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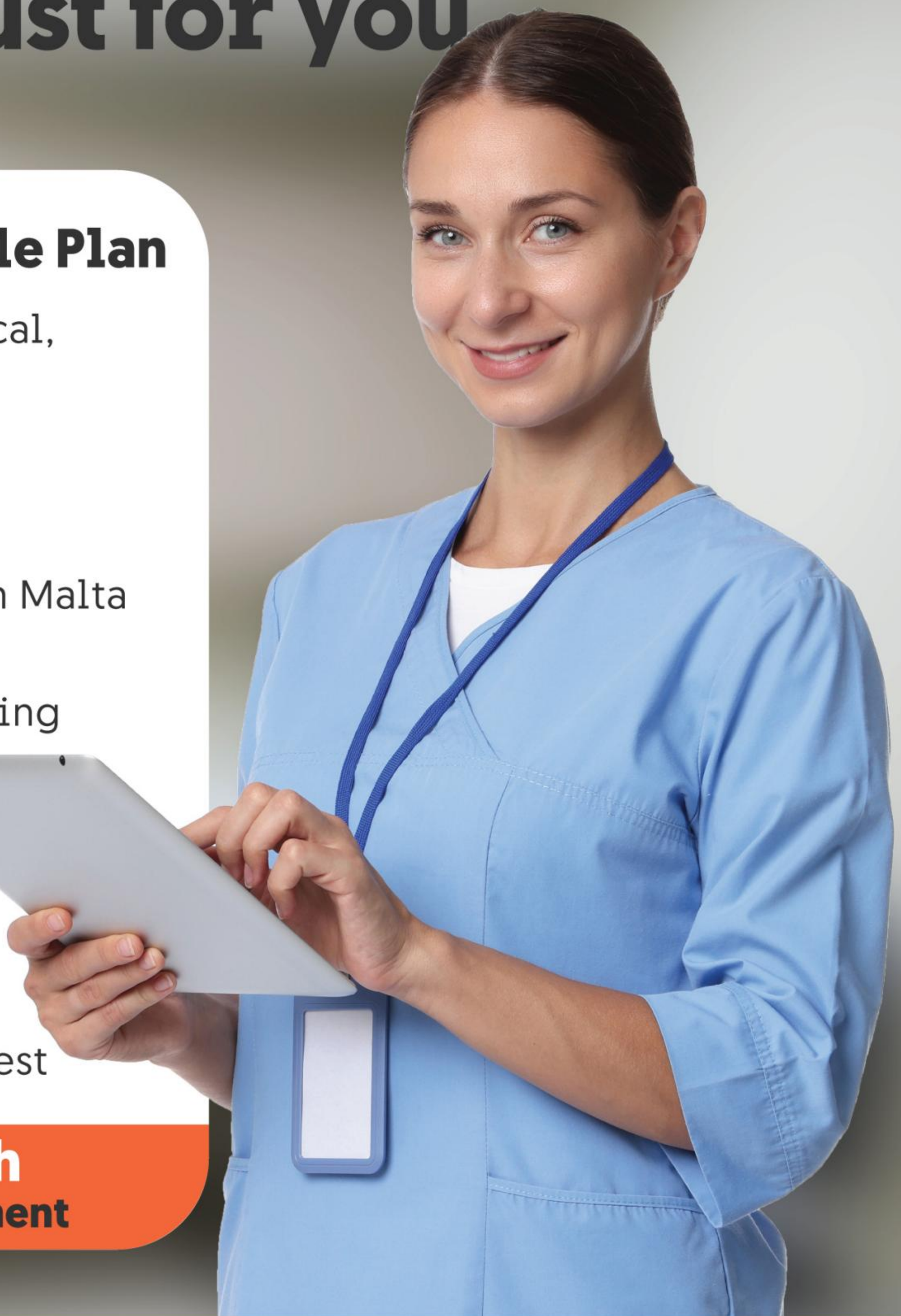
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Are we over-reliant on overseas staff?

The WHO's European region, which covers 53 countries in Europe and Central Asia, is projected to face a shortfall of 950,000 health workers by 2030 and has been turning to immigration to bridge that gap.

Europe's reliance on foreign nurses is growing and could create challenges for health systems in the coming years. Between 2014 and 2023, the number of foreign-trained nurses increased by 67 per cent. So this is not a local problem per se, Germany and the United Kingdom accounted for most of such growth. This shift has created a stark divide: countries in eastern and southern Europe are losing health workers to western and northern countries, exacerbating shortages in some areas while filling them in others.

Challenges such as the aging population and retirements in the health sector that are difficult to replace pose a constant threat related to shortage.

The WHO has called on countries, including ours, to boost efforts to retain our health workers and improve their workforce planning for the future. "Health worker migration is a reality in Europe's interconnected labour market, and it must be managed more fairly and sustainably," according to Dr. Azzopardi-Muscat.

Over 1,600 foreign nurses work in Malta, making up approximately 12% of all nurses in the country. Indian nationals constitute the largest group of foreign-born nurses. The situation with carers is even more predominant, as almost 'half' of them are foreigners. But that is another story, which in a way affects the whole scenario.

The government must be constantly committed to develop homegrown talent. What are Malta's current long-term plans with regards overseas recruits and nursing staff compliment? Malta has experienced a fair share of employed expatriats but in the last fifteen years this has grown

in such a way, that it feels out of proportion. Over-reliance on overseas staff is certainly a national shock to all and sundry. Re-evaluating the needs of TCN migrant nurses should be done on a regular basis, taking into consideration the TCN nurse migration phenomenon in Malta. The difficulties associated with over-dependence on foreign workers in our general hospital and the local shrinking nursing workforce is considered as one of Malta's profound challenges of the healthcare system. Immediate and thorough interventions are required so that our long-term health and welfare could be sustained.

It is now absolutely important to invest in local recruiting and retain the Maltese nursing workforce. More effort is needed to encourage people from our island to become nurses themselves. The government should focus on making public services a

staffing, a culture of respect and flexible working hours must also be taken into consideration.

On the other hand, nurses from overseas have somewhat stabilised the daily nursing compliment in our hospitals. In general, overseas recruits and staff can also bring skills, knowledge and passion to their roles. Even our patients are grateful for the skilled and compassionate care they have received from overseas staff. But some reports highlight that while not all Maltese patients are racist, there is a recognised problem of racial discrimination that negatively impacts the foreign nursing workforce essential to the Maltese healthcare system. Thou in general, they are much appreciated, but are we seeing the bigger picture?

Our overseas nurses actually move on from time to time. And this is because we are competing with other health systems abroad, were in some cases our working conditions, pay and career prospects are looking unfavourable compared to them. Over the past 5-6 years, 250 foreign nurses have resigned to seek pastures new. With resignations come new overseas nurses, and apart from that, there is no formal national adaptation programme, hospitals must again train them, mentor them, organise orientation programmes and follow their progress, from scratch.

Fears about overreliance on a non-Maltese healthcare workforce is a reality. Current concerns also include wards that are nearly or totally staffed by foreign nurses. This is generally not recommended due to the complexity of integration, potential for miscommunication (language), and the benefits of a blended team. Healthcare facilities typically aim for a balanced ratio of both locally trained and internationally qualified nurses to ensure successful integration and create a supportive work environment for all staff. This is not happening at present. Par condicio please.



more attractive prospect for graduates and pushing to reduce the numbers of staff choosing to leave, not only the health sector but also the country. Attractive conditions to retain nurses may include compensation, supportive work environment, and good work-life balance. Salaries, benefits, adequate

Addressing the Nursing Staffing Crisis at Mater Dei Hospital

As MUMN, we are currently engaged in important discussions regarding a long-standing and serious problem at Mater Dei Hospital (MDH): the nursing complement in the wards. According to established international recommendations, the correct nursing ratio should be 1 nurse for every 4 patients (1:4). That is the presence of day nurses and extra night nurse.

When services migrated from St. Luke's Hospital to MDH, every ward had two-day nurses assigned to support the ward shifts. Unfortunately, over the last ten years this support system has gradually eroded. Some wards still have two day nurses, while other wards within the same specialty now have none.

The nursing management at MDH has effectively hijacked the situation, ignoring written agreements and internationally recognised recommendations regarding the 1:4 nursing ratio, which is widely accepted worldwide.

Decisions have been taken with an attitude of arrogance and a "know-it-all" approach, to the detriment of the nurses working on the wards and ultimately to the healthcare system itself especially patient safety. As the nursing complement deteriorated and day nurses were not replaced, many Maltese nurses were left with no alternative but to leave the wards at MDH.

Whenever opportunities arose, nurses understandably chose to move elsewhere to safeguard their wellbeing. This is the inevitable result when nursing management isolates itself in an ivory tower, ignoring the pleas and concerns of ward nurses and risking patient safety. In fact, nurses were even told: "If you don't like it, you can always leave." And many did exactly that.

Charge Nurses and nurses requested transfers outside MDH or took the SLSL while other nurses moved to specialised units which have a better nursing complement. Currently, more than 125 nurses have requested transfers to

Primary Health Care simply to move in a less stressful environment and worried about patient safety being so risky in MDH with no day nurses available and neither night nurses.

Working under constant excessive workloads daily inevitably affects both physical and mental health. Unfortunately, the current nursing management at MDH appears to consider this situation normal. Rather than addressing the real issue, they blame the wider system and claim that other entities such as St Vincent de Paul, Primary Health Care, and Gozo General Hospital have no workloads which is total false.

This type of reasoning demonstrates not only ignorance but also a deep level of denial. The real cause of the exodus from MDH is the abandonment of the 1:4 nursing ratio. To make matters worse, the CEO of MDH recently boasted that hospital output has increased by 30%. However, nursing staffing levels have not increased accordingly. On the contrary, the situation in MDH has worsened due to numerous ward vacancies and the increasing number of patients being placed in corridors because of hospital overcrowding.

MUMN is therefore holding a series of meetings aimed at restoring an adequate nursing complement. Our objective is not merely to fill current vacancies, but to re-establish the abolished 1:4 ratio, which should never have been removed in the first place. Furthermore, MUMN is proposing that all general wards at MDH should have at least three nurses on night duty, irrespective of whether the ward is full or not.

At present, MDH is effectively being forced to set nursing complements according to MUMN directives. These directives include not admitting patients when there are fewer than four nurses on duty during day shifts and not admitting patients during night shifts

if there are fewer than three nurses on the ward.

This situation must change. Even with the excessive overtime worked by nurses, the 1:4 ratio is still not being maintained, and the situation risks becoming even worse. It is increasingly evident that nursing management at MDH is more concerned with appeasing the Health Minister than protecting the wellbeing of nurses and addressing patient safety.

Whenever nurses are transferred to Gozo General Hospital or a new service is introduced, the cost is borne by the nurses working on the wards in MDH. New services are rarely properly planned, and transfers often occur without replacement staff, further worsening staffing shortages.

The ongoing meetings are far from easy. Nurses must understand that the current nursing management is strongly opposed to restoring the 1:4 ratio, even though some wards have already successfully implemented it. This mirrors previous battles fought by MUMN, such as the struggle to introduce the 50% roster system for Charge Nurses and Senior Nurse Managers.

MUMN will continue striving to establish a proper nurse-to-patient ratio, just as it has already successfully done at St Vincent de Paul. We will keep updating our members so that nurses and midwives know that their union is not only listening to their concerns and distress but is also raising these issues at the highest level of government, including the Office of the Prime Minister (OPM).

MUMN remains committed to defending the wellbeing, dignity, and professional standards of all nurses, midwives and all the other members.

*Paul Pace
President*

mis-Segretarju Ġenerali

Kif inthom ħbieb? Reġa' wasal il-waqt li naqsam magħkom dawn il-kelmtejn dwar x'għadda mill-MUMN dawn l-aħħar tlett xhur u x'inhu għaddej bħalissa.

Kont sodisfatt ħafna, nara Nurses jersqu 'l quddiem biex ikunu parti mill-Group Committee tal-union fuq il-post tax-xogħol tagħhom. Dan huwa riżultat tal-interess li għandhom biex itejbu l-kundizzjonijiet tax-xogħol tagħhom u l-fiduċja fl-MUMN li jistgħu jirnexxu u jwettqu dak li jemmnu li huwa ġust u xieraq.

Fi Frar bdew id-diskussjonijiet għall-Ftehim Settorali godda fit-tlett gradi - Dental Surgery Assistants, Phlebotomists u Decontamination Sterile Technicians. Dawn il-Ftehim Settorali għalqu fl-aħħar tas-sena. Qed inħarsu 'l quddiem li ngħalquhom qabel jibda Sajf però fin-negozjati ma nkunux waħedna! Fiducjużi li b'rieda tajba minn kulhadd naslu biex itejbu b'mod sostanzjali l-pakkett komplut li jixirqilhom dawn l-impjegati.

Għadna qegħdin ninsistu biex il-Clinical Measurement Physiologist jiġu reġistrati taħt il-Kunsill Regolatorju. Issa wasal il-waqt biex dan isehh. L-iżvilupp li sehħ f'din il-professjoni, prinċipalment bl-isforzi tagħhom stess f'dawn l-aħħar għaxar snin, jixraq li dawn il-professjonisti jkunu regolati kif suppost. Ma nistax nifhem x'inhu r-raġuni li l-Ministeru qiegħed ikaxkar saqajh fuq din il-materja.

Smajna mill-media li Social Workers Students kien ser jitripla l-istipendji tagħhom bil-kundizzjoni li jagħzlu lil FSWS bħala l-post tax-xogħol tagħhom! Dan ma kien jagħmel l-ebda sens għall-iżvilupp ta' din il-professjoni fis-servizz pubbliku, meta n-nuqqas huwa enormi u kien proprju s-sena l-oħra li dan in-nuqqas beda jittaffa'. L-MUMN mill-ewwel ipprotestat fuq din il-miżura u s-Segretarju Permanenti People & Standards fl-OPM ħadet azzjoni immedjata u f'waqtha biex din il-miżura diżonesta ġiet innewtralizzata.

Fil-mument l-MUMN qegħda nvoluta fit-tlett każijiet fil-Qorti. L-ewwel waħda hija kawża li fetħet l-MUMN stess dwar is-sitwazzjoni Minoritarja fil-każijiet linkunu qed nirrapprezentaw il-membri tagħna li għalkemm ma ngawdux l-għarfien ewlieni fil-grad tagħhom, huma jkunu għażlu lilna biex nirrapprezentawom u fis-sezzjoni tagħhom l-MUMN tgawdi l-maġġoranza. It-talba tagħna fil-Qorti hija li fejn jidhlu materji li ma jaqgħux taħt il-Ftehim Settorali tagħhom, l-MUMN għandha tingħata appuntament għall-laqqgħa, il-materja tiġi diskussa u għandha tinstab soluzzjoni mingħajr dewmien żejjed.

Fiz-żewġ każi l-oħra, il-Ministru tas-Saħħa għoġbu jgħamlilna Mandat fil-Qorti wara li ddefendejna l-interessi tal-membri tagħna fl-SVP u l-Cath Suite. Hawn qed jiġu diskussi dawn iż-żewġ materji u l-kawża tista' tintrebaħ naħa jew oħra.

Żvilupp pożittiv ħafna kien il-ħlas kollu tad-dejn fuq il-Premises godda tal-MUMN f'Hal Qormi. Dan ifisser li mhux se jithallas aktar dejn u interessi u hekk il-bilanċi tal-union jissodaw minn sena għal oħra. Prosit kbira lil kulhadd speċjalment lis-Segretarju Finanzjarju li bl-għaqal tiegħu wasalna sa dan il-punt importanti.

Dejjem qed noqorbu biex niċcelebraw l-egħluq tat-tletin anniversarju tal-MUMN mit-twaqqif tagħha. Għaddej ġmielu x-xogħol biex jinfetaħ Mużew tan-Nurses ġdid fil-kwartieri tal-union stess. Barra x-xogħol ta' kostruzzjoni qed inheggu lill-membri sabiex jisilfuno oġġetti tal-istorja biex jiġu esebiti u jitgawdex minn kulhadd. Fiducjużi li sal-egħluq tal-anniversarju jkollna kolloxx le. Barra minn hekk għaddejja ħidma ntensiva biex tiġi ppubblikata l-istorja tal-union mit-twaqqif tagħha minn meta kienet il-union tal-Midwives biss.

Nisperaw li jirnexxielna nlesta wkoll. L-aħħar proġett għal dan l-anniversarju huwa monument ġdid biex jiehu post dak li kien ġie inawgurat meta organizzajna l-konferenza tal-International Council of Nurses fl-2011. Sfortunatament dan il-monument ġie maħkum mill-elementi tan-natura u kważi spicċa għal kolloxx.

Infatti issa qed noqgħodu attenti biex il-materjal ikun adegwat għall-post fejn ser ikun biex ma terġax tirrepeti ruħha l-istess storja. Dan il-monument jista' ma jkunx lesta fil-ġurnata tal-anniversarju bl-eżatt però qed nagħmlu minn kolloxx biex inkunu viċin.

Qed niltaqgħu mall-management biex jiġi kkonfermat il-patient to nurse ratio fl-acute set up fil-general wards. Minn dejjem imxejna fuq ir-ratio 1:4 u qatt ma kien hemm problemi. Issa, għax hemm nuqqas kbir ta' nurses, il-management qed jgħid li r-ratio huwa 1:6 u sena oħra jibda n-negozjati biex niġu 1:4. Il-union qed tkompli tinsisti li sa sena oħra nkunu 1:4 u mhux jibdeu in-negozjati sena oħra. Għandhom jibdeu issa u jkunu lesti sa sena oħra. Issa naraw.

Għal illum ser nieqaf hawn. Nieħu din l-opportunità biex nawguralkom l-Għid it-Tajjeb.

**Colin Galea
Segretarju Ġenerali**

from the archives



**Cottonera Hospital
September 1918**



EFN Briefing Note (BN) on the DG EMPL Implementation Report of the Professional Qualification Directive (Directive 2005/36/EU & Directive 2013/55/EU)

EFN welcomes the European Commission Implementation Report with the accompanying working document, and stresses the importance of strengthening the Directive 2005/36/EU, updated by the Directive 2013/55/EU (Professional Qualifications Directive (PQD) and the Annexe V). In this BN we give an overview of what is key for the nursing profession and what the EFN members need to know to act at National level based on the outcomes of the report.

In the report, the Commission highlights the healthcare sector as one of the sectors facing critical shortages (see EURES 2024 data), which may be worsened because of digitalisation and AI, if the workforce is not adequately educated and trained. In this regard, the Commission adopted the Union of Skills in March 2025, within which Skills portability plays a key role. To this end, the Commission recognises the PQD as a crucial instrument to facilitate mobility for regulated professions within the single market, and the Proportionality Test Directive (EU) 2018/958, which EFN strongly supported, as a preventative gatekeeper, requiring Member States to carry out a proportionality test before the adoption of any new and before amending the existing professional regulations to ensure that they are non-discriminatory, necessary and proportionate to the objectives pursued. This is a key policy tool when government try to lower down the minimum requirements of the PQD!

The report identified nurses among the most mobile professions: Key findings of the Implementation Report from a nursing perspective: The Professional Qualifications Directive works well and there is consensus among stakeholders about maintaining current minimum education and training requirements for general care nurses: The Commission still recognises that keeping the Directive's minimum training requirements for professions eligible for automatic recognition up to date is important. However, such an update would be done via delegated acts, under the Commission delegated powers, not by reopening the Directive, which is key for EFN – a delegated act has already been adopted for general care nurses,

and the Commission is exploring one for midwives. On the other hand, National Coordinators would like the Commission delegated powers to be extended to other elements of the automatic recognition system, including major element such as the duration of minimum education and training - EFN does not agree with such proposal!

With regards to education and training standards, all consulted stakeholders consider that the current minimum length of training in years and the minimum hours of theoretical and clinical training are still appropriate and that lowering the minimum length of training could have an adverse effect on quality of care and patient safety. With regards to including practice in simulated situations as a part of the minimum clinical training, there are divergent views, with most competent authorities supporting it, while most professional associations being against it as direct patient care stays crucial as minimum requirement.

Importantly, most stakeholders consider the current list of 8 nursing competences in Article 31(7) of the Directive adequate, as well as the combination of training subjects and minimum competences in the training programme for nurses responsible for general care.

In addition professional associations also raised challenges in some Member States concerning general care nurses being replaced by healthcare assistants or confusion in some countries caused by the creation of "parallel" professions performing very similar tasks. The professional organisations stressed the need to reserving the title of nurse responsible for general care for qualified nurses and ensuring continuous professional development. In the context of the discussion focusing on minimum training requirements for professional training, the professional organisations shared a more general view that many potential candidates do not perceive the education towards the nursing profession as sufficiently attractive.

There is a clear interest in extending automatic recognition to additional professions:

This can be done in different ways, including via common training frameworks (CTFs), which can be adopted through delegate acts. The report stresses that a CTF can be established for professions which have a notable level of mobility or possess the potential for increased cross-border movement, and for which there is sufficient alignment on professional regulation and education and training in a minimum number of Member States. As the EFN 2021 and 2025 Mappings revealed, this is the case for Advanced Practice Nurses (APNs). To develop a CTF, the following requirements are needed:

- At least one-third of the EU Member States must regulate the profession – at least 11 EU Member States have national legislation on APN.
- At least one-third of the EU Member States must currently have in place the common set of knowledge, skills and competences on which the potential CTF would be based – more than 9 EU Member States currently have this in place.

The automatic recognition and common set of training requirements under a given CTF would only apply to national qualifications compliant with its requirements and between Member States participating in such a CTF – not all the EFN Members States need to be part of the CTF. Despite several attempts, no CTFs have been developed so far, due to the different national education and training requirements for access to the professional activities in question.

Importantly, the Commission is already working to identify additional professions for which CTFs could be developed in the future, including via a study, contracted to SPARK, in which EFN was involved (see the EFN answer to the survey). Based on this study, the Commission will decide which professions are the most suitable candidate for a CTF. If APN is selected, the EFN Members maybe contacted by DG EMPL for further feasibility assessments for a CTF for APNs – the EFN Members need to be prepared for this possibility, and they can base their input on the EFN answer to the SPARK survey.

continued on page 18

Meaning in care

SENIOR CARE
AND SERVICES



Care Malta 

Promoting Genomics in Nursing Practice

Genomics once considered a skill for the future is becoming essential in the provision of personalised patient care and precision healthcare. The use of genomics in nursing practice is limited, if not absent locally. There tends to be a reluctance in the nursing profession to take on the topic of genomics.

There are a variety of reasons for this including that it is not deemed a required nursing skill, while it is seen as complex and challenging to master. It is understandable to feel overwhelmed by genomic jargon, however the basics of genomics are easily within a nurse's reach. Starting from here and developing competencies gradually is a practical and realistic approach to alleviate 'genomic anxiety'. Developing an understanding and ability to identify red flags will empower nurses to move from reactive symptom management to being proactive and actively engaging in personalised care.

The three components that nurses can embrace and commit to develop further are: doing a family health history, which some describe as a crucial nursing assessment tool; pharmacogenomics; and the role of advocacy. A family history, also referred to as a pedigree, provides a visual map of a patient's story. The assessment identifies patterns, like for example multiple members with the same cancer diagnosis or onset of cardiovascular disease. Here the nurse is flagging a need for surveillance and putting the patient on the path of crucial preventative care to reduce the risk of disease occurrence.

Pharmacogenomics is possibly one of those terms that creates anxiety and reluctance towards genomics. Nurses already apply the right patient, the right drug and the right dose etc. Pharmacogenomics adds further consideration to the right dose. Medications are increasingly selected and prescribed based on the results of genetic testing. This is found to



provide insight on the efficacy or side effects the medication will have on the patient. Nurses can contribute here by monitoring patients in view of these results for both efficacy and side effects which is vital for patient safety as well as improved patient outcomes.

Perhaps the role that resonates the most to nurses is that of advocacy. Health care is continuously evolving, with technology providing advancements in multiple aspects of care, however something that does not change is the role of the nurse as a bridge between health care advancements and the patient. There are several aspects in nursing care to consider here including ensuring that patients understand the need for genetic testing and being appropriately informed; providing education and support on family history and risk assessments; guiding patients to understand their results and what they mean; and being sensitive to cultural, ethical and religious perspectives.

Genomic informed practice is about complementing clinical responsibilities. The focus is ultimately on refining the advocate role of the nurse. By improving genomic literacy, the link between observed symptoms to why they are occurring is strengthened, promoting individualised care. Health care is dynamic and changing, yet the requirement of a good nurse remains the same. Nurses need to be informed, competent, compassionate and empathetic. Hence genomics needs to be embraced as a professional necessity and an important tool in providing equitable care to our patients.

Marisa Galea Vella

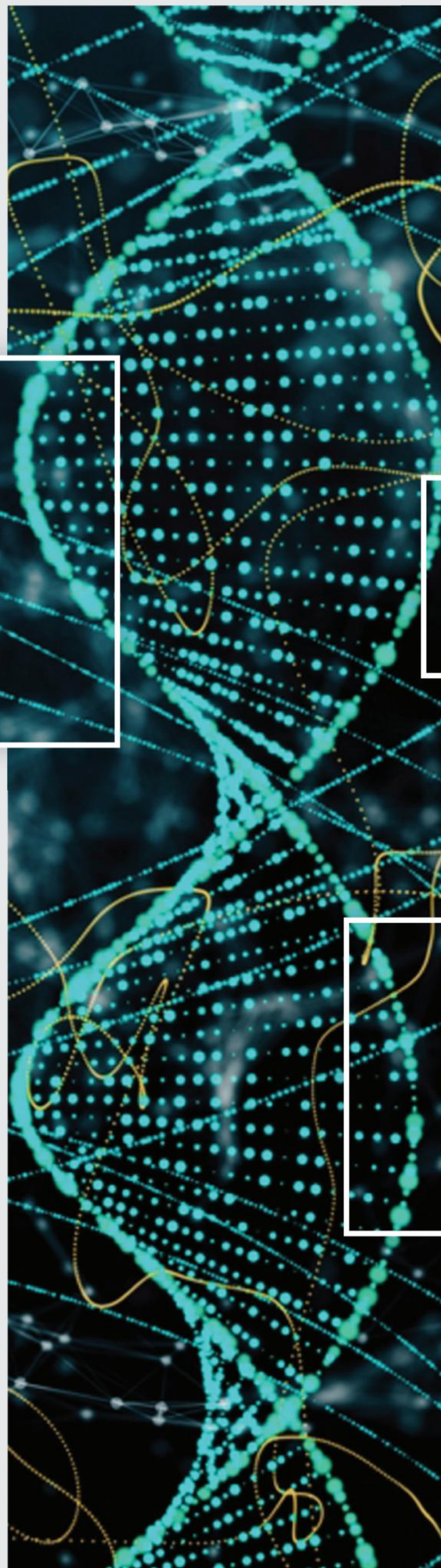
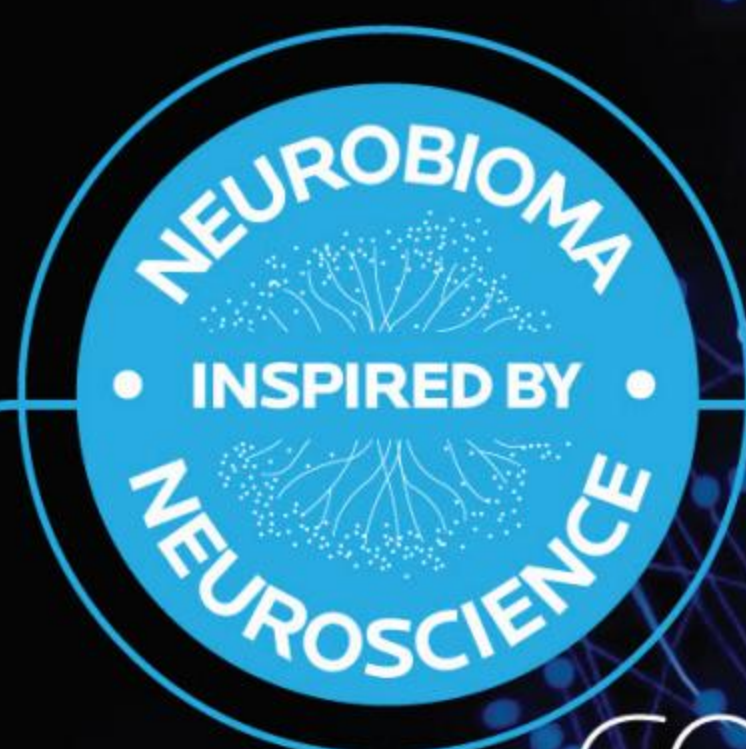


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RCN survey shows nursing staff feel more undervalued than ever

Two-thirds of nursing staff say their pay doesn't reflect their responsibilities, and four in 10 are considering leaving the profession - the RCN reports

A decade on from the first RCN UK-wide Employment Survey, the latest results show nursing staff feel more undervalued than ever. We're calling to "make the next 10 years better than the last".

More than 21,000 of our members from across all health and care settings shared their experiences in our biennial survey, and while there are small signs of progress, the findings show nursing staff feel their skill and expertise are still not properly recognised, while problems include workload and being unable to provide proper care.

Respondents identify pay fairness as their single biggest concern. Two-thirds of them believe their pay does not reflect the responsibilities, skills and risks they carry every day. This isn't just about salary – it's about recognition and value.

The current pay framework is not fit for purpose, and no annual cost-of-living increase will deliver the fundamental change needed. The survey shows record numbers of members dissatisfied with their pay band too, reflecting frustration with the current system.

Retention remains a big issue affecting the workforce. Four in 10 nursing staff are considering or actively planning to leave their roles. The reasons are clear: feeling undervalued, low pay, excessive pressure and emotional exhaustion. This is a warning sign for workforce stability and patient care, and it demands urgent action.

Workload pressures leave staff unable to provide the level of care they want to deliver. Many nursing staff regularly work beyond their contracted hours, often unpaid, and more than eight in 10 report working when unwell. These pressures affect morale, health, and the ability to provide the level of care nursing staff aspire to deliver.

There's also a dramatic decline in advocacy for nursing as a career. While most respondents still describe nursing as rewarding, only a third say



they would recommend it – the lowest figure since the survey began a decade ago. This drop signals a serious threat to the future of the profession.

The picture painted by the survey is one of not only stress and strain at work, but at home too. Rising living costs have left some nursing staff reconsidering pension contributions and struggling to meet basic expenses.

Nursing staff are clear about what would make the biggest difference: a pay rise is overwhelmingly the top priority, followed by more annual leave and greater flexibility in working arrangements. These findings provide a clear roadmap for improving morale, retention and restoring confidence in nursing.

In the foreword to the report, Professor Nicola Ranger, RCN General Secretary and Chief Executive, said: "Ten years on from our first employment survey and the results continue to paint a worrying picture – many nursing staff are considering or actively planning to leave their roles.

"The current pay framework is broken and long overdue reform to the pay structure is needed. No annual cost of living pay increase is ever going to be enough to deliver the fundamental change we need.

"Despite these challenges, nursing is an amazing profession. Our challenge now is to make the next 10 years better than the last, for nursing as a profession but crucially for patients too.

"This means securing fair pay and recognition for all of nursing; investment for safe staffing, including mandated minimum nurse-to-patient ratios in all settings; and action from employers to make workplaces safer, with every member of the nursing workforce supported, valued and protected.

"These ambitions are not new - but they need to be realised now more than ever." This evidence will be provided directly to politicians and will inform the RCN's national campaigning and policy demands.

Manual on work-life balance measures - PSMC

The Public Service strives to lead by example in fostering and promoting a healthy work-life balance. These measures are designed to achieve an effective equilibrium between organisational requirements and the personal needs of employees. This manual outlines the comprehensive range of initiatives available to public employees to support their wellbeing and enhance work-life integration.

- The manual is structured into three (3) main sections:
- 1. Paid Leave for Family Reasons Approved by Directors
 - 2. Unpaid or Partially Paid Leave for Family Reasons Approved by Directors
 - 3. Modern Work Practices

1. Paid Leave for Family Reasons Approved by Directors

The Public Service recognises that family life events often require immediate and structured support. Paid leave for family reasons ensures that employees are not financially penalised when attending to significant personal or family milestones. These measures are approved by Directors and apply equally to Public Sector Employees where indicated.

1.1 Marriage / Civil Union Leave

Employees who contract marriage or enter into a civil union are entitled to **three working days of paid leave** and should not start later than the first working day following the occasion. This leave supports employees during an important life transition while maintaining administrative clarity.

1.2 Release to Attend Ante-Natal Examinations

Pregnant employees are entitled to attend ante-natal medical appointments during working hours **without loss of pay or benefits**. This provision extends until confinement and ensures maternal health is prioritised without administrative burden.

1.3 Maternity Leave and Breastfeeding Facilities

Maternity leave constitutes a cornerstone of work-life balance. Eligible employees are granted **18 weeks of maternity leave**, with **14 weeks on full pay** and an additional **4 weeks covered under Social Security benefits**. The policy also provides safeguards for health and safety, special maternity leave where risks exist, protection of employment rights, and full reintegration guarantees.

Breastfeeding employees are further supported through **paid daily breaks of up to one hour**, flexible working arrangements, and access to appropriate facilities.

1.4 Parent Leave

Fathers or equivalent second parents are **entitled to ten working days of paid leave** on the birth or adoption of a child. This leave must be taken within fifteen days of the event and reflects the Public Service's commitment to shared parental responsibility.

1.5 Leave for Medically Assisted Procreation (I.V.F. Leave)

Recognising the physical and emotional demands of medically assisted procreation, this policy grants **paid leave ranging from 40 to 60 hours per process**, depending on the employee's role (receiving parent, prospective parent, or donor). Entitlements may be utilised flexibly and apply irrespective of gender or sexual orientation.

1.6 Adoption Leave

Adoptive parents are entitled to **18 weeks of adoption leave**, mirroring maternity provisions. Fourteen weeks are paid in full, with the remaining weeks covered by Social Security. The policy also provides flexibility for international adoptions and enforces service obligations to ensure continuity within the Public Service.

1.7 Bereavement Leave

Employees suffering the loss of a close family member are entitled to **two working days of paid bereavement leave**, extended to **seven days** in cases of the death of a child under eighteen. This compassionate provision may be supplemented where deaths occur abroad and includes access to professional support services.

1.8 Miscarriage Leave

Employees who experience pregnancy loss prior to the 22nd week, as well as the other prospective parent, are entitled to **seven working days of paid leave**. This measure acknowledges both physical recovery and emotional wellbeing, while ensuring dignity and confidentiality.

1.9 Urgent Family Leave

Urgent family leave addresses unforeseen situations such as accidents, sudden illness, births or deaths. Employees may avail of up to **32 hours per year**, split between vacation leave and sick leave entitlements, allowing swift response to family emergencies.



1.10 Donation of Vacation Leave / Time-Off-In-Lieu (TOIL) for Humanitarian Reasons

This innovative mechanism allows employees to donate unused vacation leave or TOIL to a **central fund or directly to colleagues** facing serious humanitarian circumstances. The system promotes solidarity across the Public Service and is governed by strict eligibility, documentation, and approval procedures to ensure fairness and transparency.

2. Unpaid / Partially Paid Leave for Family Reasons Approved by Directors

Where paid leave is insufficient or unsuitable, the Public Service provides a range of unpaid or partially paid leave options. These measures balance compassion with operational sustainability and are generally subject to eligibility criteria and service limits.

2.1 Leave to Accompany Spouse / Partner on Government-Sponsored Assignments

Employees may apply for up to **four years of unpaid leave** to accompany a spouse or partner on official government assignments abroad. This promotes family unity while supporting national commitments.

2.2 Parental Leave – Applicable to Parents, Legal Guardians and Foster Carers

Eligible employees may avail of up to **12 months parental leave per child**. The

leave can be taken flexibly, in blocks or part-time, and may be shared between parents. This framework supports early childhood care while preserving career continuity.

2.3 Carers' Leave

Carers' leave enables employees to support relatives or household members requiring medical care. Up to **five working days per year** are available, **with three days paid and two unpaid**, reinforcing the Public Service's commitment to dependent care.

2.4 Career Break

Parents and legal guardians may request a **career break of up to five years** to care for children under ten. Though unpaid, this leave preserves the employment relationship and allows re-entry into service with appropriate safeguards.

2.5 Responsibility Leave

Responsibility leave supports employees caring for dependent elderly parents, spouses, or children. Approved for **12 months and renewable**, this unpaid leave reflects the evolving demographic and social realities facing public employees.

2.6 Leave for a Special Reason

Employees may apply for up to **three months unpaid leave** within any twelve-month period for special or exceptional personal circumstances, including work-life balance needs.

3. Modern Work Practices

Modern work practices are integral to fostering flexibility, productivity, and wellbeing. These measures are available to all Public Officers, subject to operational compatibility and internal departmental policies.

3.1 Work on Reduced Hours

Employees may reduce their working week to **between 20 and 35 hours**, with arrangements approved annually. This option supports employees during demanding life phases while retaining skilled personnel.

3.2 Flexi-Time

Flexi-time allows employees to vary start and finish times within agreed parameters, improving autonomy and reducing work-life conflict.

3.3 Flexi-Week

Under flexi-week arrangements, employees may distribute their working hours unevenly across the week, provided total weekly hours are met and service delivery is maintained.

3.4 Remote Working

Remote working enables eligible employees to perform duties away from the traditional workplace, subject to role compatibility, technology requirements, and departmental policy. This measure enhances flexibility while ensuring accountability and performance standards.

Conclusion

The Manual on Work-Life Balance Measures positions the Public Service as a model employer, embedding flexibility, compassion, and modern employment practices within a structured governance framework. Collectively, these measures support employees across all stages of life while safeguarding service excellence and organisational stability.

To ensure access to the most accurate and detailed information, kindly refer to the PSMC online platform, which is regularly updated in real time.

William Grech



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The Silent Burden

Moral Distress and the Mental Health of Nurses

Nursing is recognised as one of the most trusted and compassionate of professions. Nurses care for individuals during the most vulnerable and challenging moments of their lives, often providing both clinical treatment and emotional support. However, as a result of this commitment to care, many nurses experience significant psychological strain, when they feel they are unable to act according to their professional and ethical values. This phenomenon is known as moral distress, and it can have profound implications for the mental health of nurses.

The concept of moral distress was initially introduced by nursing ethicist Andrew Jameton. He defined moral distress as the psychological discomfort that arises when a healthcare professional knows the ethically appropriate action to take however feels unable to take that action due to institutional constraints, hierarchical decision-making or external pressures. Although originally discussed within the context of nursing ethics, moral

distress is now widely recognised as a significant psychological experience affecting healthcare professionals across many clinical settings.

While ethical dilemmas are inevitable when one opts for the healthcare profession, moral distress differs from professional stress. Moral distress occurs when nurses start to feel constrained from an ethical perspective, thus leaving them with a sense of powerlessness and internal conflict. Over time, the repeated exposure to such situations can take a toll on the nurses' psychological well-being. Nurses may experience feelings of frustration, guilt, sadness, anger or even emotional exhaustion. Further down the line, these repeated experiences may contribute to symptoms of anxiety, depression and burn out.

From a mental health perspective, moral distress can be understood as a form of psychological conflict between professional values and practical reality. Nurses are considered the patients' advocate, thus protecting their dignity

and promoting well-being. When circumstances arise and prevent them from fulfilling these responsibilities in the way they believe is ethically correct, the tension that arises can be deeply distressing for the nurse. This internal conflict often manifests as rumination, emotional fatigue and feelings of moral frustration.

In clinical environments, situations that cause moral distress occur more frequently than people realise. End-of-life care is one of the most reported sources. Nurses may feel that certain palliative and medical interventions are prolonging suffering rather than improving quality of life. Although such treatment decisions ultimately rest with the patient's medical team or family members, in such situations, nurses may feel that they are participating in care that conflicts with their own ethical judgement.

Another common cause of distress arises from systemic pressures within

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continued on page 16

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the healthcare system per se. Staff shortages, time constraints and limited resources may prevent nurses from providing the level of care they believe their patients deserve. Prioritising tasks rather than holistic patient care may lead to feelings of inadequacy or professional guilt. When this occurs, nurses may feel that they are compromising their standards of care, even when the circumstances are beyond their control.

Whilst moral distress is far more commonly discussed in intensive care or acute medical settings, it is also highly relevant to psychiatric nursing. Psychiatric Mental Health Nurses frequently encounter ethical tensions related to autonomy, coercion and patient safety. Situations such as involuntary admission or balancing risk management with therapeutic relationships can create significant psychological conflict for nurses. Psychiatric nurses may feel torn between respecting a patient's autonomy and protecting them from harm, particularly when the individual involved lacks insight into their condition. Mental Health professionals are trained to recognise psychological suffering in others, yet they can be less likely to acknowledge their own emotional suffering. Reflecting on moral distress offers an opportunity to bring attention to the mental health of nurses themselves. These dilemmas can generate emotional distress and ethical uncertainty, thus highlighting the importance of reflective practice and psychological support within the mental health services.

From a psychiatric perspective, these experiences often involve a state of mind called cognitive dissonance. Cognitive dissonance is a psychological state in which an individual's actions conflict with their beliefs or values. When nurses repeatedly experience such dissonance, it can ultimately lead to chronic psychological strain. The emotional burden of unresolved ethical conflict may result in irritability, emotional withdrawal, sleep disturbance or persistent worry.

Another concept related to moral distress is moral residue. The term refers to the lingering emotional impact that remains after a morally distressing event has occurred. The philosopher, Margaret Urban Walker

has described how unresolved ethical conflicts can leave lasting impressions on individuals. For nurses this means that even after a particular situation has ended, the emotional weight of the experience may persist.

The mental health implications of moral distress should not be underestimated. Studies have shown that nurses experiencing high levels of moral distress are more likely to report symptoms of burnout, emotional exhaustion and compassion fatigue. In severe cases, prolonged exposure to moral distress may contribute to anxiety disorders, depressive symptoms or disengagement from their professional role further down the line.

Peer support also plays a crucial role. Nurses often benefit from sharing experiences with colleagues who understand the realities of clinical practice. Discussing difficult cases can provide emotional validation and help nurses realise that their reactions are not signs of weakness but natural responses to complex ethical situations. Education may further empower nurses to navigate ethically challenging environments. Training in communication, ethical reasoning and conflict resolution may help nurses feel more confident when raising concerns about patient care. When

healthcare professionals feel supported in expressing their ethical perspectives, the sense of powerlessness associated with moral distress may be reduced. In many ways, moral distress reflects the deep ethical commitment that nurses bring to their work. The emotional discomfort experienced in these situations arise because nurses care genuinely about doing what is right for their patients. Rather than viewing moral distress as a sign of professional weakness, it should be recognised as evidence of moral integrity that lies at the heart of nursing practice. By creating spaces for reflection, dialogue, and support, healthcare organisations can help nurses navigate the psychological challenges of their profession. In doing so, they not only protect the well-being of healthcare professionals but also strengthen the compassionate foundation upon which quality patient care depends.

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Malta's Healthcare Heroes

Investing in Nurses and Midwives for a Healthier Tomorrow

by Dr. Dylan Attard, CEO and Co-Founder, MedTech World

Healthcare systems are often measured by their infrastructure, technology adoption, and policy frameworks. Yet, at their core, they are sustained by people. Nurses and midwives represent the backbone of care delivery. Their contribution extends far beyond bedside support. They are clinical leaders, patient advocates, educators, and anchors of community health.

If we are serious about building a stronger and more resilient healthcare system, we must place sustained investment in nurses and midwives at the centre of national strategy.

Malta's healthcare system has earned respect for its accessibility and quality. However, like many small island states, it faces unique pressures. An ageing population, growing chronic disease burden, workforce shortages, and evolving patient expectations are reshaping the landscape. These realities demand more than incremental change. They require forward-thinking policies that empower the professionals who carry the system every day.

Strengthening the Foundation of Care

Nurses and midwives are often the first and last point of contact in a patient's healthcare journey. From preventive care and early diagnosis to post-operative recovery and maternal health, they play a continuous and trusted role. Their work in maternity services is particularly profound. Midwives safeguard not only clinical outcomes but also the dignity, safety, and emotional well-being of mothers and newborns during life's most critical moments.

Yet despite their indispensable role, the profession faces mounting pressures. Recruitment and retention remain ongoing challenges across Europe. Competitive international markets, burnout, and limited career progression pathways risk draining local talent. Malta must therefore adopt a long-term approach that makes nursing and midwifery not only viable careers but aspirational ones.

Investment must begin with education. Strengthening academic pathways, increasing access to specialist training, and expanding postgraduate opportunities are essential. Continuous professional development should not be seen as optional but as foundational. As healthcare becomes increasingly complex, nurses and midwives require advanced skills in digital health tools, data literacy, patient-centred care models, and multidisciplinary collaboration.

Empowering Leadership and Embracing Innovation

Technology will continue to play a larger role in healthcare delivery. Digital patient records, remote monitoring, AI-assisted diagnostics,

and telehealth services are no longer future concepts. They are present realities. However, technology cannot operate in isolation. Its success depends on the competence and confidence of those who use it. Nurses and midwives must be included in conversations about digital transformation from the outset. They should be trained, consulted, and empowered to shape implementation strategies.

At MedTech World, we have witnessed how innovation thrives when frontline professionals are part of the dialogue. The intersection between healthcare delivery and emerging technologies is where meaningful progress occurs. Nurses and midwives bring practical insight that ensures solutions remain grounded in patient reality. When we invest in their leadership development, we strengthen the bridge between innovation and impact.

Beyond technical skills, leadership is another critical area. Nurses and midwives should have clear pathways to management, policy advisory roles, and strategic positions within healthcare institutions. Representation matters. When clinical professionals influence decision-making at higher levels, policies are more responsive, patient-centred, and sustainable.

Wellbeing must also be prioritised. The emotional and psychological demands of nursing and midwifery are significant. Structured mental health support, manageable staffing ratios, and recognition programmes are not luxuries; they are necessary safeguards. A system that does not care for its caregivers risks long-term instability.

Recognition, in particular, plays a powerful role. Public acknowledgement of excellence, professional awards, and visible career progression frameworks reinforce the value of the profession. They send a message to younger generations that these careers are respected, rewarding, and impactful.



A National Priority for a Healthier Tomorrow

Collaboration between policymakers, healthcare institutions, educational bodies, and private sector stakeholders is essential. Investment cannot be fragmented. It must be coordinated and strategic. Malta's size offers a unique advantage: agility. With aligned leadership and shared commitment, meaningful reforms can be implemented more efficiently than in larger systems.

Midwifery deserves focused attention within this broader framework. Maternal and neonatal care form the foundation of long-term population health. Investing in modern birthing facilities, updated clinical protocols, and specialised training enhances outcomes not just for families, but for society as a whole. Healthy beginnings translate into healthier futures.

Looking ahead, workforce planning will be critical. Data-driven forecasting can help anticipate shortages and guide training capacity. Incentives for local retention, alongside responsible international recruitment where necessary, must be balanced carefully to ensure sustainability.

Above all, we must foster a culture of respect and partnership. Healthcare is increasingly multidisciplinary. Nurses and midwives should be recognised as equal partners in clinical teams. Their insights into patient behaviour, continuity of care, and community engagement are invaluable.

As CEO and Co-Founder of MedTech World, I have seen firsthand how healthcare ecosystems evolve when professionals are supported, trained, and empowered. Innovation, policy, and infrastructure all matter. But without strong clinical foundations, progress cannot be sustained.

Malta's nurses and midwives have consistently demonstrated commitment, expertise, and compassion. They are healthcare heroes not because of circumstance, but because of the responsibility they carry every day. The question before us is clear: will we match their dedication with the investment they deserve?

A healthier tomorrow begins with the choices we make today. Investing in nurses and midwives is not an expense. It is a national priority.

Pay Review Body recommends 3.3% pay award - but NI Nursing staff still waiting

The Pay Review Body (PRB) has recommended a 3.3% pay rise for nursing staff

Governments in England and Wales have confirmed the award will be paid from April, but nursing staff in Northern Ireland are left with no clarity about when they will receive it.

Responding to the announcement, Professor Rita Devlin, RCN Northern Ireland Executive Director, said the recommendation falls far short of what nursing staff need and deserve.

"A pay award that falls below current inflation is very disappointing to our members. Without a significant drop in inflation, this award will amount to a real-terms pay cut for health service staff.

"This year, across England, Wales and Northern Ireland, unions were led to expect direct negotiations with the government over this award. However, this hasn't happened and we are left, once again, with the Pay Review Body recommendation. The RCN, alongside most other unions, withdrew from the Pay Review Body in 2025 as we do

not consider it fit for purpose, and it continues to fail nursing staff.

"While this pay award will be implemented immediately in England and Wales, nursing staff in Northern Ireland are yet again being left without any certainty about when they will receive it. The Minister has stated his intention to act once a budget is agreed, but this cannot be an open-ended promise and must be resolved urgently. It is indefensible that the absence of a Northern Ireland budget is blocking hardworking nursing staff from receiving the pay they are owed.

"The RCN will also now examine how this award compares with settlements across the rest of the NHS and wider public sector before determining our next steps. Nursing staff will not accept being left at the very bottom of the queue, again receiving the lowest public sector pay award."

"The evidence is clear - low pay and poor working conditions are driving nurses out of the profession. Morale



is at an all-time low and nursing staff, who already feel deeply undervalued, are leaving. We must address these issues if we are to deliver safe care to the people of Northern Ireland."

EFN Briefing Note continued from page 7

In the meantime, the Commission is also engaging the Member States' National PQD Coordinators to identify suitable candidates for CTFs. It is therefore crucial for the EFN Members to continue engaging their National PQD Coordinators, as according to the report, they have shown interest in a common training framework for healthcare assistants, but EFN believes the priority should be first a CTF for APN as we started the harmonisation process already! As such, the EFN Members need to show to their National Coordinators, as well as the PQD national assistance centres, the huge progress made by EFN members on the harmonisation of APN in the EU and Europe. National assistance centres are key because they serve as primary contact points for professionals and competent authorities seeking guidance and information.

The user experience can be improved, but digitalisation can improve this: The report identified slow and complex recognition procedures due to uneven digitalisation and extensive documentation requirements as a challenge for professionals' mobility in the EU. However, the report highlights that embracing digital tools could significantly reduce administrative burden for both applicants and competent authorities, creating a more efficient and responsive professional recognition systems. In particular, building on the experiences with the European Professional Card (EPC) and the Internal Market Information System (IMI), a more unified digital approach could help to reinforce the safeguards and mutual trust that underpin the Directive while improving efficiency, transparency and user experience.

Conclusions and next steps: EFN continues raising its concerns about the lowering down of the minimum requirements by some National Governments. EFN stresses the need to fully implement the PQD in its current form, with possibilities for improvement while at the same time avoiding possible unintended consequences. However, the possible amendments to the current Directive would be limited to those related to digitalisation of recognition processes and other aspects related to the user experience – not to the minimum education and training requirements. On these aspects, policy and legislative proposals by DG EMPL are expected by the end of the year.

EFN Briefing Note on Implementation Report PQD – 24 02 2025



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*from our
diary*



IDEA Academy addressed our members during the monthly seminar. MUMN is proud to partner with IDEA Academy for the interest of our members.



The Institute of Health Care Professionals (IHCP) continue to organise the monthly seminars at the MUMN Conference Center.

Consociazione Nazionale Associazioni Infermiere/i

MUMN was invited to attend a congress organised by the Italian Nurses Federation (CNAI) on the occasion of their 80th Anniversary. Our President Paul Pace addressed the congress.



William Grech, Deputy General Secretary and Geoffrey Axiag, Deputy Chairperson IHCP participated in a Careers Fair on behalf of MUMN.



MUMN successfully defended its members in Court. The outcome was outstanding



George Saliba, MUMN's Financial Secretary informed MUMN Administration that all the debt related to the new premises has been settled. A symbolic key was presented to MUMN President.



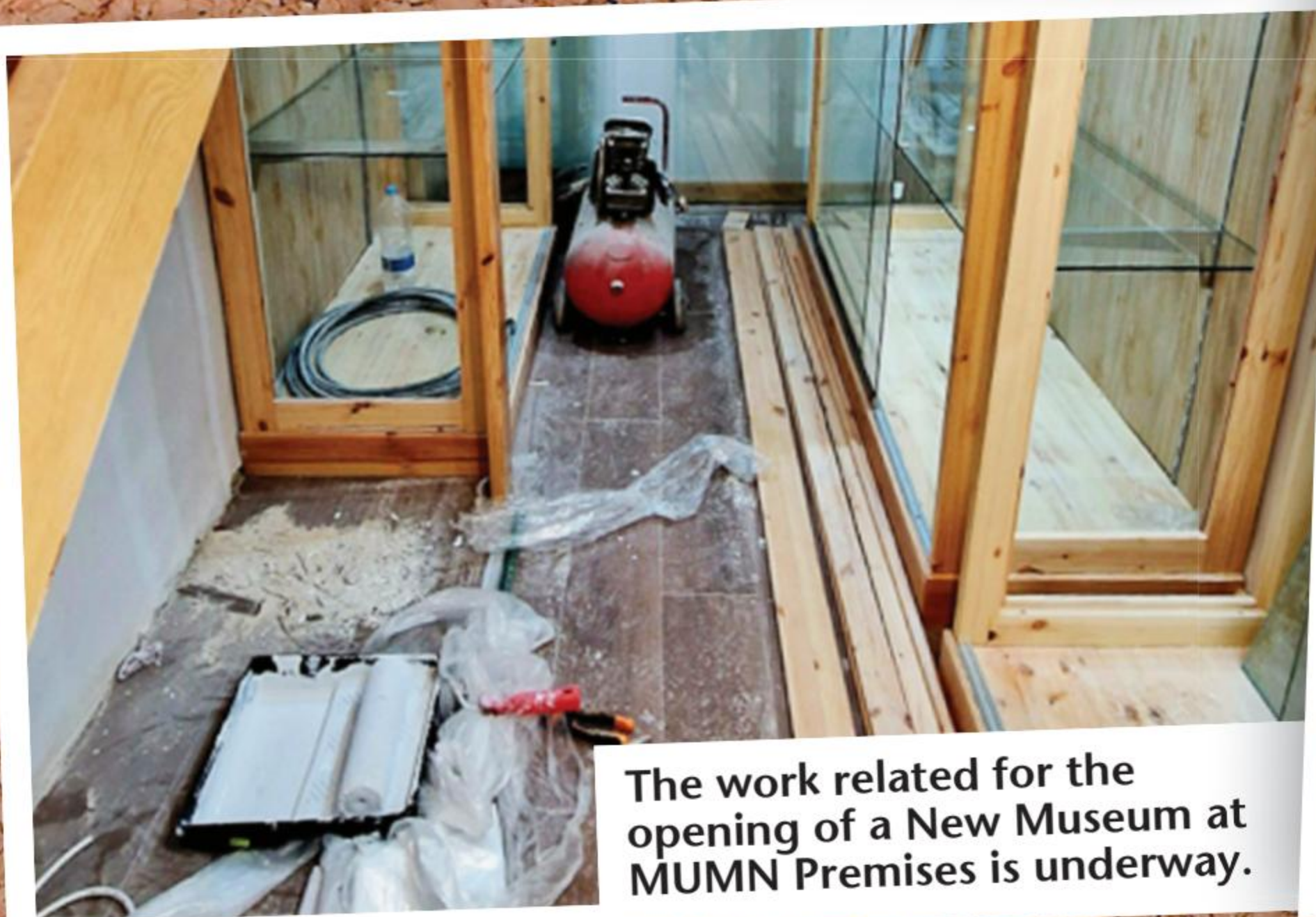
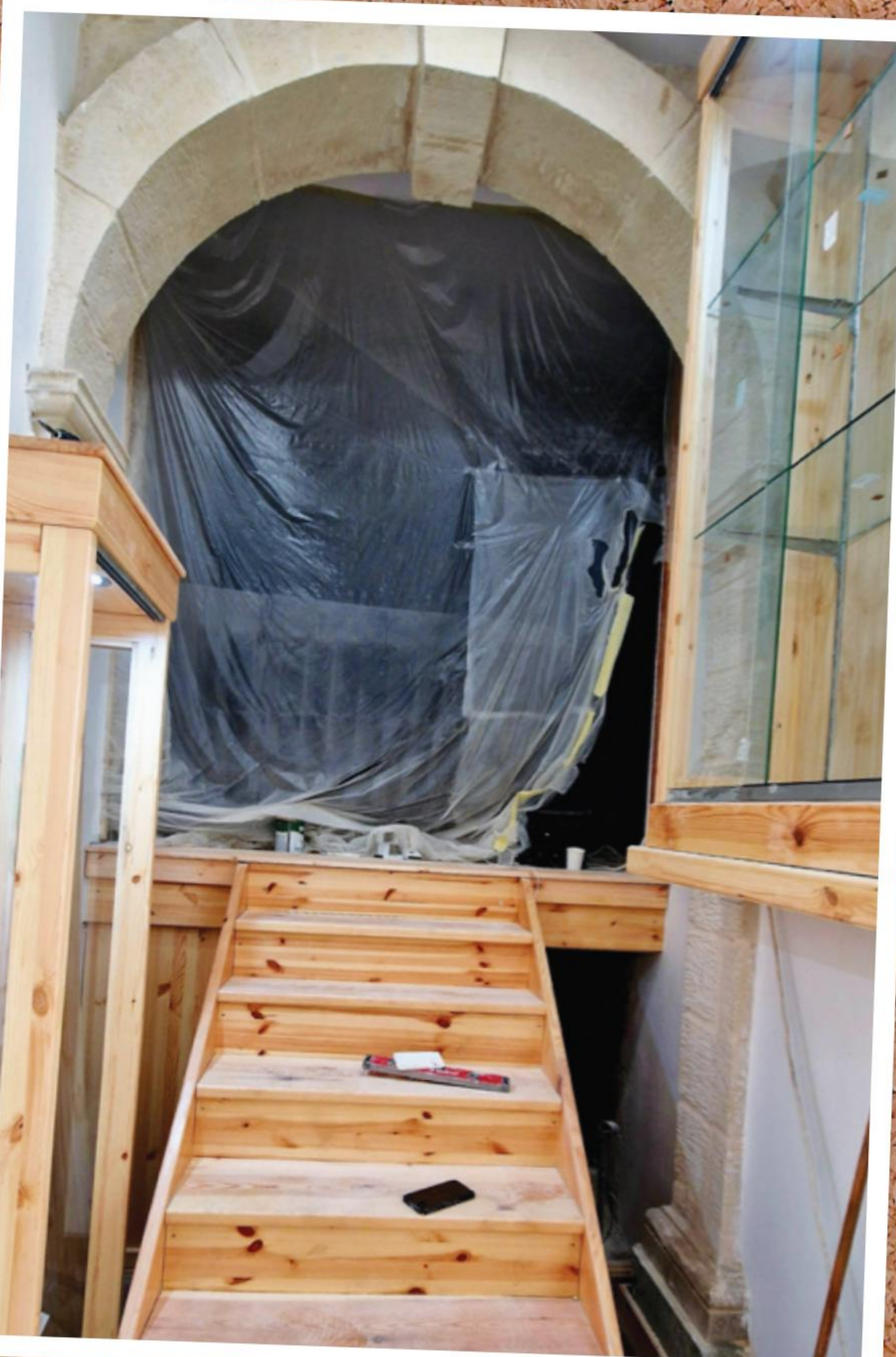
The Executive Committee of the Institute for Health Care Professionals won the Paul Bezzina Shield for their outstanding performance throughout 2025. Ms. Claire Zerafa, Chairperson received this award on behalf of her Committee.



MUMN Administration organised its Annual Activists Seminar. It was a very successful day.



MUMN received a prestigious award from IDEA Academy as recognition of the work done together by the two organisations in the interest of Nurses.



The work related for the opening of a New Museum at MUMN Premises is underway.



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idea
CARE

The Privilege of Being Invited In.

How care protects families without replacing them.



Daniela Darmanin
Director | IDEA Care

Across the past two decades in social work, I have had the privilege of walking alongside families through some of the most intimate chapters of their lives. I have been welcomed into homes at moments of joy, crisis, uncertainty, and transition. I have seen how families carry love, fear, responsibility, and hope all at once. Those experiences taught me that care is never just practical. It is emotional, relational, and deeply human. It is about dignity, presence, and the quiet promise that no one should feel alone in their most vulnerable moments.

That understanding became the foundation of IDEA Care.

For many elderly individuals, home is far more than a physical space. It is memory, identity, and belonging. It is the echo of laughter that once filled the rooms, the familiar creak of a door, the chair that holds decades of routine. The desire to remain in a place that feels safe and known is deeply personal, and it strengthens with age.

There comes a moment in many families when a quiet, painful conversation begins. It is the moment when love alone no longer feels enough to protect a dear one. Some elderly individuals choose to transition to residential care, and that decision deserves full respect. But for others, remaining in the community is not simply a preference. It is an expression of identity, independence, and continuity. And elderly people have so much to give. They are carriers of history, humour, wisdom, and resilience. They are the storytellers who connect generations. Supporting them to remain active and engaged in their communities is not just an act of care. It is an investment in the social fabric that holds us together.

I remember a mother who once shared with me how deeply torn she felt between everyone she loved.

She was rushing between her children's activities, school pressures, and the relentless rhythm of family life, while carrying constant guilt that she could not give enough time to her ageing parents. She would lie awake at night wondering who she had disappointed most.

The moment tailored support for her elderly parents was introduced, something shifted. She was still a devoted daughter, but she was no longer alone in the responsibility. For the first time in months, she could breathe without panic. Her parents gained a circle of care. And she regained the ability to simply be present with them, not as a crisis manager, but as a daughter who could sit, talk, and love without the shadow of exhaustion.



Care does not replace families. It protects them.



This is the work IDEA Care was built to do. We support elderly individuals, persons with disability, and families seeking structured wellbeing within the community. We provide personalised care support, home help, companionship, and personal assistance that adapts as needs change. We work within a multidisciplinary team to promote independence, mobility, and quality of life.

What makes IDEA Care different is this: we do not simply match a family with a carer and leave them to face the hurdles alone. We remain present throughout the journey. We provide continuity when a usual carer is unavailable. We offer emergency coverage when the unexpected happens.

We guide families through government subsidy applications and systems that can otherwise feel overwhelming.

What families seek is certainty. They want to know that someone dependable will arrive, that their loved one will be treated with respect, and that care will be delivered with professionalism and heart. IDEA Care is structured around that promise. Continuous guidance, ethical standards, and strong professional frameworks are the foundation of everything we do. Community care is not simply assistance with daily living. It is presence, companionship, and the quiet reassurance that vulnerability should never be faced alone.

In the end, care is measured in trust. It is the quiet comfort of hearing a familiar knock at the door. It is the easing of a family's constant worry. It is the ability for elderly individuals to remain connected to the spaces and communities that hold their memories. And there is no greater privilege than being invited into that journey.



IDEA Care was born out of our leadership team's personal experiences in the health and social care fields and the growing need for a holistic, community-based service that truly makes a difference. We combined our professional knowledge and expertise to design a service that places the client at the centre of every decision and every care plan.

Our mission is to help you live comfortably, confidently, and independently in the place you call home.

IDEA Care - Care that fits around your needs.



In-Nurses fl-Arti Viżiva mal-Medda taż-Żmien

Kitba ta' Joe Camilleri, C.N.

L-element viżiv, sew jekk hu forma ta' tpingija, b'lapis jew kulur; pittura ta' liema forma hi, watercolour, żejt jew acrylic; kobor u forma ta' kull għamla; tessut u tila ta' kull materjal; kompożizzjoni ta' ideat, emozzjoni u narrativa, jingabar f'kategorija waħda: l-Arti. Din tinkludi arti fina tradizzjonali, forma ta' pittura, sa stampar u mediums ġodda bħall-fotografija u mixed media. Illum se nkunu qed nitkellmu fuq il-pittura jew litografija li tfakkar lin-Nurses jew lin-Nursing.

L-immaġni tan-Nurse u l-Qabla nbidlu matul iż-żmien. Imbidlu għax xogħolna evolva minn neċessità informali għall-professjoni xjentifika. In-Nursing sfortunatament kien safa renegat bħala xogħol ta' bla valur sakemm xogħol in-Nurses waqt il-gwerra tal-Krimea iġġenera immaġni qalbiena u idealista ta' Nurses li damet matul il-gwerer kollha tas-seklu għoxrin.

Li tipprovdi kura ta' kompassjoni giet kemm il-darba irappreżentata permezz ta' paraboli Bibbliċi, bħal 'The Good Samaritan Attending to the Wounded Traveller at the Inn' ta' Giovanni Battista Langetti (1635–1676), fejn is-Samaritan it-Tajjeb narawh jikkura vjaġġatur ferut jew fejn San Kosmo u Damjan, kienu qed idewwu ferita f'pittura tal-1748 ta' Antoine de Favray.

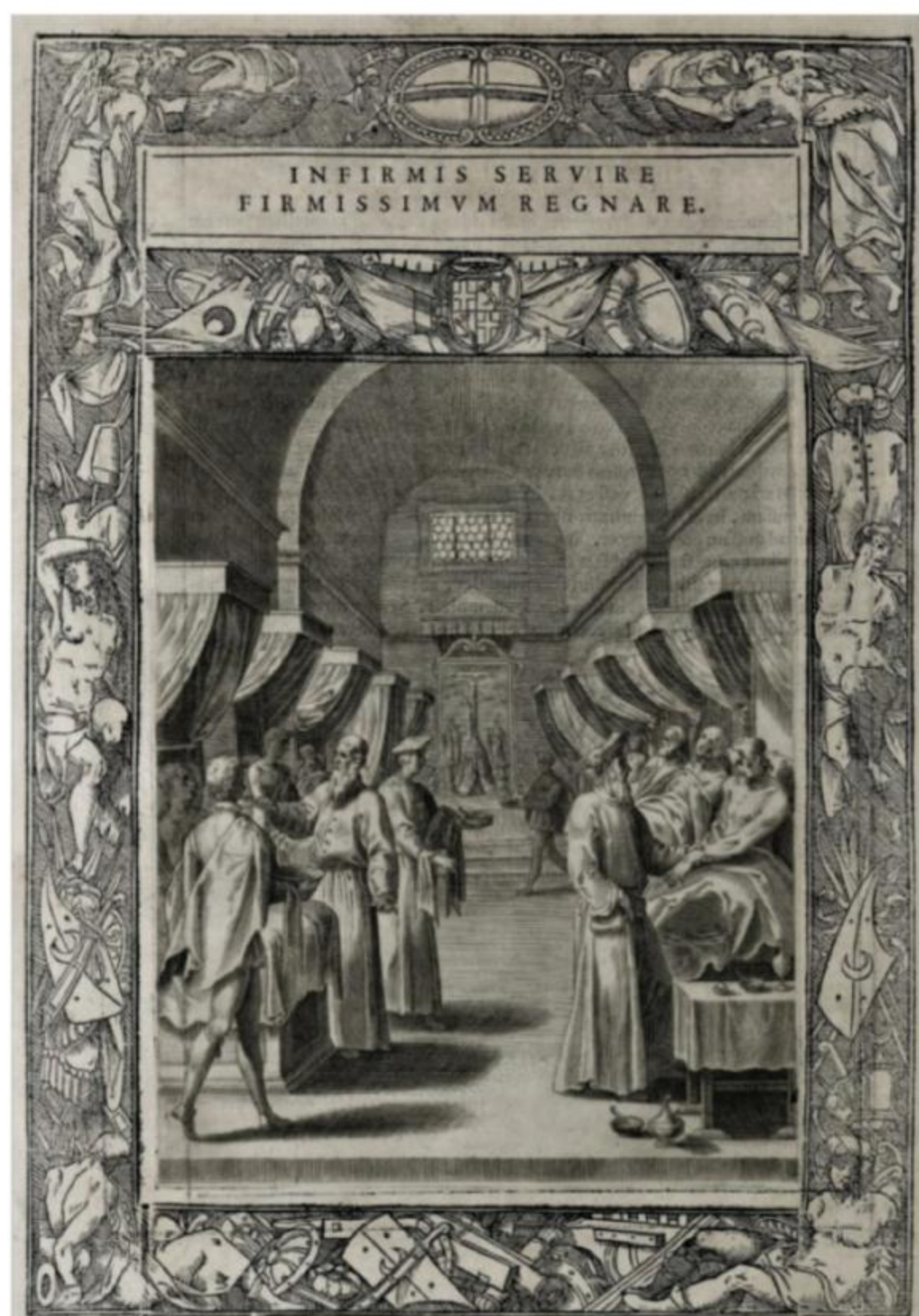


Georges de La Tour jipprezentalna is-
"Saint Sebastian Nursed by Saint Irene"

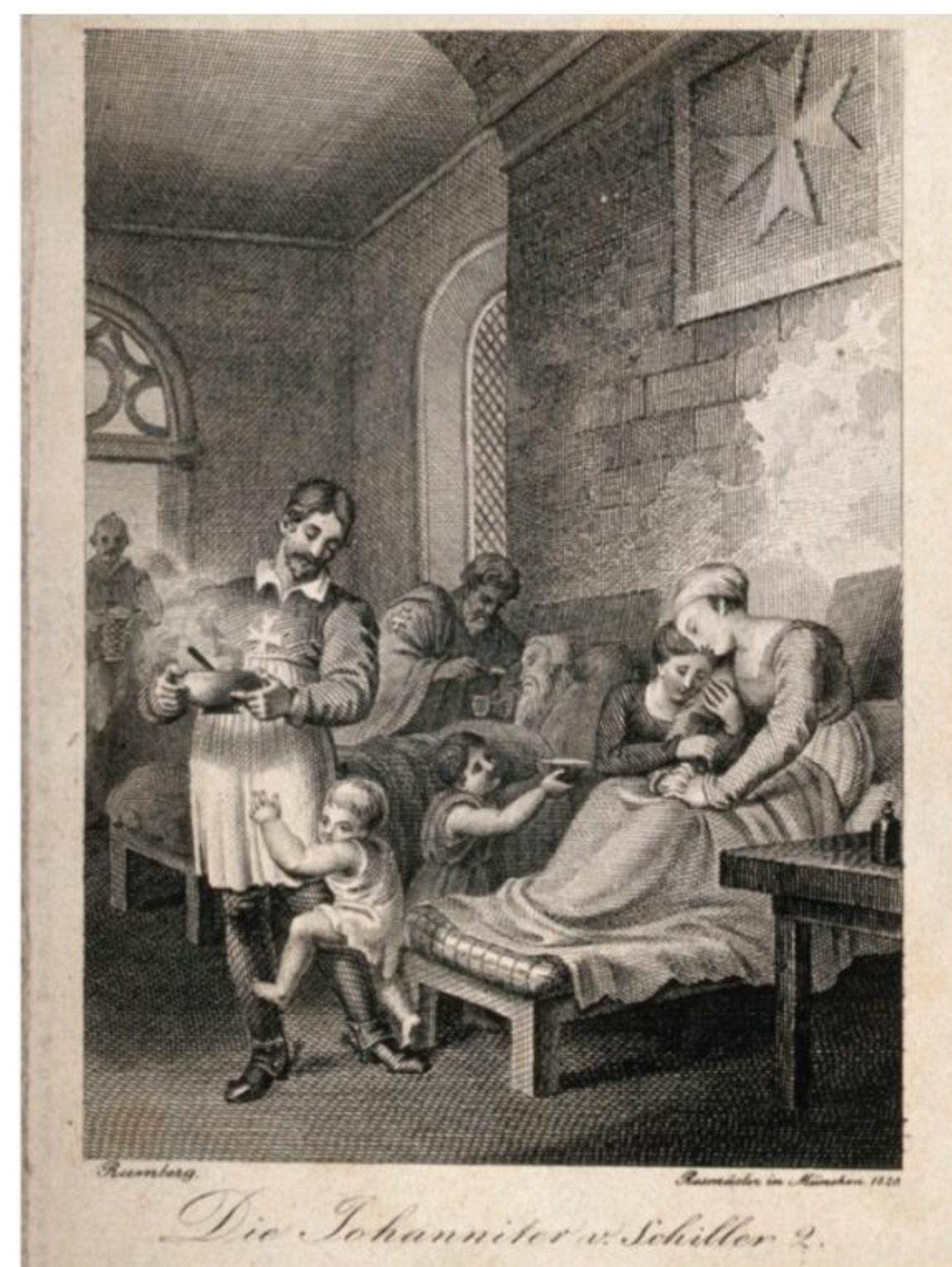
bi chiaroscuro, fejn naraw lil Santa Irene, iddewwi, tattendi għall-feriti ta' San Sebastjan. Permezz ta' hekk, dan kien ġab saħħtu lura, imma wara kien għadda għat-tieni martirju tiegħu.



Minn litogrifa ta' żmien l-Ordni Ospedallier ta' San Ġwann Battista, u allura f'kuntast Malti, ġewwa s-Sacra Infermeria tal-Belt Valletta, nassistu għall-Gran Mastru nnifsu, qed jaqdi dmiru, u jagħti eżempju billi jpoġġi hdejn il-morda u joffri l-ikel minn platt tal-fidda, waqt li qed jitkellem magħhom u jaqsam kelma ta' konfort u konsulazzjoni. L-inċiżjoni saret minn Philippe Thomassin (1562-1622) u jinsab fl-iStatuta Hospitalis Hierusalem (Ruma), 1586.



Dettal sabiħ huwa muri f'inciżjoni oħra imsejha 'An interior of a hospital of the Order of St. John' ta' Rasmäsler, magħmula fl-1828.



Matul l-era medjevali sal-era moderna bikrija, kemm l-ordnijiet reliġjużi tal-irġiel u dawk tan-nisa kienu magħrufa li jattendu għall-morda bħala att ta' karità. L-arti reliġjuża kienet donna tiffoka fuq il-fejqaq divin, imma xi immaġni kienu anke juruna l-kura tal-marid u dawk li qed ibatu, bħal dak l-affresk tal-1440 fl-Isptar ta' Santa Maria della Scala fi Siena.

In-nursing bikri kien wieħed informali, u ħafna nies kienu ikkurati fi djarhom minn qrabathom, servjenti jekk kienu għonja, u anke dawk li kellhom kapaċità jfejqu. Jacobus Vrel's bil-pittura tiegħu 'The Little Nurse' jurina propja dan, f'nofs is-seklu sbatax, bil-marid mixħut ġo soda, ma jidhirx fil-pittura.



Immaġni ta' nurses fis-sakra u mdellka dehru wkoll f'karikaturi tal-era Ġorġjana, bħall-watercolour ta' Thomas Rowlandson (1757–1827) bl-isem ta' 'The Drunken Nurse'.

ikompli f'paġna 27



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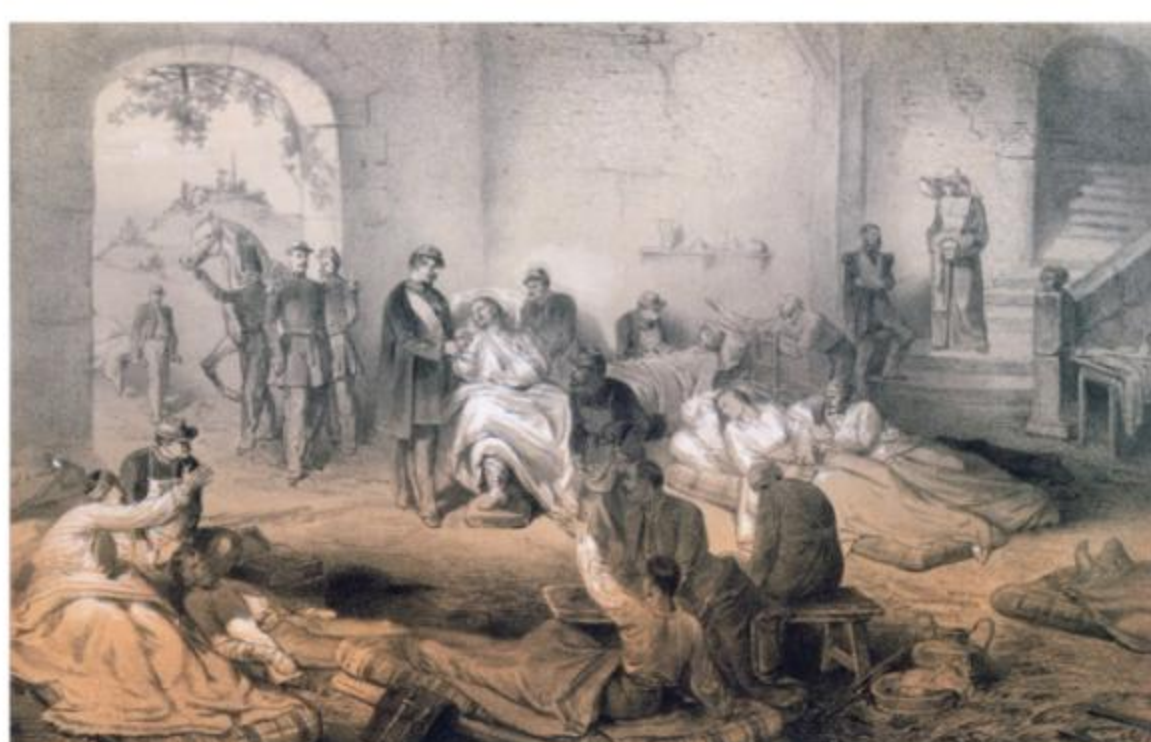
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ikompli minn paġna 25



Xena drammatika turi meta l-imperatur Napuljun III żar is-soldati feruti wara l-Battalja ta' Solferino, fl-1859, litografija bil-kulur, fejn barra attendenti u stretcher-bearers naraw ukoll soru reliġjuża, qed tara li kollox ikun fl-'ordni'.



Wellcome Collection

L-Industrializzazzjoni u l-urbanizzazzjoni tad-dsatax-il seklju ġabet il-kura fl-isptarijiet aktar milli fil-komunità. Imma t-trattament kien għadu jvarja ħafna, b'xi isptarijiet jiddependu minn orderlies mhux imħarrġa jew pazjenti li qed ifiequ li jissapportjaw lill-oħrajn. Benjamin Zix, bil-watercolour tal-bidu tad-dsatax-il seklju jurina soldati feruti ittrattati fi sptar u l-attività kaotika fi spazju wieħed.



Fost l-aktar immaġni popolari ta' nurse ta' kull era hija dik ta' Nightingale f'dak li ġie mpingi u msejjaħ 'Lady with the Lamp', figura ta' omm, b'hal donna metafora ta' mara ideali Kristjana, b'dik il-ħarsa angelika tħuf qalb is-soldati qed ifiequ fis-swali ta' Scutari. Din l-immaġni romantika deheret għall-ewwel darba fl'Illustrated London News ta' J.Butterworth tal-1855 u proliferat f'litografiji, statwi u pitturi.



Dan wassal biex l-immaġni tan-Nurse u l-Midwife ġie idealizzat u sa l-aħħar tad-dsatax-il seklju, il-perċessjoni tan-nursing imbidlet kompletament għal waħda rispettabbli, kif jidher fil-pittura biż-żejt tal-1892 ta' Sir Hubert von Herkomer (1849-1914), 'Our Village Nurse'.



Fl-Imperial War Museum', hemm pittura tal-1915 imsejjaħ 'Nurse, Wounded Soldier, and Child' fejn turina d-determinazzjoni u r-resiljenza ta' Nurse qed twiežen suldat bil-krozzi f'id minnhom waqt li qed tħaddan tifla b'id oħra. Dawn l-immaġni kienu bdev juru t-tibdiliet minn nursing patetiku, jew li l-mara hija ta' sess dgħajjef għall-ideat kontemporani ta' femminilità rispettabbli.



Jekk nibqgħu fuq il-Gwerra l-Kbira insibu wkoll 'World War I: stretcher

bearers of the Royal Army Medical Corps (RAMC)' fejn il-'medics' qegħdin iġorru ferut minn trench, pittura ta' Gilbert Rogers. Hawnhekk l-infermiera kienu predominantement irġiel anke mimnħabba li kienu fuq il-front imdemmi tal-battalji. Xogħol skabruż, perikoluż u ħafna drabi fatali. Ma' jdejn l-irġiel naraw faxex bis-salib l-aħmar u badges fuq l-uniformi li jindikaw li kien fl-RAMC.



Minn naħa l-oħra, nurses fuq in-naħa opposta' tal-gwerra kienu iddemozzati b'ħala li huma bla qalb. Dan narawh f' poster fejn jurina nurse Ġermaniża imsejjaħ 'krankenschwester' qed tferra l-ilma fl-art milli tipprovdi lil suldat Brittaniku ferut. Il-poster jgħid: 'There is no woman in Britain who would do it. There is no woman in Britain who will forget it.'



Waqt li l-artisti ta' żmien il-gwerra kienu jpingu b'mod drammatiku u erojku, artisti indipendenti pingew xeni ta'

ikompli f'paġna 28

ikompli minn paġna 27

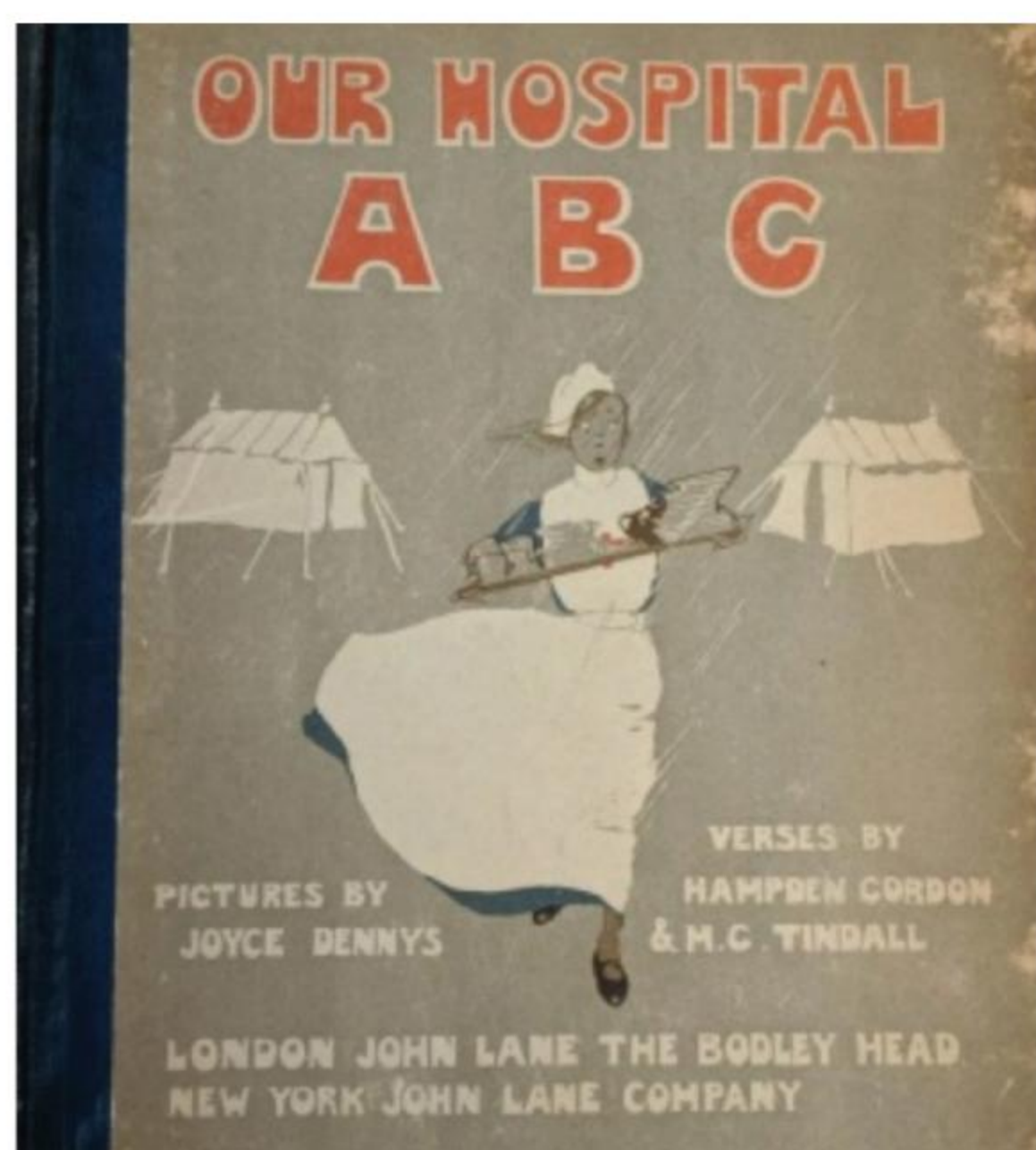
nurses fil-ħin tal-break tagħhom jew meta ma kienux mgħaffġin fix-xogħol bħan-nurse u sister f' "Le Havre, 1919: Nurse Billam and Sister Currier" ta' John Lavery, illum tinsab fl-Imperial War Museum ta' Londra.



Il-famuż Edward Caruana Dingli (1876-1950) għan-nom tas-St John Ambulance Association kien pinga fuq kartolina sbejha, aktar minn mitt sena ilu, Nurse qed tattendi suldat tal-Allejati ferut waqt il-kampanja Gallipoli. Il-kartolina turi wkoll il-Belt Valletta u d-dgħajjes tal-latini fuq wara tax-xena, l-arma tas-St John's u Red Cross.



Is-sens t'umorizmu, anke permezz tal-arti, kellu bilfors jintuża anke waqt il-gwerer. Joyce Dennys (1893-1991) pingiet fuq qoxra ta' ktieb satiriku fl-1916 bl-isem ta' 'Our Hospital Anzac British Canadian (ABC).

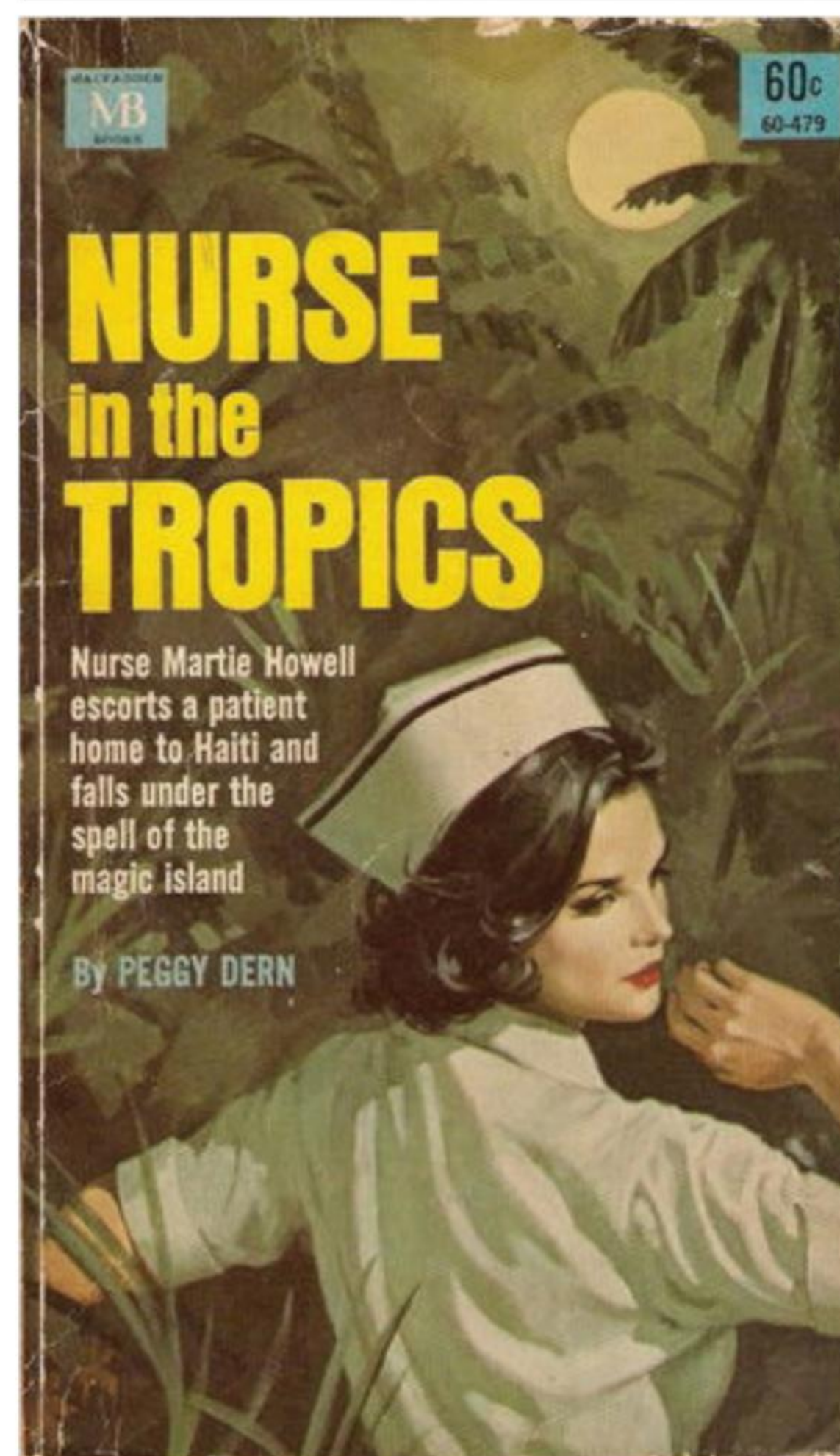
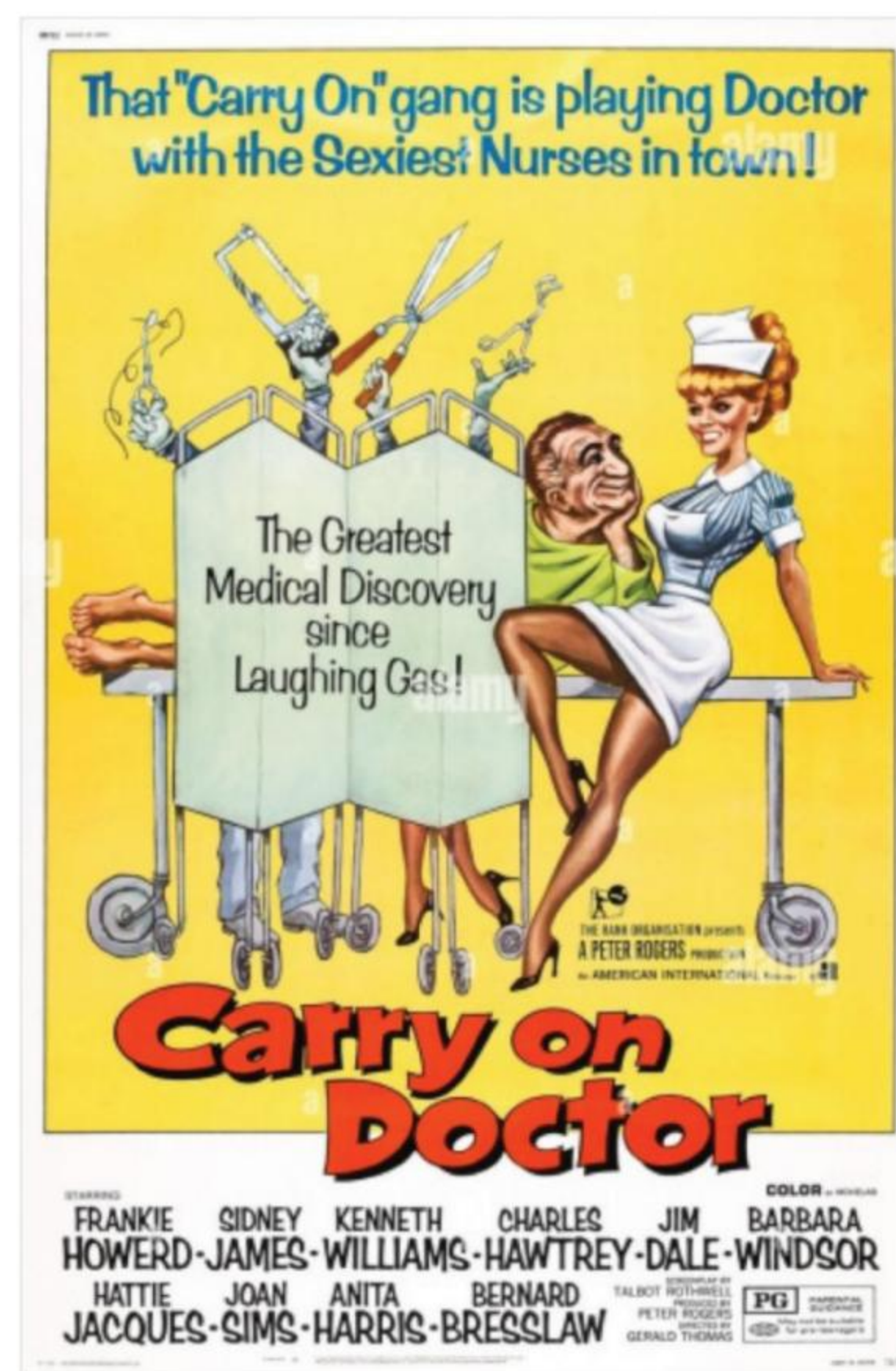


Sat-Tieni Gwerra Dinjija il-kunċett tan-Nursing kien għadu jappella għal dak li kien jissejjaħ 'ideali tas-sagrificċju' imma mas-seklu għoxrin dan beda jiċċaqilaq għall-kunċett ta' professjoni. Sa dak iż-żmien nurse mara ma setatx tiżżewweġ, imma dan beda jitbiddel fl-1944. Bdew ukoll jittieħdu miżuri biex jistabbilixxu standards nazzjonali permezz tan-Nurses Registration, u ġie stabbilit regjistru nazzjonali. Meta mbagħad ġie stabbilit l-NHS (fl-Ingilterra) fl-1948, ħafna metodi ġew standardizzati li anke affettwaw lil pajjiżna. Bdew id-district nurses li kienu jagħmlu l-in-home, imma madankollu l-immagħni ta' nursing eroiku ma sparixxiex għal kollox. In-nurses irġiel ingħataw permess jidhlu f'regjistru professjonali fl-1951, u mhux qabel.

Pittura taż-żejt fuq il-kanvas, għaliya impressjonanti, hija dik ta' Leo Serafimovich Kotlyarov tal-1956, imsejha 'Nurses. Rest after duty', illum tinsab f' The Institute of Russian Realist Art ġewwa Moska. Din turina, bi stil tal-impressjonizmu, nurses fuq in-naħa l-oħra tal-kontinent, mifluġin fuq bank, wara ġurnata xogħol, lesti biex imorru d-dar. In-nurse biż-żarbun aħmar u l-oħra bil-kalzetti strajpjati qed jilgħaqu x-xemx Russa jagħtu dehra ħelwa wisq.



F'illustrazzjonijiet oħra n-nurses ġew pjuttost impingija bħala oġġett sesswali jew provokattiv. Ġieli rajna nurses b'uniformi skullata, kważi tirrifletti l-promiskuwità fejn dawn deheru f'posters ta' soap operas tal-isptarijiet bħal dawk tal-'Carry on' fis-70s u l-80s. Deheru wkoll posters bin-nurse tirrifletti s-sbuħija, il-ġmiel. Minnu nnifsu din ma fiha xejn ħażin, imma l-intenzjoni setgħet kienet jew is-sesswalità jew il-femminilità. Eżempju ta' dan kien f'cover art ta' paperback bl-isem ta' 'Nurse in the Tropics' tal-1971 tal-MacFadden Books. Forsi b'ċajta wieħed isaqs: "X'iz-żikk qed tagħmel nurse f'nofs ġungla bil-lejl.



Bħall-professjoni nnifisha, l-immagħni moderna tan-nursing kompli jinbidel. Ħafna immigranti tas-seklu għoxrin li marru r-Renju Unit servew fi rwoli tan-nursing essenzjali minħabba bżonnijiet fil-kura tas-saħħa. Pattern li beda jseħħ ukoll f'pajjiżna madwar ħmistax-il sena ilu. L-arti issa azzardat tpingi l-immagħni tan-nurse b'kull kulur ta' karnaġġon tal-ġilda! Anya Grzesik turina dan permezz ta' 'Nurse's Station' fl-1998, pittura li tinsab fid-Dorset County Hospital. Hawn ukoll beda jitbiddel il-lingwaġġ tan-nursing speċjalment fejn jidhru il-ġeneru, għalhekk titli bħall-Ward Sister u Matron evolwew għal Charge Nurse.



Id-disgħnijiet issa bdew juruna stampa aktar kontemporanja, aktar teknoloġika, bħal dik li hażżet Virginia Powell f'xi l-1995 li tissejjaħ 'A Nurse Monitoring a Patient after an Operation and Taking Notes' li hija parti mill-Wellcome Collection. Xena li turi l-intensità u l-attwalità tal-isfidi tan-nursing. Turi wkoll in-nuqqas ta' romantiċiżmu kif wieħed ipitter nurse; m'hemmx frilli, matrons imponenti, badges u midalji, uniformijiet kważi militari, kapep u kappuni mgħoddija bil-lamtu.



Il-pandemija globali tal-Covid 19 biddlet, tista' tgħid, ix-xenarju tal-arti kompletament. Dan għaliex kien inħass il-bżonn li hafna artisti jibdwu ipingu dik li bdiet tissejjaħ immaġni ta' resiljenza li turi l-kuraġġ, id-domanda intensiva u l-istress tal-istess haddiema fil-kura tas-saħħa.

Il-mod kif ġie irrappreżentat in-Nurse fl-arti kien minnu nnifsu celebrazzjoni u turija ta' umanità fil-proviżjoni ta' kura waqt il-mard, gwerer u mwiet. Uriet ukoll il-burnout tan-nurses u l-eżawriment tagħhom, tfakkira li dawn huma umani, mhux anġli. 'Super Nurse!' hija eżempju ta' dan f'forma ta' mural jew graffiti fit-toroq. Dan huwa eżempju ta' ħajr għan-nurses kollha madwar id-dinja.



Jekk però qatt kienx hemm biċċa xogħol tal-arti, li barra li saret minn artist magħruf, kienet dik li ġiet tiswa l-aktar flus, hija dik il-monochrome ta' Banksy, ta' tifel qed jilgħab bil-pupi waqt Covid 19. Din tħalliet ġewwa s-Southampton General Hospital b'nota magħha li tgħid: 'Grazzi ta' kull ma qed tagħmlu. Nispera li din tferraħ ftit dal-post, anke jekk sewda u bajda.' Bl-isem ta' 'Game Changer' dil-biċċa arti ġabet rekord ta' £16.7m u dan meta, in-nurse fil-pittura hija sempliċement pupa-supereroj u mhux umana.



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ICN Statement of Solidarity with Nurses and Health Workers in the Middle East



ICN
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The global voice of nursing

Geneva, Switzerland, 5 March 2026 – The International Council of Nurses (ICN) expresses its deep solidarity with nurses and health care workers affected by the escalating violence across the Middle East and Gulf region.

ICN has been in contact with many of its National Nursing Associations across the region in recent days to offer support and hear directly from nurses about the challenges they are facing as the situation evolves. As part of its #NursesforPeace initiative, ICN is also launching a global photo action inviting nurses and nursing associations around the world to demonstrate their solidarity with colleagues affected by the crisis – details below.

Nurses are working in fear and uncertainty. They are caring for the injured, supporting families in distress and striving to keep essential services running. They are fulfilling their ethical duty to care, often at significant personal risk.

José Luis Cobos Serrano, President of the International Council of Nurses, said: "As nurses, our commitment is always to life, dignity and care. Today, nurses across the Middle East are working in extremely challenging and dangerous conditions, yet they continue to care for the injured, support families in distress and sustain essential health services. They are fulfilling their professional and ethical duty, often at great personal risk.

'International humanitarian law is clear. Health workers, patients and health facilities must be protected at all times. Medical neutrality is not optional. Attacks on health care are unlawful, indefensible and demand investigation and accountability.

'We stand in full solidarity with our nursing colleagues and with the civilians whose lives are being devastated. Nurses are not combatants. They are caregivers. They must be able to do their work safely and with dignity.'

Dr Myrna Abi Abdallah Doumit, ICN Board Member for the Eastern Mediterranean Region, said: Across the Eastern Mediterranean Region, nurses stand as pillars of humanity amid devastation and fear. They do not carry weapons—they carry hope. They heal the wounded, comfort the grieving, and hold together the fragile threads of life when everything else is breaking apart. Yet their courage should never be tested by war. No nurse should ever have to choose between saving lives and saving their own. Their safety, their dignity, and their mission to care must be protected at all costs. The nursing community of our region calls upon the world to uphold the sanctity of life, to stop the suffering, and to safeguard every health worker and every civilian caught in this storm. We, nurses of the Eastern Mediterranean Region, will not remain silent. We choose peace, we stand for humanity, and we demand the protection of those who protect life."

Conflict harms individuals, families and communities. It damages health systems and leaves lasting physical

and psychological scars. International humanitarian law is unequivocal. Hospitals, clinics and ambulances must never be targeted or obstructed. Patients must never be denied care. Schools and other civilian infrastructure are protected under international law and must not be attacked.

Too often, these legal protections are ignored. When health care is attacked, humanity itself is diminished. Trust is broken. Health systems are weakened. Recovery becomes harder. Through its Nurses for Peace campaign, ICN has consistently called for the protection of health workers and health services in every conflict.

ICN calls on all parties to comply fully with international humanitarian law, to protect health workers and facilities without exception, to safeguard civilians and to ensure safe and unimpeded humanitarian access. De-escalation and dialogue must be the priority.

ICN will continue to speak out clearly and firmly in defence of nurses, patients and the rule of international law.

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Hospital Chaplaincy Activities



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After almost twenty-one years working as a hospital chaplain in the Maltese hospitals as well as having healthy contacts with people who work in this important sector of any country I am coming to realize the importance of understanding and broadening the perspective of chaplaincy activities. Thanks to a recent online survey concerning the classification list of chaplaincy activities I am becoming more aware of how being a hospital chaplain is an art in progress.

First of all, a chaplain has to deal with patient-related tasks, such as that person's emotional world. As a chaplain did I discuss the patient's emotions, such frustrations, happiness, relief, anger and so forth? Did I encourage the person to engage in self-reflection? Had I helped him and her sharing his and her feelings about what he and she is going through? Did I assist the person in setting boundaries? In what way I helped the patient to reduce his feelings of loneliness? Have I been instrumental in the patient's effort to reduce his and her anxiety? How much and in what way did I comfort the patient? In our exchanges did I offer support that eventually helped the patient in detecting quality of life and/or joy in life? Did I make the patient feel accepted? In what way I offered other forms of support to the patient?

Furthermore, being a chaplain also means being focused on relationships. Since the pastoral encounter is itself a relationship it follows that relationship is essential in the way chaplaincy evolves. In my patient-related tasks it is important for me to assess myself on different vistas. Did I help the patient identify meaningful relationships in his

and her life? How supportive was I for those relationships? Was I there for him and her to identify the loss of meaning through relationships? And how did I facilitate the increasing of meaning through those revisited relationships? Was I helpful for the patient to strengthen his and her restored relationships? How, in our conversations, did I help the patient to reconnect with a meaningful relationship? Did I provide grief counselling? How did I support the patient in his and her loss and grief? Have I facilitated the grieving process? Was I catalyst in the patient's self-disclosure in helping him and her grow in gratefulness and forgiveness? Was I bridge in helping the patient engaging himself and herself with his and her community? How important I was in helping the patient be engaged in meaningful relationships? Did I reconnect the patient with the healthcare team? How much I facilitated for him and her to say their goodbye?

Core values and goal orientations in patient-related tasks are also important in the art of hospital chaplaincy. Did I help the patient explore his and her culture, religious and ethnic values? Did I give the person the chance to clarify these virtues? Have I created a moment where we had the opportunity to discuss concerns? How did I help the patient to clarify his and her values? How did I help the patient clarify his and her choices based on these values? How did I support the patient in advanced care planning? Did I discuss with him and her care options? Had I created a space for discernment? And did I create a space for making decisions? In our conversations did I help the patient to review his and her life? How much did I support the patient in making his and her end of life care choices? Was I there

for him to hear his and her conflicts of values? Did I explore with him and her ethical dilemmas? How was I supportive in helping him and her valuing his and her past achievements? Was I conducive in making the patient aware of his and her present achievements? In what way did I help the patient exploring his and her life goals? In our pastoral encounters did I encourage self-care to the patient? How much was I helpful in exploring identities and helping the patient in identifying resources? How much was I aware and helpful in understanding the limitations to goal orientations? Did I listen to existential guilt? How instrumental I was in helping the patient closing a phase of his and her life?

When it comes to beliefs, within the context of patient related tasks, I would love to ask myself some pertinent questions. Did I explore enough with the patient the search for meaning and purpose? Have I supported the patient's efforts at revisioning his and her life meaning? Have I discussed with the patient his and her beliefs, spirituality and religion? Have I provided spiritual and religious resources? Have I identified what is sacred to the patient? Did I identify the relation to the sacred? Did I identify supportive relationships in a patient's spirituality? Have I affirmed his and her faith? Have I assisted in spiritual or religious practices that are meaningful to the patient? Have I encouraged the patient to undergo a life review? Did I help people to attain a sense of (inner) peace? Did I identify, restore and reconfigure hope? How much did I invite the patient to reminisce? During my pastoral conversation did I invite the patient to imagine? Did I promote spiritual and religious practices? How

continued on page 35

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*Nielsen GB ScanTrack Total Coverage Value and Unit Retail Sales w/e 4 October 2025. To verify contact Vitabiotics Ltd, 1 Apsley Way, London, NW2 7HF. UK's No.1 pregnancy supplement brand. 1. *Journal of the American College of Nutrition*, Vol.18, No.5, 487-489 (1999). 2. For more information on this research, please visit www.pregnacare.com/mostrecommended. 3. Folic acid contributes to maternal tissue growth during pregnancy. Pregnacare® has always contained 400µg folic acid, the level recommended for all women from the start of trying to conceive until the 12th week of pregnancy. 4. Source: www.NHS.uk. 5. Agrawal, R. et al. Prospective randomised trial of multiple micronutrients in women undergoing ovulation induction, *Reproductive BioMedicine Online* December 2011. 6. L Brough et al. Effect of multiple-micronutrient supplementation on maternal nutrient status, infant birth weight and gestational age at birth in a low-income, multi-ethnic population. *British Journal of Nutrition* (2010), 104, 437-445.

Hospital Chaplaincy Activities

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did I observe the beliefs and values which are close to the patient's heart? Have I been of valuable help for the patient in his and her search for who God is for him and her? Did I explore the perception of the presence of God? Have I reconnected the patient with the Holy or the sacred?

About the issue of inner strength and resilience, did I encourage ownership in recovery or healing? Did I acknowledge the history of inner resolve? Did I identify meaning or the impact of life changes? Did I explore reactions to difficult situations? Did I discuss coping mechanisms with the patient? Did I provide a supportive presence? Have I engaged resources in well-being or healing? Did I explore motivation for inner resolve? How much have I contributed to the patient feeling empowered? Did I motivate the patient to tell his and her story? Did I encourage recognition and use of resources?

A penultimate aspect I would like to focus upon is that of crisis interventions. When the chaplain encounters patients our is encountering all sorts of circumstances, including those related to crisis not just of the person but also of his and her entourage. And since every crisis calls for a sort of intervention let me check where I am as a chaplain. Did I defuse emotionally charged situations? Was I present in situations involving sudden loss, imminent death, resuscitation and so forth? Did I give information? Did I act as a go between (family and staff)? Did I arrange practicalities? Have I offered rituals of sacraments? Did I offer space for preliminary grief work? Did I identify anticipatory grieving? Was I present with a dying patient?

The last feature I would like to visit is that associated with practices. Did I share a ritual such as lighting a candle, blessing and so forth? Did I share a religious ritual like prayer, blessing etc? Did I perform a sacrament? Have I provided spiritual literature? Did I provide spiritual or religious music? Did I put someone in touch with their faith representative or community?

How rich is this spiritual assessment concerning the activities a hospital chaplain is called to fulfill. Obviously it is impossible to fulfil them all at once. However, this great variety shows the beauty of hospital chaplaincy as well as that ongoing humble attitude which is to be the bread and butter of every chaplain to keep learning and assessing himself and herself individually and collectively in supervision. Let us keep praying to the Lord to keep sending us hospital chaplains who provide pastoral care, act as a go-between for patients and providers, advocate for the patient to medical staff, explain their hospital experience through sharing their toughest trials with others and keep offering an invaluable resource to hospital staff who are under a great deal of stress.

Fr Mario Attard OFM Cap



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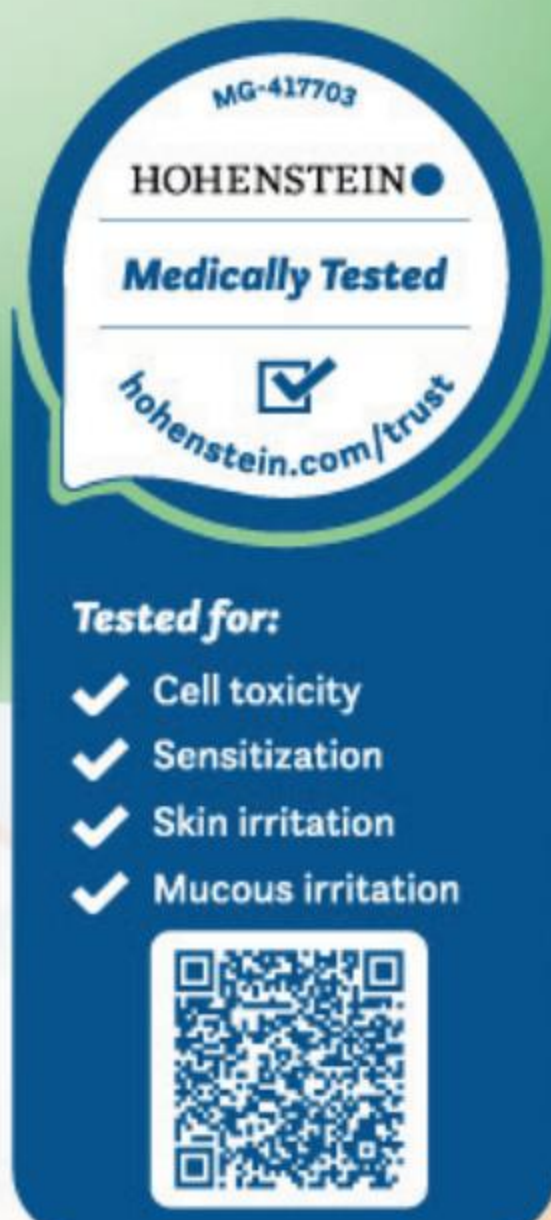


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“I’ve been given a second chance at nursing”

Hannah’s nursing career was cut short after she experienced a mental breakdown. She shares her encouraging story of hope and how she’s helping to break down the stigma of mental illness



I’d been a nurse for just under a year caring for people with HIV when I was sectioned under the Mental Health Act. My employer asked me to fill in a form for occupational health as part of a routine assessment which revealed I was depressed. I was referred to a psychologist where I eventually admitted my serious self-harm and suicidal thoughts – I was sectioned while sitting in a room in the emergency psychiatric department with my uniform in my bag for a shift.

No way back

For the next eight months I was in a mental health ward. I think my colleagues thought I had cancer as I’d shown no signs of how unwell I actually was and then suddenly, I wasn’t at work anymore. Nursing had been my dream and now it was being taken away from me.

Between 2007 and 2012 I spent around 75% of my time on acute mental health units. I have been sectioned over 10 times and been seriously ill in hospital on a ventilator after attempting to take my own life. I completely lost my mind and couldn’t see a way back. It was scary as a lot of the people I was on the ward with were people who bounced in and out of mental health wards for many years. I couldn’t see my life being anything other than what it was then.

If I’d recovered from cancer, I’d go back to nursing, so why can’t we say the same for mental illness?

Eventually, I was treated as an in-patient at a small therapeutic hospital, the Cassel Hospital in London, and I was able to access the psychodynamic therapy I needed and get to the root of why this happened.

I understand a lot more about myself, and have found ways of coping with overwhelming emotions, such as mindfulness. This can take many years and is hard. I’ve also had to learn to wait.

Before, if I was struggling, I’d want help instantly, but now I can manage those intense emotions for a few days. It’s OK to not feel OK sometimes. I can go for a walk, I can chat to my partner or a friend. You can’t stop emotions, but you can change how you deal with them. I often write down my emotions or how I’m feeling at the end of a shift as I find this helpful in not holding too much in.

New beginnings

I haven’t been an in-patient since 2014. I started volunteering with Fine Cell Work, who teach embroidery to prisoners, which I’d initially trained in and found therapeutic. It was difficult to explain what had happened to me. How do you explain your life outside of a mental health unit?

By this point I felt OK with never nursing again, but then other people said to me, why not try? If I’d had cancer and recovered, I would be able

to go back to nursing, so why can’t we say the same for mental illness? This is a disservice to the NHS and all the other people working in mental health services as to me it’s like saying the treatment doesn’t work, you cannot recover. But you can and I did.

We need to really think about how we listen to those we care for

I did my return to nursing course and began my first nursing role in 12 years in a hospice in March 2020 – right at the start of the pandemic. Starting my nursing career again in a pandemic was a struggle, but I couldn’t believe it had happened. I’d been given a second chance. I’m also a nurse lecturer at the University of Roehampton.

As a nurse I feel it’s important I listen to the lived experience of people and apply it to the way we provide and design services. There were many people who helped with my own recovery, but I found the support of people that were going through the same thing to be the most helpful. It’s also better to seek help than leave it like I did.

We need to really think about how we listen to those we care for, not just in mental health, but in other services too. We need to be able to facilitate their voices being heard as it is important in every element of nursing care.

“The price of unsafe staffing is too high”

Professor Jane Ball on the case for ratios

The director of the RCN Institute of Nursing Excellence sets out why mandated minimum nurse-to-patient ratios are essential

It's a false economy to think you're saving money by having fewer nursing staff. When we talk about recruiting more nurses, often we're met with resistance around costs. However, not investing is what is financially unsustainable.

There are costs associated with having someone readmitted because the care they've received initially wasn't up to standard due to lack of nursing staff, and with litigation when things have gone wrong because there aren't enough staff. Nursing is an asset, not a cost.

The price of unsafe staffing is too high. We need the right number of nursing staff, in the right places, with the right skills and experience, to keep patients safe.

Funding restrictions and NHS budget cuts that impact nurse staffing are having a devastating impact, resulting in many nurses caring for unsafe numbers of patients, in turn causing overwhelming pressure and burnout.

And time and again we have seen that patient care – and outcomes – are put at unacceptable risk when there are too few registered nurses to deliver nursing care safely.

However, to get staffing right there needs to be an increase to the baseline of registered nurses. Evidence-based tools are useful in helping to determine where staffing is needed based on patient need.

But it's important that such tools are used to calculate the additional staff needed, over and above mandated minimum nurse-to-patient ratios, to ensure unsafe levels are never breached.

The RCN Nursing Workforce Academy, part of the RCN Institute of Nursing Excellence, recently commissioned the internationally leading Health Workforce and Systems Research Group at the University of Southampton to conduct independent analysis of existing international research, on the impact of



mandatory minimum nurse-to-patient ratios and safe staffing legislation.

This evidence-based brief pulls together the conclusions from their findings. This evidence is another important step in reinforcing our call that acceptable levels of nurse staffing are always achieved, and in our campaign for enforceable nurse-to-patient ratios to protect patients and staff from harm. Read the evidence brief in full.

The question is not whether we can afford to invest in nursing – it's whether we can afford not to.

One of the most compelling pieces of evidence comes from a recent observational study involving more than 600,000 patient admissions across 185 wards in four NHS hospitals. The study found that relying on temporary staff – whether bank or agency workers – was less effective than employing permanent staff.

Specifically

- increasing permanent staff (to prevent low RN staffing) reduced the risk of death by 7.7%
- filling gaps with temporary staff reduced the risk by 4.1%.

This suggests that while temporary staff can help mitigate staffing shortages, permanent staff contribute significantly more to patient safety and outcomes.

Ensuring there are adequate levels of registered nurse staffing doesn't just improve patient safety, but there's evidence it's cost effective, too. The studies show the value of reduced hospital stays and readmissions exceeded the costs of additional staff, meaning there's a net cost saving.

The next generation of nurses need to learn from experienced mentors in the workforce, also.

However, this isn't just about numbers. The skill mix in nursing matters as much as overall staffing levels. Simply adding more staff is not enough if those staff are not registered nurses with the right education, skills and expertise. The roles of all members of the nursing and multidisciplinary team are important – but they are distinct and not interchangeable.

Diluting the registered nurse proportion in the workforce risks undermining patient safety, increasing costs, and worsening outcomes. Most studies in the review indicated that reduced skill mix led to worse outcomes at increased net cost.

The conclusion is inescapable: safe staffing saves lives, safeguards nurses, and strengthens health care systems in the UK. The question is not whether we can afford to invest in nursing – it's whether we can afford not to.

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