riħ', 'deni tal-ħuxlief' jew 'deni tal-għatis' (*hay fever/allergic rhinitis*); 'fgat'; 'riħ fid-dahar'; tirziħ' jew 'tnemnim' (*numbness*); 'bruda' (*cramps*); 'fwawar' jew 'fawra tal-ġilda' (*hot flushes*); 'rogħda' jew 'tkexkixa' (*quiver*); 'gangrena' (*gangrene*); 'demm baxx' jew 'anemija' (*anaemia* jew *low haemoglobin*); trasfusjoni tad-demm (*blood transfusion*); 'pjastrini' (*platelets*); 'Manjesja' (*Milk of Magnesia*); 'żejt ir-riġnu' (mill-pjanta Ricinus/*castor oil*); 'qratas' (*sachets*); 'bil-ġebla' (*calculi*); 'ħa r-raġġi' jew 'inixxef il-kanċer' (*radiotherapy*); 'kielu l-kanċer', 'inbaram' jew 'mixrub'; 'niexef' / 'nixfa' (*dehydrated*); 'ħalq xott' (*dry mouth/ xerostomia*); 'telf ta' piż/għadma u ġilda/irquqija żejda' (*cachexia*); 'tumur' (*tumour*); 'tumurett' (tumur żgħir); 'massa' (*mass*); 'vixxri'/ 'interite'/ 'enterite'/'dijareja'/ 'fetħa'/ 'għamel imsarnu'/ 'għamel ilma'/ 'għamel maħlul' (*the runs* jew *diarrhoea*); 'uġiegħ ta' żaqq' jew 'barma'; 'tgergir/taqlib fl-imsaren'; 'bil-gass'/ 'mimli gass' / 'jitfa l-gass' jew 'jitfa r-riħ'/ 'jgħaddi l-arja'; 'bruda'; 'imxija' / 'bil-passa' (*outbreak*); 'disenterija'/ 'disinterija' (*dysentry*); 'ingwent' (*ointment*); 'duwa' jew 'idewwi' (*a medicament/ to apply a medicament*); 'mistura' (*medicine usually in a syrup form*); 'garża' (*gauze*); 'ħarqa' (*diaper*); stomatite (*stomatitis*); ulċerazzjoni (*ulceration*); 'ħrieq' (*burns*); 'tixwit' (*friction burn*); 'rieq' ('bżieq', 'bili' , 'sputu' jew *sputum*); 'katarru' (*catarrh*); 'sputatur' (*sputum mug*); 'ballu San Vitu' (*Sydenham's chorea*); rogħda (*tremor*); 'ħruq ta' stonku'/ fil-pipi (*heartburn* jew *dysuria*); 'għoqla fl-istonku' (*lump*); 'mrar'/ 'qrusa' (*acid reflux*); 'tifwiq' (*belching*); 'demm fl-awrina, fl-'ippurgar' jew 'minn wara', 'ra d-demm' ('ippurgar iswed' jew 'lewn il-qatran'), mal-bili jew mar-rimettar' (*haematuria, maelena, haemoptysis* jew *haematemesis*); 'ippurgar lewn it-tajn' (*clay-coloured stool*); 'ritenzjoni/ soppressjoni tal-awrina; 'rimettar'/'riġettar' jew 'vomtu'/ 'vumtar' (*vomit*); 'taqliħ' jew 'tqalliħ', 'dardir', 'nawsja', 'taqliba ta' l-istonku' (*nausea/stomach upset*); 'indiġistjoni' (*indigestion*); 'ulċera' fl-istonku jew 'ulċera ipperforata/ ulċera fis-sieq' (*stomach/leg ulcer*); 'barxa fl-istonku' jew 'fl-utru'; 'mard taz-zokkor', 'biz-zokkor' jew 'dijabete' (*Diabetes Mellitus*); 'għaraq bil-lejl' (*night sweats*); 'għandu l-ilma fil-pulmun/mal-pulmun, fl-irkoppa, maż-żaqq, mal-qalb' (*pulmonary oedema/ cirrhosis ecc*) jew 'se jneħħulu l-ilma' (*tapping/thoracocentesis/ knee aspiration/ pericardiocentesis*) ; 'mard tas-sider' jew 'tuberkolożi' (T.B. jew *tubercolosis*); 'għandu griżmejh'/ 'bi griżmejh'/ 'griżmejh juġawh' (*sore throat*); 'tagħrixa fil-griżmejn/ irritazzjoni/ħakk fil-grizmejn' (*itchy throat*)/'bit-tunsilli' (*tonsillitis*); 'ħanqa' (*throttle/courseness*); 'jisgħol' jew 'bis-sogħla'/ 'iqaħqaħ'/ 'tqaħqiħa'/ 'xrieraq'/ 'xerqa' (*coughing* jew *cough/dry cough*); Insibu wkoll 'sogħla konvulsiva' (*whooping cough* jew *pertussis*); 'sogħla ta' kelb'/ 'sogħla bil-bili'/ 'mimli'/ 'sogħla misjura'/ 'sogħla vojta'/ 'sogħla

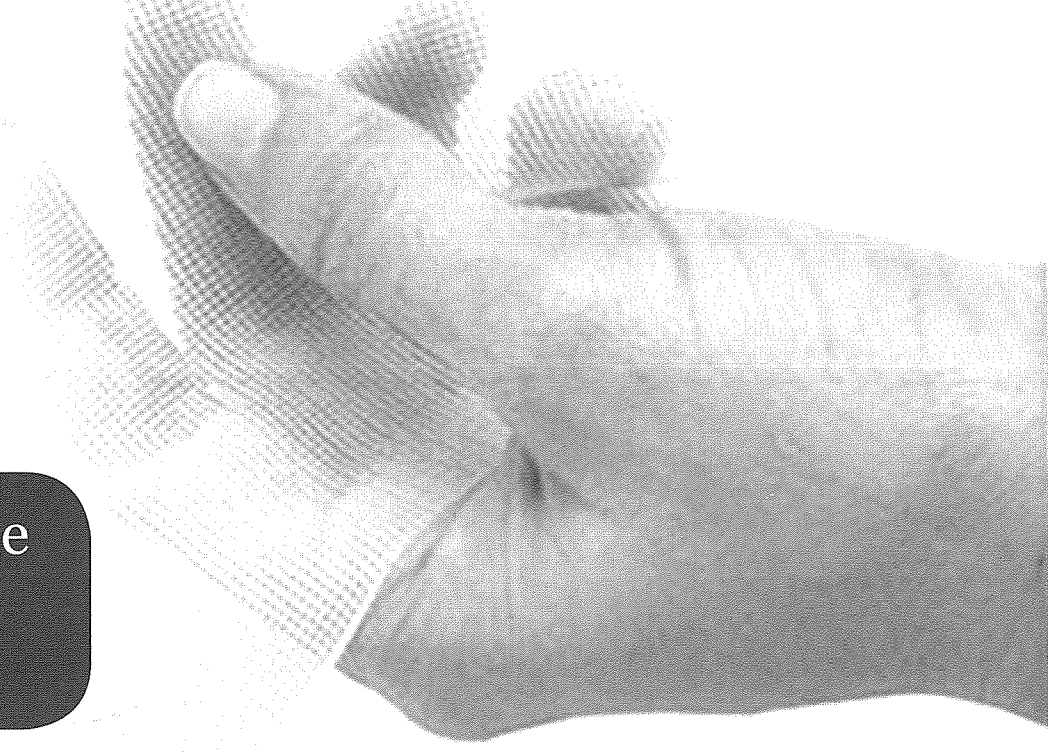


Is-sangisugi

xotta' wkoll; 'nefħa' / 'nefħa tnixxi' (*swelling /oedema/ weeping oedema*); 'bezzun' (*bump*); 'fiswet/biswet il-kelb' (*glandola* taħt il-ġilda/ *lymphadenopathy*); 'glawkoma' (*glaucoma*); 'ostjoporosi' (*osteoporosis*); 'artrite' (*arthritis*); 'rumattiżmu/rawmatiżmu/rewmatiżmu' (*rheumathoid arthritis/ rheumathic fever*); 'newralgja' (*neuralgia*), 'lumbagni' (*lumbago*); 'glawkoma' (*Glaucoma*); 'trakoma' (*trachoma*); 'meninġite' (*meningitis*); 'pesta' (*plague*) jew 'pesta Bubonika' (*Bubonic plague*); 'kolera' (*cholera*); 'tal-ilsien u dwiefer'/ 'deni tal-afta' (*foot and mouth disease/ coxsackievirus*); 'angina' jew 'djuq fil-koronarji'; 'attakk tal-qalb', 'trombosi koronarja' jew 'infart' (*heart attack, coronary thrombosis, myocardial infarction* jew *cardiac arrest*); 'uġiegħ fis-sider'/ 'dejjaq'/ 'tgħafis' (*chest pain*); 'mard kardjovaskulari' (*cardiovascular diseases*); 'faga' (mit-Taljan *affogare, to choke*) kultant tingħad 'vaga' jew 'soffokazzjoni'/ 'waqaflu n-nifs' (*respiratory arrest* jew *suffocation*); 'aspira' (*he aspirated*); 'sturdament'/ 'imdaħdaħ' (*dizziness, vertigo* jew *light headedeness*); 'epatite' jew 'epitate' (*Hepatitis*); 'emfisima' jew 'emfisema' (*emphysema*); 'tilqim' (*immunisation*); 'vaċċin' (*vaccine*); 'zokkra' (*sugar*); 'mikrobi' (*microbes*); 'ġermi' (*germs*); 'batterji' (*bacteria*); 'infezzjonijiet' (*infections*); 'infezzjoni virali' (*viral infection*); 'kontaġjuż'/ 'mard jittieħed'/ 'infettat'/ 'infettiv' / 'infetti' (*contagious / infectious*); F'Malta għandna 2 lokalitajiet imsejħa 'Tal-Infetti' li huma taħt il-Foss tal-Imdina u anke Birkirkara. Insibu wkoll 'rejazzjoni' (*reaction*); 'ħosba', 'ħosba Ġermaniża, (*German Measles, measles* jew *Rubella*); 'il-ġidri' jew 'ġidri r-riħ' (*small pox, chickenpox* jew *Varicella*); 'l-iskarlatina' (*Scarlet Fever*); 'Spanjola' (*Spanish fever*); 'rabbja' (*rabies*); 'kontaminazzjoni' jew 'dekontaminazzjoni' (*contamination* jew *decontamination*); 'sterilizzazzjoni' (*sterilisation*); 'pasturizzazzjoni' (*pasteurisation*); 'fumigazzjoni' (*fumigation*); 'gattone' (*mumps*); 'ħruq' jew 'ħarqa' (*burns*); 'ħruq ta' Sant Antnin' jew 'ersipla' (*shingles/herpes zoster/ erysipelas*); 'samta' (*scalds*); 'bukgħawwieġ' (*cramps*); 'sinusite' (*sinusitis*); 'ażma' jew 'ażżma' (*asthma*); 'ftuq' jew 'bażwa' (*hernia*); Fuq din tal-ftuq nisimgħu lit-tabib jgħid lill-pazjent biex 'jisgħol' meta' jiġi eżaminat; 'piressija' (*pyrexia*); 'konvulsjonijiet'/ 'aċċessjoni' (*convulsions*); 'ħajta deni', 'deni biered', 'deni qawwi', 'deni kwartjan', 'deni ta' żiemel', 'deni tas-suffejra', 'deni terzan', 'deni ta' kull erbat ijiem' jew 'deni bin-newba'; 'deni rqiq' (*Maltese Fever*); 'deni tifojde' (*thyfoid fever/enteric fever*); 'deni tifu' (*thyfus*); id-deni 'ħallih' (*afebrile*); 'settiċemija' (*septicaemia*); 'difterite' (*dyphteria*); 'ġdiem'/ 'imġiddem'/ 'tinġiż'/ 'imniġġeż' jew 'lebbra' (*Hansen's disease*); 'alopeċja' ('jaqa' x-xahar'/alopecia); 'imnifsejn misduda' (*blocked nose*); 'mħat' jew 'muku' (*mucous/nose secretions*); 'djuq fil-pajp tal-ikel' (*achalasia*); l-ikel il-pazjent ma 'jkunx jista' jiddiġerih' (*unable to digest food*); 'appendiċite' (*appendix*), 'astenja'; 'gotta' (*gout*); 'ħotba' jew 'għaqba (*hump*); 'sulluzzu' (*hiccough*); 'truxija' (*hard of hearing*); 'xatka'/'xjatika' (*sciatic pain*); 'ksur'/ 'frattura' (*fracture/s*); 'ifekkek'/'tfekkika' (*sprain*); 'jigbed/jilwi/jinqata' muskolu' (*strain*)'; 'ortopedija' (*orthopaedics*); 'nerv ikkripat' (*pinched nerve*); 'irkoppa tqarmeċ' (*patella meniscus tear*); 'kuxxinett tal-irkoppa' (*meniscus*); 'kurpett' / 'ċintorin tad-dahar' (*corset belt*); 'uġigħ tad-dahar' (*backpain*); 'uġigħ muskolari' (*masculapain*); 'antisepsi/antisettiku' (*antiseptic*); 'disinfettant' / 'disinfezzjoni' (*disinfectant/ disinfectant*); 'asettiku' (*aseptic*); 'aċidu karboliku/karboniku' (*carbolic/ carbonic acid*); 'aċidu boriku' (*boric acid*); 'permanganat' (*Potassium Permanganate/Condy's*); 'tetnu'/'tetanu' (*tetanus*); 'kaliko' (*calico*); 'irrigazzjoni' ta' diversi tipi (*irrigations*); 'punti' (*sutures*); 'ħarir' (*catgut*); 'tajjar' (*cotton wool*); etere (*ether*); 'pulmonite' jigifieri 'riħ fis-sider'/ 'fil-pulmun'/ 'pnewmonja' (*pneumonia*); 'perikardite' (*pericarditis*); 'plewro-pnewmonite' (*pleura-pneumonia*); 'kardite trawmatika' (*traumatic carditis*); 'plewrite' (*pleuritis*).

Kliem ieħor imma li spiċċa kompletament (jew kważi) huma 'fumenti' (tat-termentina/tal-laudnu/ tax-xaħxiħa/tal-kamumilla/*spongiopilina*'), 'kataplismi'/ 'ġbara'/ ' ġbara sħuna' jew 'sufa sħuna' (*poultices*), 'fintużi' (*cupping glass*), 'sponżaturi' (*sponging*), 'arkett' (*bed cradle*), 'twittija' (*bed making*), 'inċirata' (*mackintosh*), 'pjagi tad-dekubitu' (*pressure ulcers*), 'sputaturi' (*sputum mugs*), 'lavattivi' (*laxatives*), 'klistier'/ 'enteroklismi' li jfissru 'pompa' jew 'enema', kelma li ġejja minn clyster,

• ikompli f'paġna 36



Controlled Release Silver Dressings in Wound Care

Background: Treatment of antibiotic-resistant bacterial infected wounds poses a major problem in wound care. The development of silver-containing wound dressings has improved the local management of critically colonised and infected wounds. Silver is a broad-spectrum agent effective against a large number of Gram-positive and Gram-negative microorganisms, many aerobes and anaerobes, and several antibiotic-resistant strains such as methicillin-resistant staphylococcus aureus and vancomycin-resistant enterococci[2]. Unfortunately, released silver ions are cytotoxic to human cells, and there is an inherent problem balancing antimicrobial activity against cytotoxicity. Technically, this issue can be addressed by controlling silver ion release by varying the amount of available silver in the dressing, the surface area of the silver particles and the chemical composition of the silver preparation[1]. Although all silver dressings are assumed to be safe and effective, it is important to note the ways in which silver acts physically and chemically[2].

How it works: Silver ions absorbed into the wound site, bind to bacterial cell membranes and are transported into the cell. Interfering with the membrane transport system, silver ions impede the bacterial cell's energy source and disrupt peptidoglycan within the wall, causing structural damage. Inside the cell they bind to DNA, impairing cell replication; they also bind to and inactivate intracellular enzymes. The bacterial cell is then prevented from growing or replicating, and often dies as vital components leak through a weakened cell wall [2].

Physical and Chemical Properties: Different isotopes of the same element behave the same chemically but have different physical properties, which can affect their clinical behavior. The total amount of silver in a dressing, as well as its crystalline structure, contributes to how much and how quickly silver is dispersed from the dressing onto the wound surface. If a given amount of silver is divided among a large number of smaller crystals, its chemically active surface area will be greater than when the same amount is divided among fewer, larger crystals[2].

Antimicrobial Effects and Toxicity: Silver compounds in various wound products differ in the manner and speed with which they release the bactericidal silver ions[5]. With enhanced bacterial killing effects, there is also concern clinically that too much silver could be delivered into the tissue, resulting in adverse effects on wound healing[6]. Three in-vitro studies have shown that the release of nanocrystalline silver from dressings is toxic to keratinocytes and fibroblasts[3]. A comparative study of 5 different Silver dressings showed a strong inhibition of wound re-epithelialisation occurring when using 2 of the dressings[7]. Another comparative study of 3 different silver dressings showed that nanocrystalline silver results in a fast and strong silver release, associated with significant cytotoxicity[1].

The way forward: Indiscriminate use of any material is inappropriate and product choice should be based on published scientific evidence[4]. Although some silver product companies will boast about how much silver their dressing contains, it has still not been shown that a larger amount of silver in a dressing necessarily results in better clinical outcomes[2, 5]. Cytotoxic effects of silver should also be considered when deciding on wound care dressings[9]. The choice of an appropriate antibacterial dressing should be based on the wound type and condition and on clinically applicable measures and not on any single laboratory parameter[6]. Cost is also an important factor to guide dressing choice[10], considering that NHS (UK) expenditure on silver dressings in 2006/7 amounted to £25million[11].

Conclusion: Selection of the right dressing is vital for successfully managing infected wounds and those prone to infection. Besides balancing the antimicrobial action with cytotoxicity, the ideal dressing should also minimize trauma on application and removal and conform well to the wound bed[12]. Clinical evidence and laboratory tests have shown the beneficial profile of action, of low toxicity and potent antimicrobial action, of sustained release, also known as controlled release type of silver dressings[1,8,12].

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

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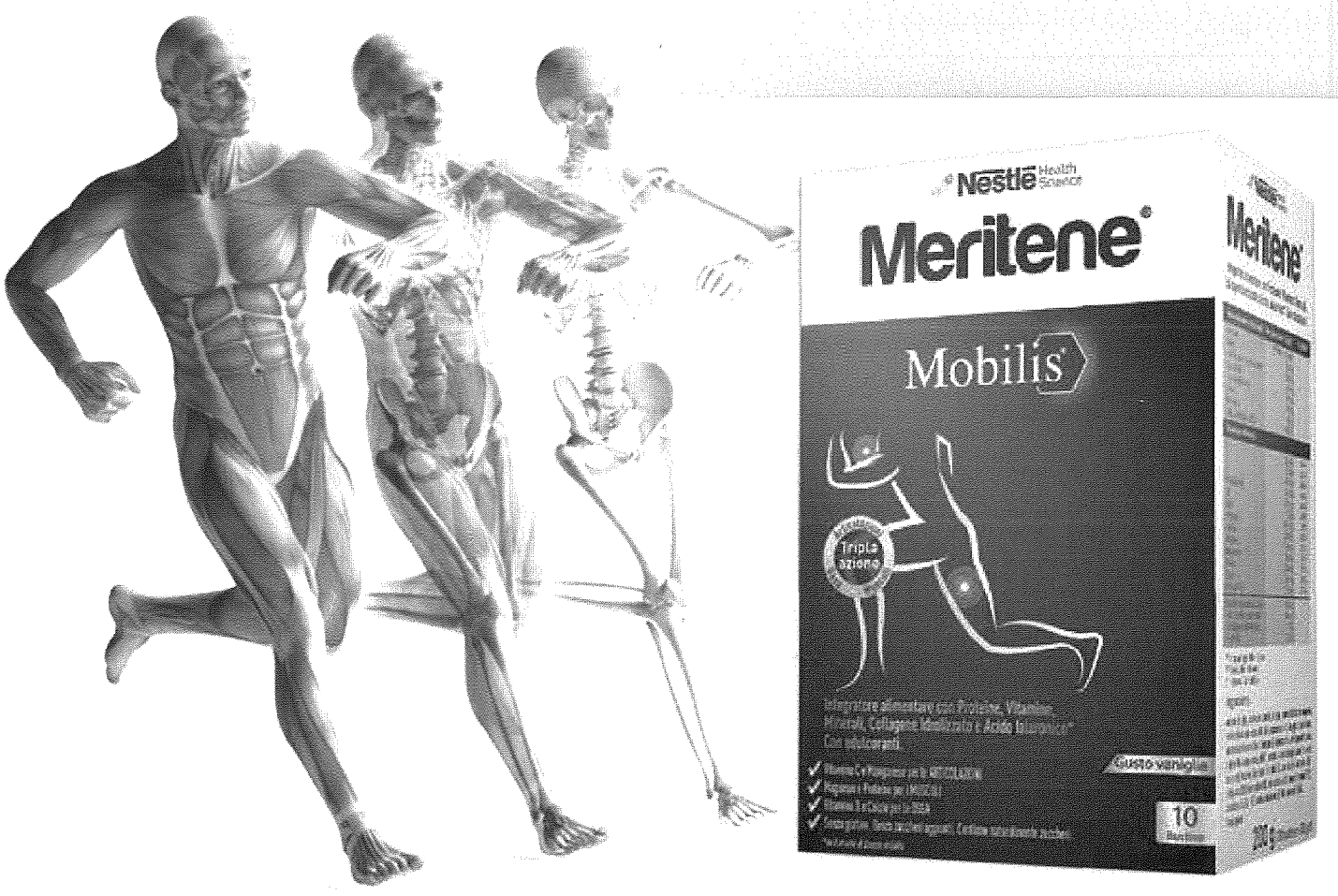

Protein intake in adults for muscle and bone health

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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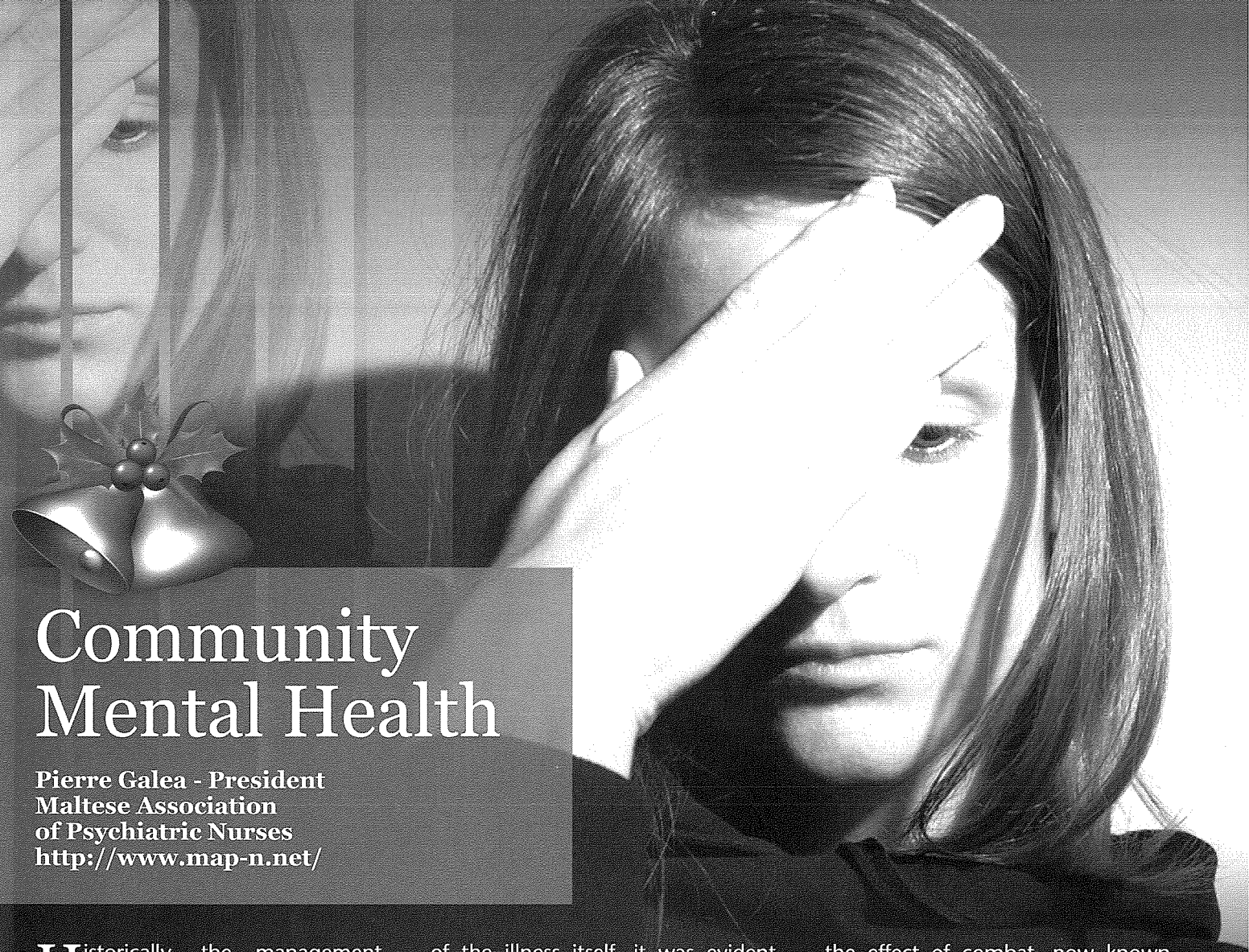

Community Mental Health

Pierre Galea - President
Maltese Association
of Psychiatric Nurses
http://www.map-n.net/

Historically, the management of mental illness was about restraint and segregation. Nowadays, it's completely about the opposite, it's about engagement and integration. So what brought about this change?

Community mental health is a concept which internationally started in the 60's and 70's, and was instigated by what is known as the process of de-institutionalization (Barton, 1976). Russell Barton had noted that patients who were treated in hospital for long periods of time, developed symptoms which were beside the symptoms of mental illness. These were characterized by a loss in personal abilities and functions, and manifested in loss of individuality, apathy, and loss of interest in activities which are considered part of the daily life of every human being. This was named by Barton as "Institutional Neurosis". Although it is unclear how much of these symptoms were the result of the illness itself, it was evident that long periods of hospitalization were, if not causing, maintaining and exacerbating these very dilapidating symptoms. The causes of Institutional Neurosis were factors which were associated with large psychiatric hospitals (or asylums as they were known at the time). These included loss of contact with the outside world and lack of activities associated with daily functioning, which most often were catered for by the institution itself. Other factors which contributed towards institutionalization were lack of daily structured activities, loss of friends and personal possessions, poor ward atmosphere and an authoritative approach by the hospital staff (Barton, 1976).

Interestingly, the Second World War was a major influence towards community care. Mental health care became highly valued when it was a major aid for soldiers who were returning home suffering from the effect of combat, now known as Post – Traumatic Stress Disorder (PTSD). Most people were much against high regarded soldiers being treated in rundown asylums and most care was given into what was known as therapeutic communities. This promoted soldiers helping themselves, which had similarities to what today is recognized as support groups. Moreover, any measures were taken to prevent these soldiers from being admitted to hospital, and so, most of the care was provided in the community.

Another factor which contributed towards community care, was medication (Burns, 2006). Chlorpromazine was founded in the 1950's by a French anesthetist who noticed that it had a calming effect on patients post-operatively. This was consequently used in psychiatry, and its effect on symptoms of mental illness was remarkable. For the first

• **continued on page 38**

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Katrina Camilleri għandha 20 sena, u hija waħda mill-mija u erbgħin infermier ġdid li t-Tnejn li għadda bdiet taħdem fl-Isptar Mater Dei.

Ma' One News Katrina qalet li sa minn ċkunitha dejjem ħasset il-ġibda għal din il-vokazzjoni li fiċ-ċentru tagħha għandha l-pazjent.

Għas-sitt xhur li ġejjin, katrina u l-infermieri l-ġodda se jaħdmu f'oqsma differenti tal-isptar biex wara jiġu assenjati post iktar permanenti.

Katrina saħqet magħna kif matul it-tlett snin ta' studju fl-Università kien hemm element qawwi ta' prattika iżda wkoll ta' riflessjoni, "għax aħna niltaqgħu ma' ħafna problemi ta' ħafna nies matul dawn it-tliet snin u tkun għadek ma drajtx ma toħodhomx miegħek id-dar u allura trid tagħmel ħafna riflessjoni".

> "L-aqwa li f'dak li nagħmel f'xogħli fil-futur tiegħi, inkun sigura għall-pazjent u nagħmel x'nagħmel, anke jekk ikolli tnax-il siegħa f'ġurnata, anke jekk inkun għent persuna waħda u għamiltilha l-ġurnata aħjar, għalija dak huwa sodisfazzjoni biżżejjed".

Hija tkellmet ukoll dwar id-differenza minn fuq il-bank tal-università għas-swali tal-operazzjonijiet fl-isptar, fejn "issa taqa' ħafna responsabbilità fuqek u barra minn hekk inti qed tieħu deċiżjoni għall-pazjent u dak li tagħmel, ħadd m'hu ser jiġi jgħidlek "isma dik m'għamiltiex tajba.." Inti trid issaqsi jekk filkas ta' xi opinjoni."

Marylene Zammit hija infermiera ġdida oħra fl-isptar Mater Dei. Saħqet li xtaqet issir infermiera bl-iskop li 'l quddiem tkompli tistudja għal tabiba. Madankollu qalet li tħoss li sabet postha.

"Għażilt in-*nursing* biex inkompli għall-mediċina, għax jogħġobni ħafna għarfien u l-istudju tal-anatomija u l-fiżjoloġija tal-bniedem, imma sibt li n-*nursing* jikkumplimenta ħafna l-personalità tiegħi. Itini opportunitá kbira fejn nista' nuża l-*empathy* u l-*compassion* fejn jidħol il-pazjent u r-*relatives* u ġieli anke ma' *staff* stess."

L-infermiera Katrina Camilleri saħqet li l-għan tagħha dejjem se jkun li ġġib il-pazjent l-ewwel u qabel kollox:

"L-aqwa li f'dak li nagħmel f'xogħli fil-futur tiegħi, inkun sigura għall-pazjent u nagħmel x'nagħmel, anke jekk ikolli tnax-il siegħa f'ġurnata, anke jekk inkun għent persuna waħda u għamiltilha l-ġurnata aħjar, għalija dak huwa sodisfazzjoni biżżejjed".

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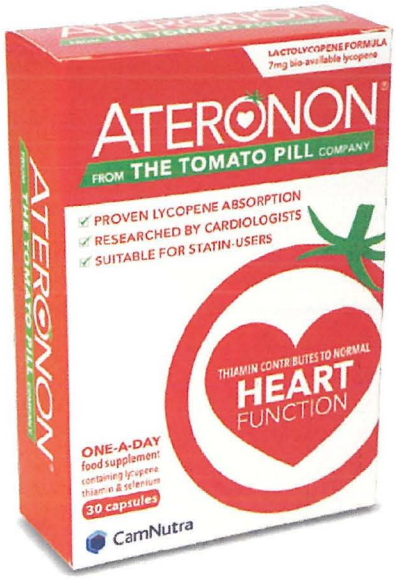

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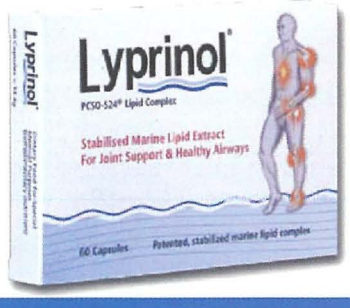

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...from our diary

MUMN 1996
Malta Union of Midwives and Nurses

The Pensioners Group Committee organised another successful outing where they recognised the strong commitment of one of their members.

The FNBF Group Committee organised another successful ceremony for those nurses and midwives who retired from work at the Presidential Palace.

The FNBF Group Committee with H.E. President of Malta during the Annual FNBF Cermony.

The presentation of certificates to the successful candidates after MUMN & the UOM organised a joint course on Management.

A Press Conference to announce that MUMN signed another Sectoral Agreement for Nurses & Midwives with a 5 year duration.

An old photo where one can see the facade of the St. Vincent de Paul's Residence with the staff posing for the photo.

The Extraordinary General Conference started with a minute silence as a sign of respect to our fellow nurses who passed away during these last weeks.

The Nurses & Midwives present at the Extraordinary General Conference voted to give approval to the MUMN Council to sign the New Sectoral Agreement.

Infermier f'San Vinċenz de Paule jirbaħ il-premju Ħaddiem tas-Sena

Rapport: Mario Micallef - TVM

Infermier li jmexxi sala fir-residenza għall-anzjani San Vinċenz de Paule huwa r-rebbieħ tal-Premju Ħaddiem tas-Sena.

"Iddeċidejt li ninnomina lis-Sur Anthony Borg minħabba l-kwalitajiet umani, umli u l-professjonaliżmu lejn il-pazjent, lejna u lejn kulħadd." "Għandu ħafna kwalitajiet sbieħ li jagħmluh tajjeb biex ikun il-ħaddiem tas-sena. Dejjem żamm bilanċ bejn l-impjegati u r-residenti, però dejjem żamm f'moħħu li r-resident għandu tiegħu u l-impjegat għandu tiegħu wkoll."

Hekk iddeskrivew lil Anthony Borg, Nursing Officer fis-sala St Joseph 4 f'San Vinċenz de Paule, l-impjegati li nnominawh għall-Premju Ħaddiem tas-Sena. Malli ġie mħabbar bħala r-rebbieħ fil-kategorija "Il-Ħaddiem Mudell tas-Sena", Anthony irreċiproka bi kliem ta' radd il-ħajr lill-istaff kollu tas-sala.

"Għax mingħajr il-ħidma tagħhom ma nistax nirbaħ dan il-premju żgur. Għax trid l-għajnuna ta' ħaddieħor. Ħadd ma jmur il-ġenna waħdu, kif jgħid il-qawl Malti, dejjem jieħu lil xi ħadd miegħu. Hekk irnexxieli bil-ħaddiema tiegħi nirbaħ dan il-premju," qal l-Infermier Borg.

Il-Ministru Dalli qalet li l-istess bħall-għanijiet ta' dawn il-premijiet, il-Gvern bid-deċiżjonijiet li qed jieħu qed jirrikonoxxi u japprezza s-sehem tal-ħaddiema fl-ekonomija.

Il-Ministru Dalli qalet li l-Gvern irid jibgħat il-messaġġ li meta tinvesti fil-ħaddiema, tkun qed tinvesti fl-intrapriża li tmexxi, għax b'hekk iżżid il-produttività. Qalet li dan ir-raġunament kien rifless fis-suċċess bla preċedent li kiseb il-pajjiż, li llum għandu l-anqas rata ta' qgħad fl-istorja.

Growing, preserving and transitioning of wealth

The Seneca asked "How many funerals pass our houses? Yet we do not think of death. How many rich men suddenly sink into poverty before our very eyes, without its ever occurring to our minds that our wealth is exposed to exactly the same risks? When, therefore, misfortune befalls us, we cannot help collapsing all the more completely, because we are struck as it were unawares: a blow which has long been foreseen falls much less heavily upon us."

The only certainty in our life is that we must one day pass on. Yet it is only because we know that we must one day leave this life that we can live our life today, dedicated to the people and things we care about most.

An important part of our peace of mind is knowing that once we do pass away, that which we have worked so hard for throughout our lives will continue to be of help to our loved ones. The best way of assuring ourselves and not being caught unawares is to plan ahead.

Each stage in our life brings with it different experiences and requirements, particularly in the financial aspect – from the generation of wealth stage, to the accumulation, protection and distribution of wealth.

From the first bit of change we are given as pocket money to buy our first packet of stickers or put in our "karus", we are quick to learn the value of managing our earnings. Much of what we are taught as children carries on later in life.

Whilst not everyone may follow the same pattern or has identical financial requirements throughout their life, there certainly are similarities.

We all have different goals in life and managing ones wealth is a personalised approach. It is fundamental for the Financial Advisor who is managing your wealth to understand you, your present position and circumstances to draw up a bespoke financial strategy.

By taking the lifecycle approach to financial planning, the Financial Advisor takes into account the investor's life path to craft the most suitable portfolio of sound investments: whether proactively seeking high-growth opportunities earlier in life or building a defensive strategy meant to preserve capital in preparation of retirement.

As young adults, we tend to prioritise our careers while also entering marriage and beginning and family. Buying our first home usually comes hand in hand with our first home loan. Building a career earns you money, but lifelong learning entails significant expense, especially at the postgraduate stage. Finally, weddings –from the engagement ring to the honeymoon – also involve significant expense.

Our midlives are more settled: our earnings are at their peak and our family is established. We slowly come to terms with our parents' ageing and our responsibilities of caring for them as they cared for us. Assisted living facilities would need to be considered and, coupling the ageing demographics with economic realities of demand and supply, these can be expected to become more expensive. Our children have also grown now and we may feel the responsibility to help with the wedding expenses.

It is very common to reach a maximum income level between the age of 50 and 60. This stage may be considered as the 'freer' stage, with the likelihood of children who have graduated and empty nests. Savings for retirement may be accelerated during this stage.

Just before retirement is usually a stage where investors start to take stock of their investments, reduce risk and target increase in stable income.

Eventually, at retirement the focus shifts to the preservation of income. This is also a stage where clients may decide to consider estate planning.

Investment services are there to assist investors throughout each of the stages of life – helping you plan for each stage whilst maximise returns in a knowledgeable and wise manner. Experienced guidance is provided at each stage the investor feels that his/her personal circumstances have changed.

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Health Literacy and Cancer Preventive behaviours

Justin Attard SN. B.Sc.(Hons) Nursing, Pg.Dip Nutrition & Dietetics, MSc. HSM
Supervised by Dr. Kenneth E. Grech M.D. (Melit), MSc. (Lond), MBA (Melit), DLSHTM, FFPH (UK)

Exploring the impact of Health Literacy of the Gozitan population on the uptake of the National Colorectal Screening Programme

Colorectal cancer (CRC) is one of the most common cancers in the world, with an increasing incidence in developed and developing countries worldwide, yet it's highly curable and preventable if detected and localised at an early stage 1-3. In Malta, an average of more than 250 males and females were diagnosed yearly with CRC (in 2012, 2013 and 2014) 4. Moreover, the mortality rate due to CRC (in both genders) was found to be slightly above the EU average, while the incidence rate (for both genders) is lower than the EU average 5.

In November 2012, the National Colorectal Cancer Screening Programme was launched to ensure screening of those at the highest risk (those being between 55 and 66 years of age) and receiving appropriate treatment and follow-up. The screening test utilised is the FOBt (Faecal occult blood test) which is sent through a mail invitation, hence the invitees incur no expenses and ensure total privacy.

In spite of that, the impending issue of low uptake of CRC screening is present, with only half of the invitees are accepting the invitation to participate, putting the Maltese population at a considerable risk for late-stage presentation of CRC 6, 7. This means that at the moment, the coverage mechanism of the National screening programme is inefficient, as it's not reaching the targeted population.

Health literacy is defined as the "...the degree to which individuals can obtain, process and understand, and communicate about health-related information needed to make informed health decisions" 8, and together with the elements of 'income' and 'education' were found to be the leading causes of inconsistencies and disparities in CRC mortality 9-11. For the local context, the ability to pay does not necessarily explain uptake inequality, as the National Screening Programme is offered for free to all those who are eligible. On the contrary, education and HL are strongly related, possibly leading to negative expectations and beliefs about screening, creating imbalance in participation rates 10, 12-14. The element of HI was also

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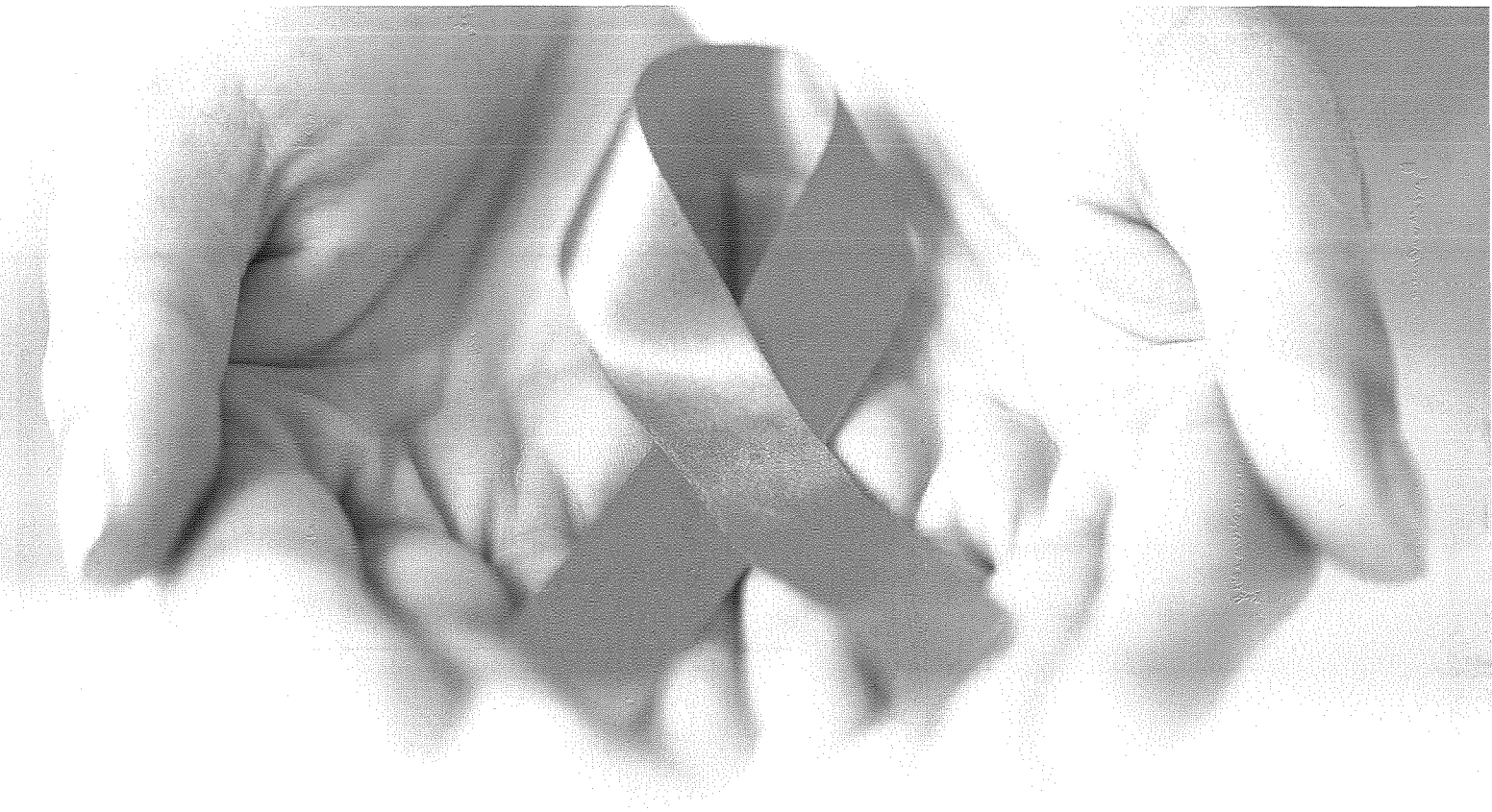

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found to be highly associated with low screening rates, even when equal access exists 9, 12, 15, 16. This means that HL is a key determinant of health and can explain variations in health status among different populations 17.

Low HL levels affects 45.8% of the Maltese population, while the Gozitan population were termed as 'vulnerable' as more than 50% of the population were found to have limited or inadequate HL levels 18. For the present study, the researcher was able to explore the effect of HL, together with other demographic variables on the completion of FOBt, of those born between 1949 and 1959 in Gozo and underwent the first screening phase. The author found that the element of HL was strongly related to the acceptance of CRC screening invitation in Malta. Those with an adequate HL level were highly significant and positively associated with the completion of the FOBt. As a matter of fact, the participants having inadequate or marginal HL were 3 times more likely to conduct the FOBt when compared with those being illiterate. Moreover, the age range of 61 – 66 years, together with the element of a previous cancer diagnosis, and being able to carry out an informed decision, were all associated with a higher uptake of CRC screening. On the other hand, those having weak HL skills were more likely to suffer from a decreased ability in understanding the real effect of screening behaviour, leading to non-uptake. Low HL levels are associated with riskier behaviour, poorer health, less self-management and more hospitalisation and costs 19, 20.

The results achieved through this study shed light on whom to target, and what are the main elements hindering the acceptance of CRC screening invitations in Malta. One of the strategic directions of the National Health Systems strategy for Malta 2014-2020 is the strengthening of disease prevention and health promotion. This can be achieved through a variety of actions, such as: making sure about the viability of a cancer screening programme; the re-evaluation of evidence and review of existing guidelines, the setting up of an outreach programme and active involvement of the GP, with the aim to effectively reach the eligible and high risk people; the bundling of CRC screening with another preventive health intervention in primary care practice and by the provision of gloves with the FOBt kit to reduce the visceral response and beat the element of disgust 21, 22.

Moreover, other recommendations that focused on the amelioration of the HL level of the population were highlighted: HL should be set high on the main public health agenda for policy makers; using social marketing through creative development of health education programmes; the transmission of health information amongst the health care professionals, patients and within the whole population via 'community-based educational outreach' and through a properly set 'Patient Navigation process', which is a decision support tool administered through specialised health care professionals, able to offer one-to-one support and address specific barriers in accepting the CRC screening invitation.

You can contact Mr. Justin Attard on justin.att@gmail.com for any clarifications and references.

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by brieann.rn@gmail.com

The hardest part about nursing that nobody knows

I was recently helping another nurse clean up an incontinent, elderly patient. She was so weak and deconditioned that she couldn't help us turn herself even a little bit, and she wasn't a small lady either. I stood straight and tall as I held her weight, trying to save my back and my co-worker grabbed washcloth after washcloth to mop up the liquid stool that had pooled underneath the woman. The aroma of diarrhoea that can only be associated with a gastrointestinal bleed permeated the air, and we worked quickly since the patient's lungs wouldn't allow her to remain flat for long.

The patient's daughter stood against the far wall. She exclaimed, "Gosh, Momma, that stinks!"

But to us she commented, "I don't know how y'all do it, day in and day out. Y'all are better people than me!"

Nurses, she meant. And it was true; we did deal with poop on a daily basis. As an ICU nurse, and not having the assistance of auxiliary staff, I personally changed and cleaned all my incontinent patients. Then I helped my co-workers clean there's too. Antibiotics made people sick to their stomachs, and yep, bleeding was common also. Then of course the Gastroenterologist would have us give them medicine to make them totally evacuate their bloody bowels! It could get pretty crazy. But that wasn't the hard part of my job. Not even close.

So many times my patients would ask me how long I was there until, and when I responded, "oh, about 7:30," they'd get wide-eyed.

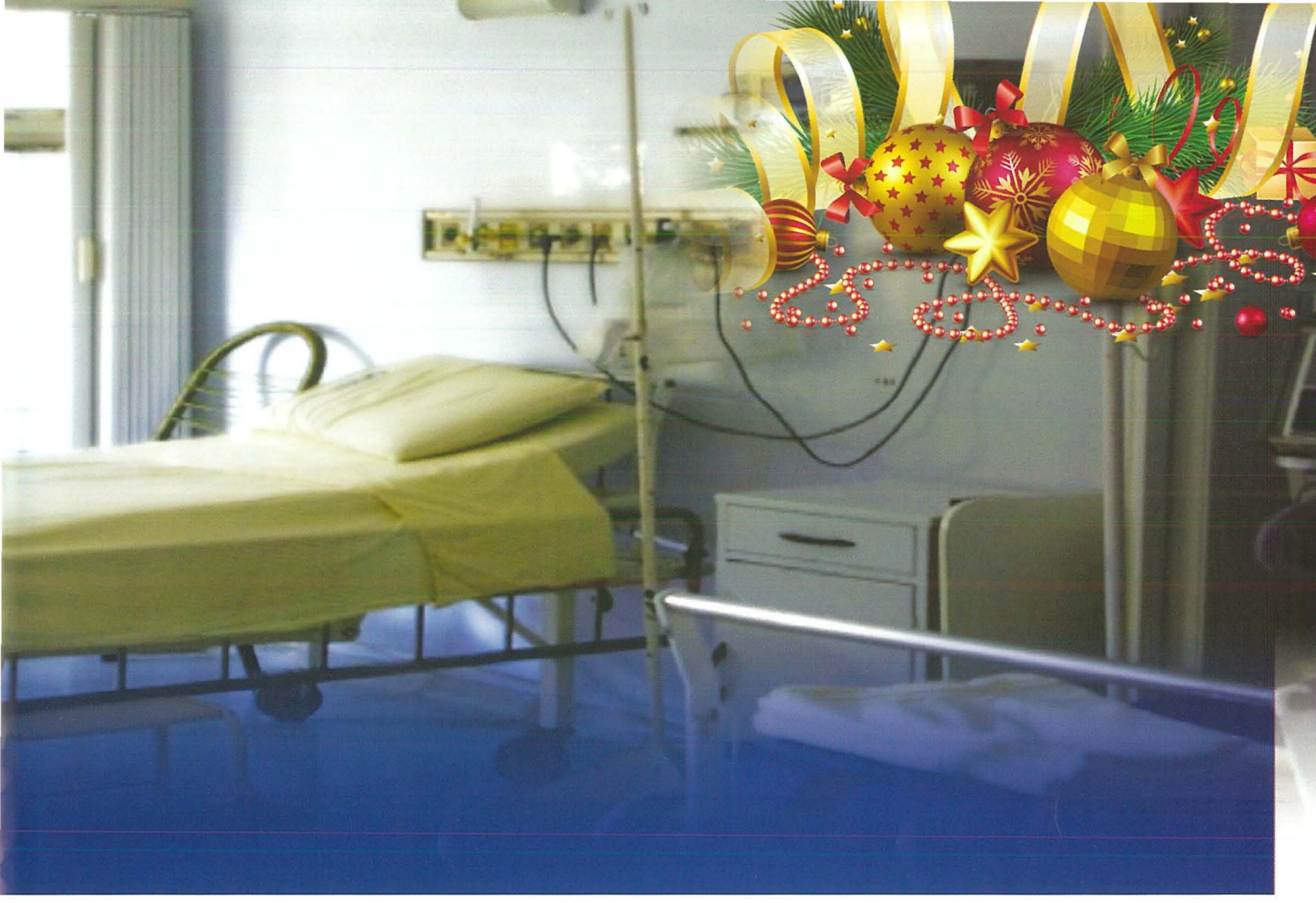
"That's a long day! 12 hour shifts, huh?!" They'd ask incredulously.

If you've followed me for any length of time then you've heard me talk about The Nurse Hangover. It's that fog you find yourself in after a string of consecutive 12 hour shifts. It's crazy. And yes, it's hard. But it's not the hardest thing I do. Not even close.

My poor husband gets to hear me vent about things like increased charting requirements, billing reimbursement and how that affects my job, or the dreaded white board. I'm still amazed people get paid just to check and make sure I keep that information board updated in the room of my sedated, ventilated patient who never has visitors. But I digress. The administrative duties of my job that prevent me from spending quality time at the bedside are aggravating, but they're not the hardest part of my job. Close. But not really.

I can still recall what I consider one of my worst days. I have never been so emotionally and mentally exhausted than I was after watching my postpartum patient at risk for DIC hold her dead baby and cry. She dressed his 36 week old body in the blue, striped sleeper she was supposed to have him wear home, and she sang to him while she stroked his small, cold head. There was nothing I could do.

I still remember holding a homeless, nineteen year old daughter as she broke down against me. Her devastated tears soaked my hair, her flakes of skin from out of control psoriasis covered my dark scrubs, but I didn't care. All I could do was hold her as she looked over



my shoulder at her dead mother on the bed. The mother she didn't even know was sick. She had no family or friends nearby, no home, no money, no food, and now no mother.

I still remember the day I coded a new admission 30 minutes after her arrival. It happened so quickly. As I began cleaning her up after the code was called and she was pronounced dead, all I could see was her grown son, scared, and kissing her on the cheek just a little while ago. "I love you, Mom," he had said. He didn't even know yet she was dead. I broke down crying. I had seen so many people die, had done so many codes, but that day I broke when I pictured a loving son's last moments with his mom. Maybe I was thinking of my own mom who I never got to tell goodbye.

I can still remember standing with the doctor in the hall as he explained to a mother that her 25 year old son was brain dead, that there was no hope for recovery. She collapsed on the floor in hysterical tears. She just kept wailing, "no, no, not my baby!"

So many days I have stood at the bedside for hours, never leaving, changing the numbers up and down on multiple IV medications to make the numbers on the monitor stay in the realm of something compatible with life.

The aroma of diarrhoea that can only be associated with a gastrointestinal bleed permeated the air, and we worked quickly since the patient's lungs wouldn't allow her to remain flat for long.

I've walked in to assume care of a patient who was breathing like a fish out of water far too long, and then looked at his face and realized we graduated high school together. I've held a lot of hands after deciding to remove life support, and I've prayed with patients more times than I could possibly count. There's a lot of things about Nursing that are difficult, perhaps even disgusting to some.

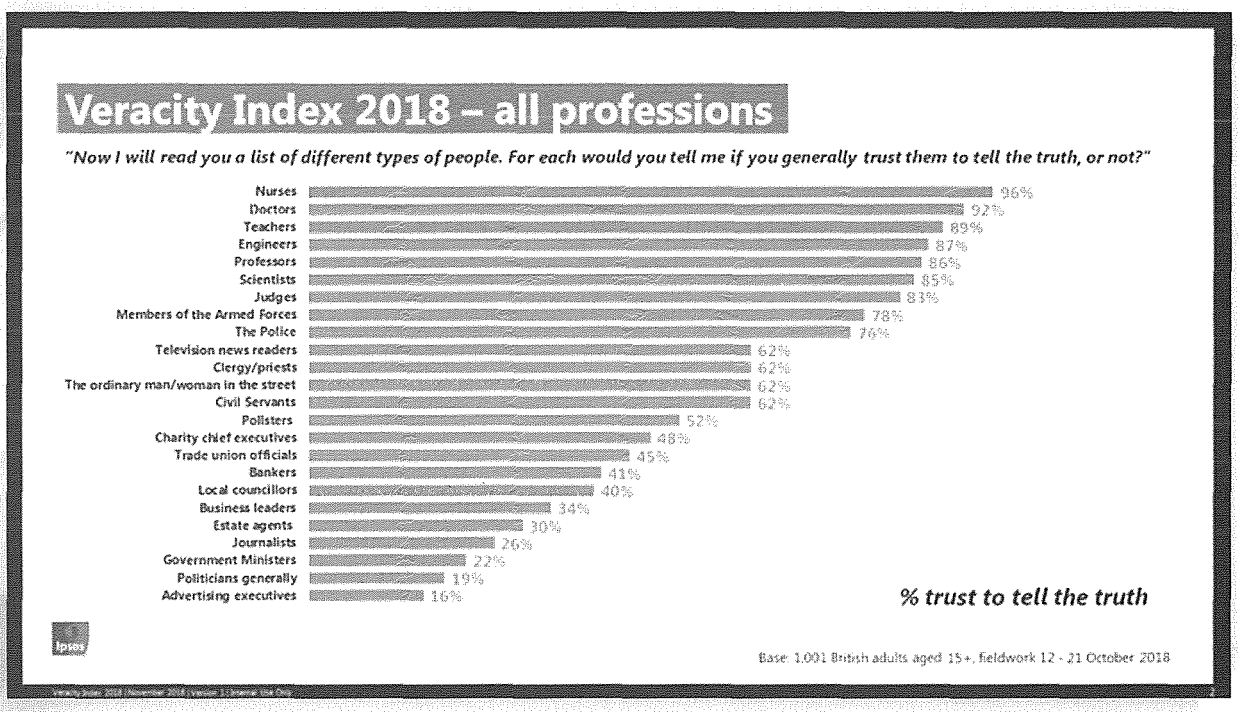
Many days I get highly aggravated at documentation requirements or problems with supplies and the pharmacy. The days are long, and after a shift where I've fought tooth and nail to keep another human being on this side of heaven, haven't eaten lunch, or barely had time to pee, I will think I need a huge pay raise! When we're short-staffed, dealing with that family member you just cannot please, or getting swung at by an agitated patient, it's tough work! But I tell you this… those things don't even touch the surface of the hard parts about this job. You can think you know why it's hard, but unless you've stood at the bedside and comforted a gentleman as he weeps for his wife of 56 years taking her last breath, you really have no idea. That's the hard stuff. That's the stuff we don't talk about. That's the stuff we try to leave at work, but when we pull into our driveway after a particularly trying day, where we faced the things we could not change, and we finally let the weight of it hit us, that's what's hard about Nursing.

Nursing once again tops chart of most trusted professions

by Jo Stephenson - Reporter

Nursing has once again been identified as Britain's most trusted profession with the vast majority of the public saying they have confidence in nurses to tell the truth.

According to Ipsos MORI's Veracity Index for 2018, a whopping 96% of people have faith in nurses to tell them the truth – up from 94% in 2017.



Nursing has once again come out on top of Ipsos MORI's Veracity Index

The long-running annual survey of more than 1,000 adults shows nurses rank above doctors at 92%, teachers at 89% and engineers at 87%.

Nurses are also more trusted than professors, scientists, judges and the police, having topped all other professions since being added to the list in 2016.

Donna Kinnair, acting chief executive and general secretary of the Royal College of Nursing, said the achievement was "well-deserved" but warned that public appreciation would not fix staff shortages or falling student numbers. The poll, which has been undertaken every year since 1983, shows Britons are mistrustful of politicians with only about one in five – 22% - having faith in government ministers.

When it comes to "politicians generally" that drops to 19% just up from the lowest ranking profession – advertising executives at 16%, included in the list for the first time this year.

However, the poll shows people are more inclined to trust civil servants, such as those working behind the scenes at the Department of Health, who have seen their standing rise over time.

This year 62% of those surveyed said they trusted civil servants to tell the truth – up from 59% in 2017 and 56% in 2016.

Civil servants have been the strongest risers in all the time the Veracity Index has been going with public trust in the profession increasing 37 percentage points since the poll first took place.

> "It is a testament to the hard work and care nursing staff provide to patients"
> - Donna Kinnair

The index also shows how various factors in people's lives such as political outlook and personal circumstances affect how likely they are to trust different professions.

While some professions see wide variations in trust from different groups, the data appears to show nursing is almost universally trusted by all sections of society.

For example, 98% of people who voted Conservative said they trusted nurses compared with 96% of Labour voters.

Of those who voted remain in the referendum on the UK's membership of the EU, 97% said they trusted nurses compared with 96% of those who voted leave.

Meanwhile, people with degree-level qualifications were equally likely to trust nurses as those without with 96% from both groups saying they felt nurses told the truth.

Dame Donna said: "This is a proud and well-deserved achievement for our profession. It is a testament to the hard work and care nursing staff provide to patients.

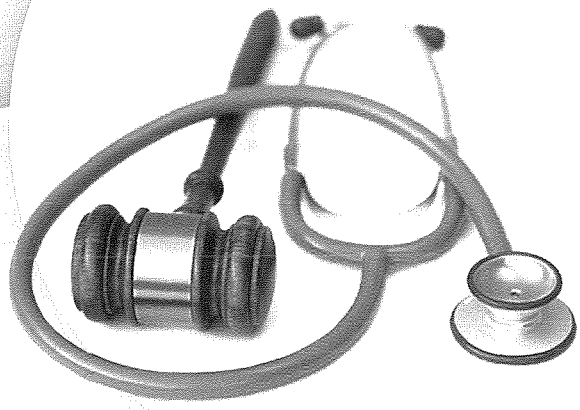
"Public appreciation will not fix staff shortages nor reverse falling student nursing numbers.

"As nursing vacancies in England increase and are expected to hit 48,000 in the next five years, the government must do more to show nurses they are valued."

She called on ministers to put at least £1bn a year back into nursing higher education.

"The public is on the side of nurses, the government must now build the future nursing workforce of tomorrow," Dame Donna added.

Nurses & Human Rights



This month's contribution is inspired by a heartfelt speech recently made by Her Excellency the President of Malta Marie Louise Coleiro Preca. The speech was delivered during an annual activity organised by MUMN and hosted by the President at San Anton Palace. Her Excellency referred to the relationship between nurses and the promotion of human rights. This is in fact quite a relevant and timely topic, as 70 years ago, precisely on the 10th of December 1948, the United Nations General Assembly adopted the Universal Declaration of Human Rights.

The World Health Organisation (WHO) believes that "promoting and protecting health and respecting, protecting and fulfilling human rights are inextricably linked" where "access to health care is a fundamental human right, enshrined in international treaties and recognized by governments throughout the world" (WHO, 2011). Nurses are the largest professional workforce within the healthcare sector and therefore their role and responsibility in safeguarding and promoting human rights in the health care sector is tangible. When nurses uphold the values and ethics of the nursing profession they are also promoting as well as safeguarding human rights.

The International Council of Nurses (ICN) endorses the Universal Declaration of Human Rights adopted in 1948 and advocates that the inclusion of human rights issues and the nurse's role at all levels of nursing education is crucial. The ICN's position on human rights states that:

"Human rights in health care involve both recipients and providers. The ICN views health care as a right of all individuals, regardless of financial, political, geographic, racial or religious considerations. This right includes the right to choose or decline care, including the right to accept or refuse treatment or nourishment; informed consent; confidentiality, and dignity, including the right to die with dignity."

It is vital that nurses are aware of human rights. This is particularly important as nurses are not only at the forefront of health care provision, they are often involved in critical decisions and procedures. Furthermore, nurses are well positioned to witness first-hand the impact of safeguarding human rights on patients and relatives. Health policies, health practices as well as research may, unwittingly, violate human rights. Nurses need knowledge and skills as well as the attitudes and values to successfully safeguard human rights in patient care. Literature on the subject emphasises the need for nurses to promote human rights.

Patients' rights can be strongly related to ethical principles. Nurses must use their voice to promote the values of the nursing profession. Forexample, nursescan advocate to policy makers and health administrators that health services should strive to be centred around patients'needs and not vice versa. Additionally, nurses and all health care providers must respect each patient's dignity, promote patient autonomy and involve them in decision-making, provide care in a safe environment, ensure informed consent is carried out, and acknowledge that patients have a right to refuse treatment. Moreover, privacy, confidentiality and ensuring that patients have access to information on their health status and treatment options are also a key role of the nurse professional.

In striving to safeguard human rights in patient care, nurses may face many challenges. These include amongst others,difficulties in promoting human rights amongst colleagues and the multi-disciplinary team, being involved at policy level to promote awareness of human rights in the formulation of policies and strategies, and balancing ethics and human rights in everyday practice. These can be overcome by educating nurses and nursing students on the importance of human rights in patient care, developing health services within a human-rights framework, ensuring support for those nurses and health care professionals that identify human rights violations where protection is provided to whistle-blowers.

Nurses are encouraged to adopt a human-rights based approach to patient care. Local nursing organisations, both governmental and otherwise, are encouraged to consider issuing position statements on human rights and patient care to support nurses in this role and responsibility. The current Maltese Code of Ethics for Nurses and Midwives broadly refers to patient rights in two separate statements. Aside from a position statement, it is anticipated that when the current Maltese Code of Ethics for Nurses and Midwives is updated, human rights in given due importance, addressing the needs of patients, midwives and nurses.

Please contact Marisa Vella on marisalvella@gmail.com for references and information related to this article.
Join the group Ethically Speaking on Facebook.

Some pastoral insights from Tomislav Ivancic book "The Discovery of Spiritual Therapy"

Fr Mario Attard OFM Cap

The Armenian-Russian American writer of fantasy, science fiction and other "wonder fiction" , Vera Nazarian, said: "Whenever you read a good book, somewhere in the world a door opens to all in more light" . In my experience reading the book by Tomislav Ivancic, *The Discovery of Spiritual Therapy*, helped me a great deal in the understanding of my pastoral ministry as a hospital chaplain.

In his fourteen-paged introduction for his book Ivancic augurs that his "little book contributes to the construction of a more effective spiritual therapy, if it opens someone" eyes regarding the reality of man" spiritual dimension, if it offers an insight into the unutterable dimensions of human suffering, but even more into the unfathomable capacities for offering spiritual remedy and friendship with the Lord, if it gives at least one person more hope to live and remain faithful to his call, it will fulfil its purpose" (p.19).

Does the human person have a spiritual dimension? Certainly that she and he does! But how do we know? The very presence of spiritual illness that every human being carries within himself and herself shows the dire need for spiritual recovery. In his chapter dealing with identifying and healing spiritual illness Ivancic puts conflict with conscience as a source for man" spiritual illness. Thus, he writes:

"Conscience demands of a person that he should do good and avoid evil. If a person does evil he contradicts the voice of his conscience. In this way by assaulting his conscience he may injure, weaken or even kill it. A dead conscience is unable to distinguish good from evil. Thus addiction to sin, material things and evil arises. Inner conflict is caused. A person perceives his conscience as an enemy. In this collision of the person and his conscience, either the conscience or the person himself suffers. If a person persists in doing evil, he loses the meaning of his life, and as a consequence he ceases to function as an organism. He often falls ill. The psyche and the body become paralysed and spiritual meaninglessness pushes

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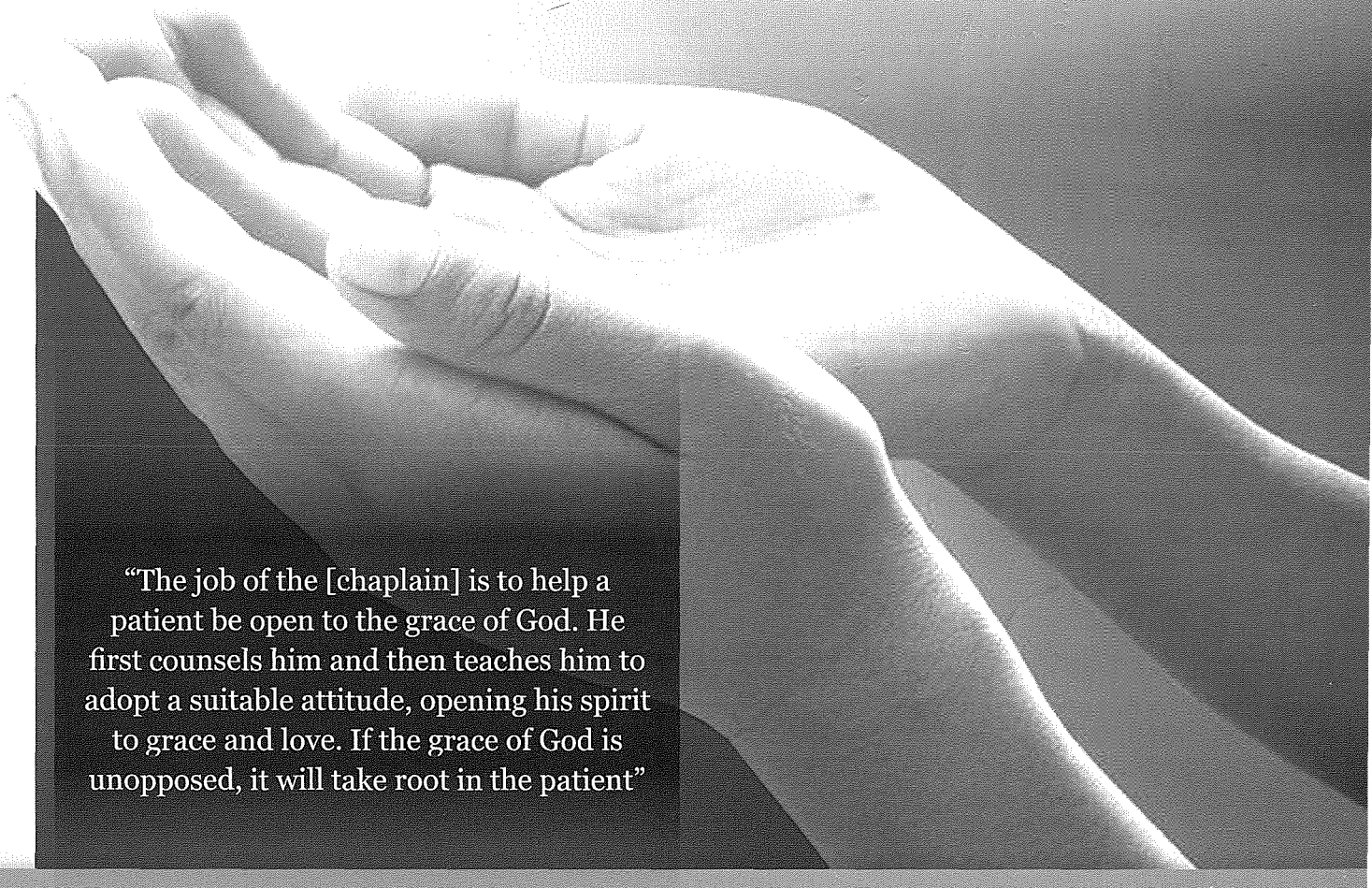

"The job of the [chaplain] is to help a patient be open to the grace of God. He first counsels him and then teaches him to adopt a suitable attitude, opening his spirit to grace and love. If the grace of God is unopposed, it will take root in the patient"

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him to suicide. At the same time this conflict with the conscience brings suffering. He suffers from guilt, he experiences existential fear, restlessness tears him apart and depression intensifies. A person looses himself, resigns, grumbles at everyone, has no strength to work, avoids others, is afraid of death and seeks consolation in the occult. This conflict with conscience in a person gives rise to aggression, bitterness and fury. He begins to destroy nature and to assault people. He becomes inconsiderable and intolerable" (pp.49-50).

But how can one get healed from such an internal conflict of conscience?

Ivancic offers the following reflection:

"When guilt is removed through repentance or confession, suicidal thoughts are also removed, because in most cases he is not able to do so. To enable him, it is first of all necessary to communicate God" love to him in order to pull him out of depression and self-piety. Confidence in the spiritual therapist who pray for and with the sick person can be helpful in this situation, but also confidence in the words of Sacred Scriptures which help the patient to become conscious of God" love. Repentance is the acceptance of the demands of conscience. It is a withdrawal from conflict with conscience. Self-accusation, aggression, anxiety and fear slowly disappear.

The patient experiences that he is again in an authentic place where body, spirit and soul can function freely. Now he can live life fully because with a clear conscience he can once again be whole in spirit, soul and body. The whole of nature co-operates with him once more. People love him and spiritual powers around him and in him work for his benefit. Converts sometimes experience this dramatically and this can mark their entire future life" (p. 51).

In *The Discovery of Spiritual Therapy* Ivancic, after identifying evil, lust and insult as the primary agents of the human person" spiritual illness, passes on to draw a list of symptoms of spiritual illness that undoubtedly hamper his and her spiritual growth.

"When evil, lust and insult attack any of the spiritual organs, a whole range of symptoms arises. Every insult, every turning to a lesser good brings forth aggression, meaninglessness, depression, suicide, resignation, self-rebuke, hatred, vengeance, self-pity and hostility, separation from others, envy, self-destruction and pitilessness" (p.61).

However, later on in his discussion, Ivancic singles out three main symptoms as motivators for other symptoms of spiritual illness that come into play.

"But among them all, there are three symptoms which stand out; guilt, addiction and suffering. These are in fact the fundamental symptoms of spiritual illness. In almost every case of spiritual illness there is an explicit or latent sense of spiritual guilt. At the same time the inclination towards illness, guilt and pain increases. An experience of conscious or unconcious guilt is an experience of suffering, anxiety and spiritual death, aggression or resignation, enslavement and frustration.

When we are afflicted by pain or injustice, we experience subconscious guilt, and consequently attachment to evil, negative thoughts and helplessness, fatalism and resignation in the face of evil, cruelty and sin" (pp. 60-61).

When I personally come across these spiritual symptoms in the patients I daily visit at Mater Dei Hospital what would my response be? Upon reading about the laws of the spirit" bit I found this subsequent spiritual insight, proposed by Ivancic, directed towards my ministry as a hospital chaplain, particularly when administering the Sacrament of Confession.

"The job of the [chaplain] is to help a patient be open to the grace of God. He first counsels him and then teaches him to adopt a suitable attitude, opening his spirit to grace and love. If the grace of God is unopposed, it will take root in the patient" (p.108).

Nevertheless the patient" responsibility is, without a shadow of a doubt, called for. Thus, Ivancic comments:

"But it will be sufficient for the patient to adopt a correct moral attitude and decides to be just for the beginning of the healing process to take place or even for complete spiritual healing to occur. The moment a person turns away from evil to good, from hatred to love, from vengeance to forgiveness, from dark toward light, he becomes spiritually healthier. He is then open to a work of God" mercy, which leads him to complete healing.

As soon as the patient chooses humanity, he experiences a change, joy, satisfaction, peace and meaning in life" (pp. 108-109).

Towards the end of the book Ivancic engages himself in an interesting discussion on what really constitutes spiritual health. He makes the following observations:

First, "leading a person to God means making his spirit healthy. One leads a person to God primarily by showing him how well-founded belief is in reason, how credible God" existence is, and then, through prayer enabling him to encounter God" (pp. 137-138). Second, "only an encounter with God gives a person absolute certainty of the existence of God and of the possibility of knowing him" (p.138). Third, "being spiritually healthy means accepting and loving oneself" (p.139). Fourth, "by accepting himself a person begins to coperate with the abilities he possesses, he is in harmony with his conscience and his Creator, he begins to take care of himself, guard his life, save it and render it indestructible" (p.139). In practice this means that "he will endeavour to avoid addiction, evil, and harming others, he will attempt to preserve

his own health and strength, to restrain his emotions, imagination, feelings and memories, to maintain purity of thought which will lead to a greater development of his personality" (p.140). Fifth, let us not forget that "when a person begins to love himself, he loves others as well. He uses every opportunity to achieve friendship with God" (p.140).

Before concluding this reflection I would like to present an excellent meditation Ivancic gives at the end of his book regarding living in friendship with God, which should be the goal of authentic pastoral care.

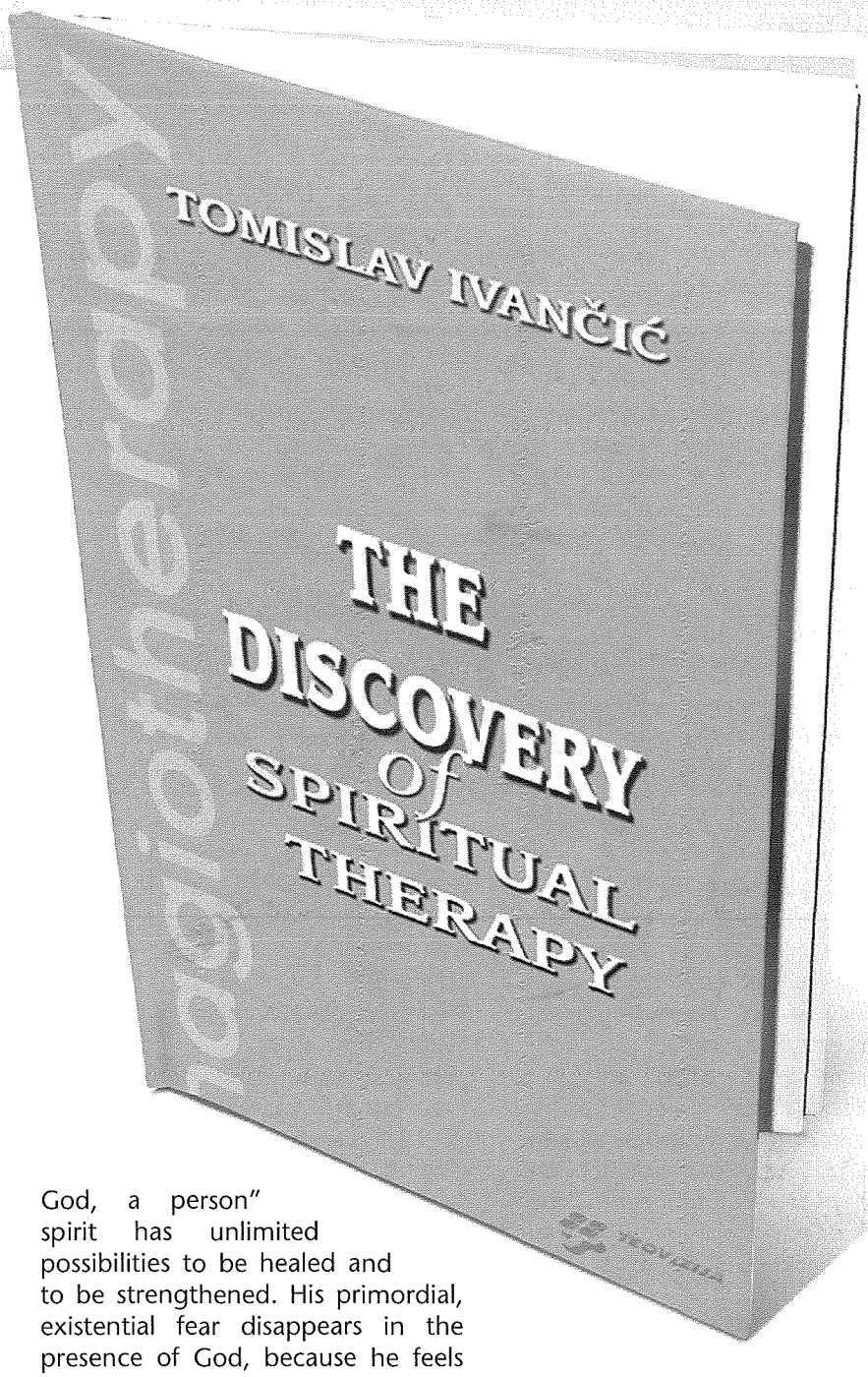
"Living in friendship with God a person receives the strength to love others, not to crush and destroy his fellow man, but to show mercy and to offer each his help. So the material can no longer be the most important, as he perceives that his life comes from God, not nature. The most important thing is to live in companionship with God and that means living for others, being humane, good, honest, and virtuous... Walking with God it becomes clear that he has a place and a purpose and he feels at home in everything he experiences. Since a person is not only body and soul but spirit as well, so his spirit finds the deepest joy and fulfilment of his longings precisely in friendship with God. Knowing and acknowledging God, religious realities become clearer to him, prayer is revealed as conversation with the Creator, repentance as a sign of love in the name of friendship with God, the Church as the place where God reveals himself and enters into a real relationship with man, Christ" cross as a sign of the unique love of God for man, but also of the unbelievable horror of man" wickedness. Places of worship, temples, churches, and altars are revealed as places where man communicates with his Creator in a significant way.

Those are the places of human gratitude to God, reconciliation with the Creator, decisions to live in harmony with God, himself and all created things.

Living in friendship with God, a person" spirit has unlimited possibilities to be healed and to be strengthened. His primordial, existential fear disappears in the presence of God, because he feels the ground is steady under his feet, he knows that nothing can destroy him, that he has conquered sickness, death, guilt and fear. His spirit is not afraid of sin anymore, because he experiences God" merciful forgiveness.

His reason has no limits anymore, because he can always learn more. He can grow in humanity, virtue, and excellence, because he is continuously in touch with the source of goodness, love, justice and trust. His eyes and ears are open and healthy, his life is secure, and he can give himself unconditionally to the examination of life" (pp.136-137).

As it stands out, Tomislav Ivancic book, *The Discovery of Spiritual Therapy*, has enriched my pastoral role at the Hospital I work in. To begin with, it amplified my understanding on the patients"™ spiritual needs and how I can respond to them. Secondly, it inculcated in me a far greater responsibility as to how I can give them Christ, the Saviour of the fallen humanity. Thirdly, it inflamed me with the longing to read, research, write and ongoingly reflect on my pastoral calling as a hospital chaplain in today" ever changing world. Needless to say, all this has to be carried out and directed towards a much more fruitful living in friendship with God.



• ikompli minn paġna 9

Klistier, pompa jew enema (Clyster)

l-ewwel forma ta' siringa; 'enema saponis' (*soapsuds enema* li sa ċertu punt għada tintuża f'forma oħra illum); 'siringa ta' Higginsons', 'doċċa tal-imnieher' (*nasal douche*), 'senapismi', 'vesikanti', 'sangisugi' (*leech*), 'linimenti' (*liniments*), 'gargarismi' (*gargles*), 'kolliri' (*eye washes*), 'inunzjoni' (*the application of anointments* jew *ointments*), 'inalazjoni' (*inhalations*), 'kitla tal-bronkite' (*steam kettle*), 'bronkite' (*bronchitis*); 'pessari medikati' (*pessaries*), 'sħana xotta', 'suppositorji nutrittivi', 'medikatura tal-misħun/ ilma kiesaħ', 'lozzjonijiet medikati/ evaporanati' (*lotions*), 'kompressa mxarrba' (*compresses*), 'tubi ta' Leiter', 'skrakkar' (*secretions*), 'għeriek'/ frizjoni' (*massage*), 'beritta ippokratika' (*head/scalp bandage*), 'kompressjoni tas-swaba/kompressjoni bit-tourniquet/allacciatura' (*compression*); 'jikkoagula/jagħqad' (*coagulation*); 'stikk/stikki' (*splints*) fejn insibu lista twila bħall /ta' l-injam (ta' Liston)/ tal-metall (*Macintyre*)/ tal-landa (*Levis*)/ taż-żingu jew pistoli (*Cline*)/ angulari/ b'ħafna bċejjeċ (*Carr* u ta' Gordon)/ bi xquq maqtugħin fihom (*Goochs*)/ tal-gutta perca/ tal-feltru/ tal-ġild/ u tal-kartun'; Insibu wkoll 'imbottatura ta' l-istikki'; 'sublimat korrosiv'; 'Jodoform'/ 'Jodju'; 'pinzi/ pinzi ta' l-arterji/ pinzi ta' Pean/ pinzi ta' Spencer Wells/ pinzi tad-dissezzjoni' (*forceps*); 'pinzetti' (*tweezers*); 'taljent' fejn qabel kienet tinkiteb taglient; 'il-Folliero' (likwidu li jwaqqaf id-demm); 'skannellata'; xpakkapietra/ xpakkapjetra (*Maltese Savory*); 'termentina' (*Acqua di Rasa*); 'pakk'/ 'impakk' (*dressing*); 'aħtriq'/ 'eħtriq'/ 'riħtriq' ('*sried*' jew *chapping of the lips*); 'qrada'/ 'debbieħa/ dubbieħa' (*foot sole abcess/athlete's foot*); 'axxess' (*abcess*); 'qollieba' (*scab*); 'tgħaxwix' (*stomach discomfort*); 'xupat' (mit-Taljan *sciupato/ emanciated*); 'torbċija' (*oedema*); 'xaqq is-safra/flieli tas-safra'; 'ħmewwa' (fawra tal-gilda); 'żokma/żoqma' (*blocked nose*); putrefazzjoni /putrifikazzjoni /intiena (*putrefaction/putrification*); 'lavanda' (*vaginal douche*); ħabb (*measles*) u 'tnell' (*bath tub*). Għall-ħasil tal-marid insibu 'friskatur' (*basin*), 'biċċa tal-wiċċ' (*facecloth*), 'sponża' (*sponge*), 'xkupilja tas-snien' (*toothbrush*) u anke 'krema tas-snien' (*toothpaste*). Interessanti li 'nħija' (kelma rari) kienu tfisser dijareja, tneħħi l-bili, id-demm tal-mestruwazzjoni u allura tfisser discharge.

Konna ngħidu wkoll 'insajru d-drums' meta nieħdu l-apparat biex 'jissajjar' is-CSSD. Il-'Grisol' li llum inqatgħa għal-kollox biex jinħaslu s-swali, u kellu rieħa partikolari ħafna, saret kelma li tintuża ta' kuljum u minn kulħadd. Il-kelma 'fattiga' minn dejjem kienet tintuża biex tispjega min inaddaf, illum però nalludu għall-*cleaners* jew *domestics*.

Fid-'Dentistrija' (*Dentistry*) nsibu 'mard tal-ħanek' (*gum/periodontal Disease*), 'uġiegħ tad-dras' (*toothache*), 'sinna/darsa mnawra' (*tooth decay*), 'mili' (*filling*), 'taħsir' jew 'snien imħassra' (*tooth erosion*); 'dentatura' (*dentures*); 'sinna tal-għaqal', 'ġebla fis-snien' jew 'tartru' (*plaque*), 'sinna mtajra', 'sinna/darsa nieqsa'/ 'telf ta' snien', 'qsim tal-ħanek' fit-tfal; 'sinna tiċċaqlaq', 'moffa fil-ħalq' (*trush*), 'dentifriċji' (*dentifrices*) u 'sinna mtebba'.

Fid-dinja tal-'farmakologija' (*Pharmacology*) u allura nsibu 'farmaċija' (*pharmacy*), 'dispensary' (*dispensary*) jew 'spiżerija'. Ngħidu 'mediċinali' (*drugs*) u 'mediċini' imma skont L-Ordinanza dwar il-Ħwejjeġ ta' l-Ikel, Mediċinali u Ilma tax-Xorb ta' l-1904 il-kelma 'mediċinali' tfisser il-

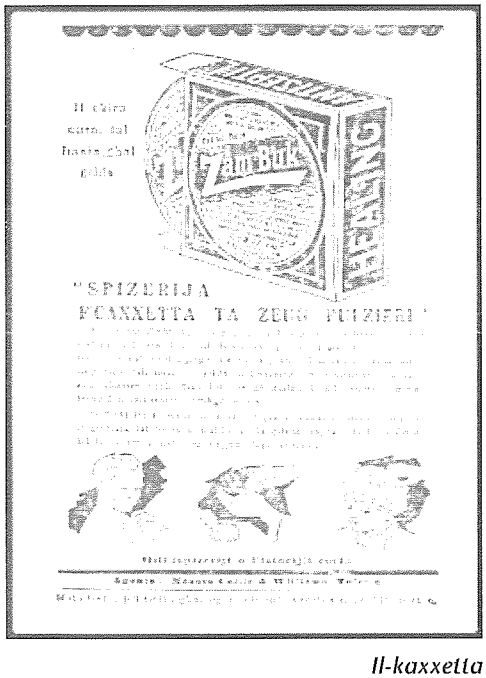
Aħtriq jew eħtriq

mediċini għall-użu minn ġewwa jew minn barra, u fiha jidħlu d-'diżinfettanti' u kosmetiċi. Il-popolin jirreferi b'mod simplistiku għall-mediċini bħall-pinnoli tal-ħadid, porga, kremi, balsamiku, kapsuli, pastilji, pinnoli tal-moħħ, pinnoli tal-ġogi, pinnoli tal-uġiegħ, 'Morfina' (*Morphine*), 'Petadina' (*Pethadine*), pinnoli tal-qalb u ta' kull organu ieħor possibli. Ngħidu 'qlaı tal-għajnejn/tal-imnieħer' eċċetera. Iltqajna mat-termini 'ostja' li kienet forma ta' mediċina (*cachets*) u 'labarbru' li tfisser rhubarb (*porga*). Insibu wkoll 'kaxxetta' jew 'landa' li kienet iżżomm il-kremi jew pastilji. Il-*medicine chest* ngħidulha 'kaxxa tal-medicini'. Għall-*prescription* insibu 'preskrizzjoni' jew 'riċetta'.

Fl-anatomija nsibu wkoll 'awrikli tal-qalb', 'ventrikli' u 'dwodenu tal-imsaren'. Fil-Patologija ltaqt ukoll mal-kelma 'balzmatura' (*embalming*) meta l-mejjet jiġi 'bbalzmat'.

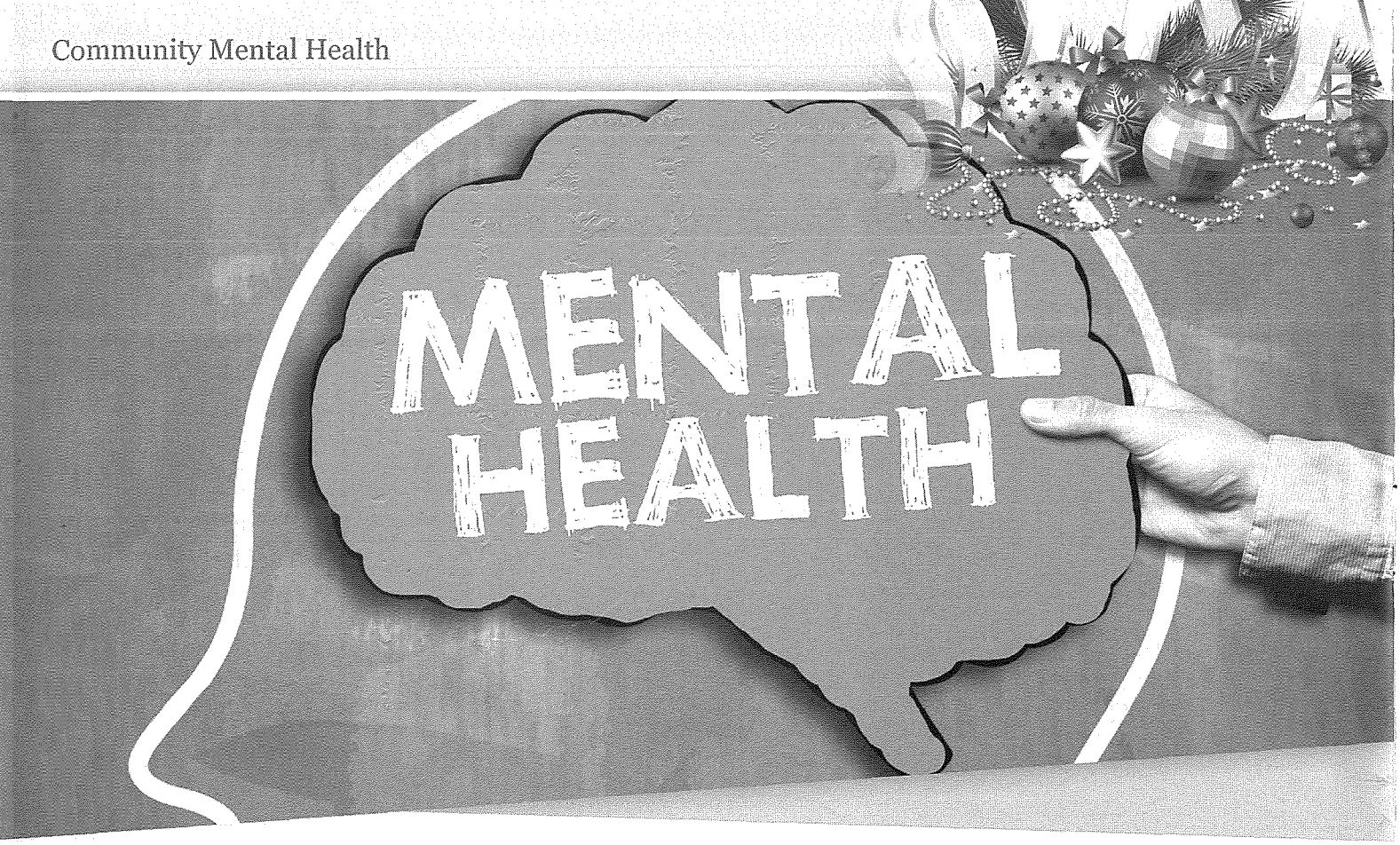
Hija xi ħaga normali li lingwa tinbidel u ċertu kliem jintilef maż-żmien imma hija wkoll ħasra li l-ġenerazzjoni tal-lum diġà ma tafx ħafna mill-kliem u frażijiet li semmejna. Il-bumbardiment kontinwu minn kliem barrani ikompli jnessina minn kliem safi Malti (u anqas safi) użat fix-xogħol tagħna.

◦ Tmiem



Il-kaxxetta

Għar-riferenzi kkuntattjaw lil: Joe Camilleri



• continued from page 16

time in the care of mental illness, there was an effective medication which had an effect on the agitation experienced by the patients. Psychiatric hospitals became less daunting and the atmosphere in wards less chaotic. It allowed for human conversation and opened the way for patients to be eventually sent out of hospital and even discharged. However, one problem which was occurring was the relapse of the illness. This was triggered by patients not taking their medication, which resulted in symptoms to reoccur. This was dealt with, by closer follow up outside the hospital, in out-patient clinics, and the patients' own home and communities.

All these factors contributed towards the move to care in the community, where initially, large psychiatric hospitals were closed down. However, community care is not just about that, but about providing the care outside of the hospital environment. The first publications referring to the first community psychiatric nurses in the U.K. dates back to the mid-1950's (Bowers, 1992). As Burns (2006) stated, the development of community mental health services in the U.K. was made possible by community psychiatric nurses. These were the main force behind community mental health teams and other specialized teams like Crisis intervention and Home Treatment, Assertive Outreach and Early Intervention Services.

The Community Care Act in 1991 had a huge influence of how mental health care was delivered in the community. This was not only as a compliment to hospital but as an alternative. Patients, who were in the past admitted, were now maintained in the community, and the care provided in hospital, was transferred to the patient's home.

The Community Care Act in the U.K., introduced the legislation of the Care Program Approach (CPA), where people suffering from mental illness were allocated a key worker, who was responsible in the formulation of a care plan and regular reviews with the mental health team (similar to the 2012 Mental Health Act and the Community Treatment Order in Malta).

The move towards care in the community has revolutionized mental health care. It has lessened the stigma associated with mental illness, leading to a positive effect, not only on the patients, but also on their families and the professionals working with them.

Community care is about providing the service to those who need it the most, since the people most vulnerable to mental illness are usually the most reluctant to seek help. Therefore, a good liaison with the local communities is essential, including G.P.'s, police and the local support nucleus. Community care is a move towards normality. However, this is not just about being normal (since normality is a very broad term and open to interpretation), but about the community accepting what it's not, what is diverse and understanding our differences, needs and issues. It is about receiving mental health care outside of hospital, while continuing to face life's daily challenges. Hospital stays remain a necessity in mental health, however those stays can be kept brief and to the minimum, so that the individual can continue dealing with life and learning to cope with its difficulties and the symptoms of mental ill health.

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