GOVERNMENT OF MALTA

Government response to the consultation on *The Social Regulatory Standards for Residential Services for Persons Living with Dementia*

21.07.2021

Ministry for Senior Citizens and Active Ageing
Zone 3
Central Business District
Triq in-Negozju
Birkirkara CBD 3010

Any enquiries regarding this publication should be sent at onlineconsultations@gov.mt.

Published by the Ministry for Senior Citizens and Active Ageing

Contents

CONTENTS

Executive Summary

Introduction and overview

1. A brief introduction about the subject:

   The Social Regulatory Standards for Residential Services for Persons Living with Dementia are aimed at defining the responsibilities of residential service providers towards residents living with dementia, and ensuring that these individuals receive the best possible care and the best possible outcomes. They will guide decision-making across a range of aspects of service provision, including residents' health and wellbeing, protection and safeguarding, the physical environment provided, the services provided, the management of the services and its workforce. These social regulatory standards are based on the below basic principles: dignity, person-centred care, privacy, physical and mental wellbeing, self-fulfillment, empowerment and equality.

2. The public consultation date:

   On the 7th May 2021, the Government launched this set of Social Regulatory Standards for Public Consultation. The purpose of this public consultation exercise was to receive feedback from the general public regarding the proposed standards and indicators regarding residential service provision for persons living with dementia. The Social Care Standards Authority aimed at having a comprehensive and extensive public consultation which reached different professionals and staff working in the area, as well as relatives of residents receiving such services and any other persons with an interest in the subject.

3. This consultation sought views on:

   This consultation sought views on the proposed Standards for Residential Services for Persons Living with Dementia. Seven standards, all with associated quality indicators, were presented for consultation, addressing: Residents' Rights, Personal Care Plan and Portfolio, Residents' Personal Health and Medical Care, Protection and Safeguarding, Physical Environment, Service Provision and Service Quality Management.

Responses to the consultation and process used to seek stakeholder views

This document is the Government Response to this consultation and sets out the Government's decisions on these matters.

4. The closing date of the public consultation. Which methods were used to receive the feedback. The total amount of responses. From whom you received the feedback.

This public consultation closed on the 18th June 2021. The consultation document was available online and responses were accepted by electronic mail or by post. There were 14 responses in total, with circa 241 comments on different aspects of the standards. Feedback was received from a number of individuals with an interest in this field, individuals and professionals working closely with persons living with dementia, as well as a number of entities with an associated interest.

5. Include (if any) meetings with stakeholders and list who the stakeholders were.

No meetings related to this set of Social Regulatory Standards were held.

Summary of responses and decisions

The following is a summary of the consultation responses received. We would like to thank all those who took the time to respond to the consultation and participate in stakeholder meetings around the consultation exercise.

6. Statistics.

- Total feedback received: 14
- Total feedback received from individuals: 9
- Total feedback received from organisations: 5
- Total feedback received through email: 14
- Total feedback received through online form: 0
- Total feedback received by post: 0

7. Summary of feedback received.

14% of all the comments received related to the standards in general, including comments relating to their introduction. The need for these standards as a key tool to protect persons living with dementia was repeated, with other general comments including:

- Accompaniment to hospital by staff and/or relatives, with hospital staff given all relevant information about the patient
- A lack of reference to whether residential wards for persons living with dementia should be "closed" wards, particularly for residents at risk of hurting themselves or others
- A lack of reference to advance directives
- The need for these guidelines to link to and go over and above other guidelines for residential services for older persons
- The need for these guidelines to specify staffing levels for residents living with dementia
- The need to include cognitive assessments within these guidelines
- The need to make reference to different types of dementia, and to define dementia as opposed to delirium
- The need to consider what happens to residents who have no relatives and no legally appointed representative
- The need for residents diagnosed with dementia who have good judgement should be

autonomous and allowed/assisted to make decisions, rather than decisions being taken solely by their legally appointed representative

- The need to make reference to the Maltese National Dementia Strategy 2015-2023
- The need for a protocol for the use of medication to manage challenging behaviour to be drawn up by a specialist medical professional trained in geriatric/dementia management and care. Professional staff within the residential care home should be aware of the protocol and follow it, with the protocol reviewed on an annual basis. The resident, relatives and legally appointed representative should be informed of the medication which is being administered to the resident and of any changes in medication
- With dementia currently classified as a mental health disorder, it falls under the Mental Health Act and thus the whole Act applies to persons living with dementia. This also raises the question, should such residential care homes be licenced as Mental Health Facilities, and should they have a Clinical (Psychiatric) Director to be responsible for clinical care? Furthermore, this response raised the possibility of involuntary admission, which might thus need to be in accordance with the requirements of the Mental Health Act
- Whether such residential care homes should also have a multi-sensory room
- A timeframe for the implementation of these Standards, and any resulting costs incurred by service providers, particularly with regard to training costs and opportunity costs (e.g. reduction in productivity, disrupted planning), were queried
- The need to consider migrants with dementia, which is a minority group likely to experience a double barrier

While possibly beyond the remit of these Standards, one respondent raised their concern that *when the capacity of exercising the right to autonomous decision making fails, the systems must be in place to determine loss of capacity and appoint a suitable substitute decision maker to safeguard the individual from abuse and neglect and to ensure that the individual continues to be treated with dignity. However, in end stage dementia (ESD), the loss of ability to make meaningful decisions about their current and future care, seriously hinders their autonomy.*
In ESD, the transfer of decisional responsibility to relatives and clinicians may not always reflect the wishes, interests, feelings, values and beliefs of the person in their care and this situation renders patients in end stage dementia vulnerable to the interests of others and also with threats to their dignity.
This is especially evident when the patient suffers from life threatening swallowing difficulties, where decisions for, or against tube feeding have to be taken, but even though swallowing problems are common in end stage dementia and they represent a serious health issue, this decision making is scarcely discussed. The situation is made more complex because in Malta practice in end of life care is not guided by a national policy and there is no legal framework to regulate advanced directives rendering decision making more difficult and complicated.

Consequently, they recommended the need for training regarding palliative care, end stage dementia and end of life care, the need to introduce advanced directives in healthcare (not only applicable to persons living with dementia), and the need for the development and implementation of policies and procedures around end of life issues (including, but not limited to, artificial feeding and resuscitation on admission to as residential care facility).

Glossary

8% of comments made (20 comments) made reference to the glossary, including both comments regarding the definitions provided and suggestions for additional terminology which could be defined.

A number of terms were thought to need re-wording in order to improve clarity, as follows:

- Palliative care: to indicate whether there is a difference between palliative care for residents living with dementia and residents without dementia
- Individualised portfolio: to use the word "residents" rather than "his"
- Legally appointed representative: to clarify that the person nominated should have power of attorney or guardianship. It was also suggested that the Standards should specify how the legally responsible person is to be appointed where the patient lacks mental capacity or fails to appoint a responsible person, particularly given that:
    - the Standards currently indicate that the management of the residential care home should ensure that residents have a legally appointed representative prior to their transition to the residential care home;
    - the Courts may also appoint a Curator to act as an individual's legally appointed representative.
- Performance indicator: to clarify definition
- Persons living with dementia: to include that the person has a diagnosis of dementia. It was also pointed out that the definition of "person living with dementia" provided under these Standards refers to "a person struggling to preserve a sense of self, to retain, and re-evaluate one's values in new circumstances." The respondent queried whether these Standards would apply in situations where an individual has clinically progressed beyond this definition.
- Person-centred dementia care: to also include personality as one of the factors considered when providing care
- Resident: to consider that a legally-appointed representative may not be available or not necessary; definition not to include whether or not a resident has dementia. Furthermore, in cases where the individual's dementia is so advanced that they are unable to enter into the agreement, could the agreement only be entered into with a legally appointed representative?
- Residential care home: to include that the facility provides support services to a group of persons
- Restrictive care: to specify the local legislation being referred to and to clarify whether this also includes seclusion. It was also suggested that this definition make reference to any other requirements listed under Article 34 of the Mental Health Act
- Staff: to clarify whether this refers only to caring staff, or to clarify whether it also extends to non-caring staff (e.g. security)

Suggestions were also made regarding terms which should also be defined in the glossary, provided below:

- Palliative care
- Dementia-friendly
- Dementia-friendly environment

Furthermore, general comments about the glossary included:

- The need to make a distinction between mental competence and mental capability
- The need to refer to the different levels of dementia (e.g. regarding ability to make certain decision, whether the individual has a legally appointed representative, their cognitive scores and assessments on admission)

Standard 1: Residents' Rights

This standard received the most feedback out of the whole document, receiving 52 comments in total (22% of all comments received).

Given the high number of comments received for this standard, comments are being presented separately for each quality indicator. There were also a number of comments about the standard in general, indicated below:

- Rights for residents living with dementia should be the same as rights for residents who do not have dementia
- The need to consider advance care planning (planning for a time when one is alive but may no longer have the capacity to make decisions), and advance decisions to refuse treatment
- Referencing Article 3 of the Mental Health Act

Quality Indicator 1

- To consider including residents' autonomy
- To indicate that prospective residents being considered for admission to such residential services should have a robust diagnosis of dementia made by an appropriate specialist (i.e. geriatrician, psychiatrist or neurologist)
- To consider also residents' transition from a general ward to a dementia-specific ward, or relocation from the residential care home to a specialised dementia ward in another facility
- To indicate that information about the residential care home should be made available to prospective residents in a manner/format that can be easily accessed and understood by a person living with dementia
- To consider the needs of migrants living with dementia

Quality Indicator 2

- To include a geriatrician and general practitioner/specialist in family medicine as part of the inter-disciplinary team
- To reword Performance Indicator 2 as follows, "The management and the staff shall consult with professionals listed in Annex VIII (p. 53), who shall establish the resident's holistic needs."
- To reword Performance Indicator 10 to indicate that residents should not be excluded from any activities in which they wish to participate
- To reword Performance Indicator 12 as follows, "The management and the staff shall ensure that the residents, their relatives and their legally appointed individuals can speak with the staff in a private and confidential manner, if required."

Quality Indicator 3

- To consider shifting Performance Indicator 1 to Quality Indicator 4 of the same Standard
- To clarify content of the psycho-educational programme referred to in Performance Indicator 3 and specify whether this should be offered to all residents living with dementia. Furthermore, other professionals (e.g. psychologist, counsellor, educator) could also be involved in discussing this programme.
- One respondent indicated that where visits, as per Performance Indicator 5, are not possible face-to-face, the use of electronic communication technology should be encouraged. A different respondent however suggested that this Performance Indicator might need to be

removed as the resident may not be able to take such decisions
- One response suggested that it may not be feasible for residents living with dementia to develop new relationships

Quality Indicator 4

- To consider that management should be responsible for ensuring that staff have a basic command of English and Maltese and well-versed in local culture. Where residents are conversant in neither Maltese nor English, when necessary, services of a professional interpreter should be employed.
- Regarding communication, it was suggested that the service provider should employ appropriate measures to overcome sensory impairments (e.g. through use of appropriate devices)
- To reword Performance Indicator 4 to indicate that staff shall prompt residents to identify and celebrate special events or occasions if they wish to
- To consider whether deciding on their own appearance is feasible for residents living with dementia. It was suggested that this Performance Indicator could be reworded as follows, "The residents shall decide on their appearance. When required, the staff shall ensure that residents are wearing the most appropriate clothing."
- It was also suggested that the individual's spiritual needs should be considered and respected

Quality Indicator 5

It was suggested that Quality Indicator 5 itself be extended, to include "and any other intervention including non-pharmacological therapies that benefit the person living with dementia." It was also queried whether the events co-ordinator referred to in the Quality Indicator should be the same person for the whole of a residential care home, or whether one should be appointed specifically to cater for the needs of residents living with dementia or for a dementia-specific unit

Suggestions regarding activities, as referred to in Quality Indicator 5, were as follows:

- The need to indicate the training/qualifications required for the Events Coordinator
- Relatives should also be involved with activities in the residential care home, especially for group activities
- Consideration should also be given to risk factor when involving residents in planning activities within the residential care home (Performance Indicator 5.1.2)
- Activity programmes, as indicated in Performance Indicator 5, should not be limited to social and leisure activities, but should include psychosocial non-pharmacological individual or group activities supported by healthcare professionals
- To consider revising Performance Indicator 8 as follows, "The management and the staff shall review activities and programmes on a quarterly basis and adapt them as necessary to ensure that these meet the residents' changing cognitive and physical needs. Such changes should be regularly assessed with the use of a number of instruments such as the MMSE, MoCA, RUDAS and Barthel, conducted by trained professionals."
- To specify that activities should also be organised for individuals with advanced dementia
- To consider including non-pharmacological interventions, which should be planned, organised and delivered by trained individuals

One response observed that care standards for persons living with dementia should enable learning rather than focusing on containment, in light of research that shows that persons living with

dementia are able to relearn and regain abilities.

Quality Indicator 6

- Performance Indicator 1, which indicates that residents shall be able to address financial, legal and personal needs when it is convenient for them, was queried, with suggestions that this be reworded to indicate that residents will be able to address such needs if they are competent to do so
- Performance Indicator 7, which prohibits management and staff from taking any advantage from the residents' wills and possessions, was suggested to need slight rewording
- It was suggested that with regard to residents' right to vote (Performance Indicator 8), management should ensure that coercion to participate in the voting process by any relatives or third parties is not allowed
- It was also suggested that all residents being admitted to residential environments for persons living with dementia should have or be able to demonstrate that they are in the process of having either a guardian or legal curator appointed, as per Article 1864A of the Civil Code), and that values and preferences for future care are documented on entry to the residential care home

Quality Indicator 7

- It was suggested to reword Performance Indicator 1 to indicate that at the end of life, residents shall be treated in accordance with the preferences expressed by the resident and/or legally appointed representative
- Regarding pain relief (Performance Indicator 3), it was suggested that alternative therapies (e.g. music), with the involvement of the interdisciplinary care team, could also be used to relieve pain. It was also suggested that rather than pain relief, this performance indicator be reworded to make reference to symptom control/relief, since pain is often not the only symptom in terminal dementia
- It was suggested that Performance Indicator 5 be reworded as follows, "The service provider shall ensure that residents, their family and significant others are provided with optimal palliative care, practical assistance, advice and bereavement counselling provided by trained professionals/specialist agencies."

Standard 2: Personal Care Plan and Portfolio

This standard, which received 14 comments (6% of total comments) covers the individual's personal care plan and portfolio, with respondent comments summarised as follows:

- A query regarding who should carry out a resident's initial assessment and draw up the portfolio
- Suggested rewording of the term "medical professionals" to include allied health professionals and use the term "health care" rather than "medical care"
- The need to also involve the resident's relatives and legally appointed representatives as part of the holistic needs assessment process and as part of any decision-making processes
- Specification that a geriatric assessment should only be done "where relevant", given that younger individuals may also develop dementia and these will require other expertise
- A need to specify the assessment guides/indexes to be used, possibly also including an ABC chart (antecedents, behaviour, consequences)
- Suggestion that care home nurses may be able to carry out pressure sore assessments and make some other decisions themselves rather than requiring a doctor

- The need for regular meeting between the legally appointed representative, the professional in charge of the resident's care, and the residential care home's senior nursing professional
- A plan for DNAR decisions, escalations in medical management decisions and end of life care should be put in place upon admission and reviewed at least every six months
- Performance Indicators 4 to 7 of Quality Indicator 2 may be unnecessary given that the process regarding changes in a resident's needs are also laid out in an Annex. During this process, some needs observed may not be medical, so a decision needs to be made by the interdisciplinary care team regarding who to involve
- Rather than reviewing care plans more frequently than every six months (Performance Indicator 5 of Quality Indicator 1) "in case of an acute phase," this should be done "if required"
- Quality Indicator 2: The use of the term "stakeholders" may be replaced by "all parties involved in the care process"

Standard 3: Residents' Personal Health and Medical Care

10% (25 comments) of total comments were received regarding this standard.

A number of comments were received regarding the provision of food and drink, namely:

- Residents should be assisted to make their own personal food choices
- Menus should include culturally-appropriate foods, i.e. which residents are likely to be familiar with as part of a typical local diet
- Menus should be made available to relatives and legally appointed representatives, as well as residents
- Staff to be aware of the possibility of dehydration and prompt the individual to drink when necessary
- Care workers to have enough time to feed residents, particularly those with severe dementia
- Residents not to be left alone while eating

The Quality Indicator referring to medical care was also commented upon. While one respondent commented favourably on the inclusion of an assigned psychiatrist for each resident as well as a primary care physician and/or geriatrician, another commented that the two posts (primary care physician and geriatrician) should not be considered interchangeable and that both are required. It was also pointed out that not all persons living with dementia require a psychiatrist, but all who do must have access to one.

Other comments included:

- Any aids used by residents (hearing, visual, or dentures) should be regularly checked and cleaned if necessary
- The issue of pain: one respondent indicated the need to be vigilant for signs of pain and assessment/treatment provided, while another suggested that pain relief be given when treating any wounds
- The need for staff to ensure residents are provided with proper footwear
- Regular health checks should be available, within the home or an interdisciplinary clinic
- The need for residents to be able to access care from a doctor of their choice, as well as the one appointed by the residential care home

Performance Indicators 1,9 and 11 of this Quality Indicator (Quality Indicator 2) were also commented upon as requiring some rewording.

Regarding Quality Indicator 3, Performance Indicators 5 and 7 received some suggestions for rewording, while it was suggested that a performance indicator be included which specifies that all medicines and cleaning materials should be kept under lock and key, and all medication stored and administered by competent staff.

Standard 4: Protection and Safeguarding

7% (18 comments) of all comments made reference to this standard.

Four of the comments received for this standard related to the use of restrictive care, with respondents highlighting the need for restrictive care to be used only as a last resort (i.e. when other interventions: non-pharmacological, psychosocial and person-centred communication) have been tried and proven ineffective. Furthermore, it was suggested that management should ensure that nurses/carers receive education and training to ensure that their use of restrictive care is minimised.

Other areas regarding which feedback was received were:

- Risk assessments, with a query regarding what areas the risk assessment should cover, and a suggestion that individualised risk assessments should also be carried whenever a resident's condition significantly changes his individual risk.
- Reporting, with a suggestion that accidents/injuries/illness should be reported to any relevant authorities, as well as investigated by the management of the residential care home. In the case of communicable illness, it was suggested that such cases ought to be reported first to the Superintendent of Public Health, then to the Authority.
- Complaints, including both the need for the person making a complaint to be informed about the outcome in a timely manner, as well as a suggestion that complaints should first be dealt with in-house using the residential care home's own quality assurance procedures, and referred to the Authority if the issue cannot be resolved satisfactorily. Complaints, including outcomes, should also be made accessible to the public
- Abuse, inclusion of verbal abuse as one of the types of abuse against which residents are to be safeguarded. It was further suggested that any type of abuse should be reported to the Authority and to any other competent authority
- Safeguarding of staff to also include consultation of the sex offenders' register when recruiting new staff
- The need for laundry sorting by staff to ensure belongings are returned to the rightful owner
- The need for a performance indicator which covers emergency situations regarding restrictive care, with reference to Article 34 of the Mental Health Act
- The need for a performance indicator stating that the residential care home shall have all necessary safety features
- The need for regular assessment by the Department of Health

Standard 5: Physical Environment

8% of all comments received (19 comments) made reference to aspects of the physical environment of the residential care home.

Comments received regarding this standard referred mainly to additional items which should be considered regarding accessibility and safety aids throughout the residential care home (e.g. the type of grab rails, height and features of any chairs, lighting, type of signage). While this standard indicates the need for dementia-friendly design, one respondent further suggested that trained professionals be consulted to ensure that the residential care home's design is truly dementia-

friendly.

The need for outdoor space was raised by a number of respondents, who identified features which should be present and highlighted the importance of an outdoor area for the wellbeing of persons living with dementia.

Other feedback included:

- The need for informed consent prior to the use of any assistive technology
- The need for staff to be careful about minimising damage to and loss of any assistive aids, indicating that relatives may remove or not replacing aids due to repeated loss of devices)
- The need for a distinction between a dementia-friendly environment and a specialised dementia unit
- The need to consider safety in particularly high-risk areas (e.g. kitchens) and ensure these are secure due to residents with a tendency to walk with purpose
- The need to consider resident behaviour when planning the use of space within the residential care home

Standard 6: Service Provision

Only two respondents addressed Standard 6 as part of their comments, making 9 comments in all (4% of comments). The feedback given related to:

- The need for information to be provided to relatives and legally appointed representatives, as well as the residents themselves
- A suggestion for the inspections by and contact details for the Authority in Quality Indicator 1 also be extended to cover any other competent authorities
- A suggestion for management to undertake regular reviews to ascertain whether the residential care home is meeting residents' needs, and that the SCSA undertakes regular inspections
- A comment that the specified admission process may not be feasible under present circumstances
- A suggestion that some Performance Indicators do not tally with the Quality Indicator under which they are gathered

Standard 7: Service Quality Management

17 comments were made regarding this standard (7% of all comments). Comments here were split between responses related to the position of manager of the residential care home and responses relating to staff.

Management comments were as follows:

- Quality Indicator 1 may need to be reworded to remove use of "**his** responsibilities to the full"
- Suggestions for the accepted Masters area of studies to include dementia care/dementia studies, with one query that a degree in management may not be relevant
- A suggestion that it may not need to be the Manager who has regular contact with the residents, but may be a ward charge nurse if applicable
- With reference to Performance Indicator 1 of Quality Indicator 1, management should ensure that making surveys/audits available to any parties should be done in conformity with GDPR requirements
- Information about inspections and access to Assessors should cover both the SCSA and any

other relevant bodies

Comments relating to staff within the residential care home referred mainly to:

- The need for local language fluency to be considered as part of the skill mix when drawing up rosters
- Comments regarding the need for "adequate" staff numbers. While one response commented on the lack of detail regarding staffing levels, another indicated that staff ratios for persons living with dementia should not be less than 1:5, with 1:3 being ideal, especially in severe stages
- Performance Indicator 9 of Quality Indicator 2 may possibly fit better within Standard 6
- Reiteration of the need for staff to be adequately trained, evaluated and supervised
- Queries over the terminology around training ("basic" and "advanced") and whether this should be considered in terms of hours
- Release of staff to follow related training programmes which are not covered in-house
- Need for staff to have a vocation and to know not to retaliate

Annexes: 13% of all comments (32 comments) received related to annexes, with feedback given per annex presented below:

Annex I: the below additional items were suggested for inclusion as part of the Manual of Policies and Procedures:

- 3.0 Health and Safety: inclusion of a policy on accompanying residents to appointments and a policy when taking residents on outings

- 4.0 Emergency Procedures: inclusion of Mental Health First Aid in addition to First Aid, and the inclusion of psychiatric emergencies as part of medical emergencies

- 5.0 House Procedures: inclusion of a Smoking and Alcohol Policy

Annex II: it was suggested that the information in this Annex, relating to information for prospective residents on the physical environment and services offered by the residential care home, also be given to their relatives and legally appointed representatives. It was also suggested that this Annex include any costs in relation to the services offered (point 6), and that the inspections referred to in point 12 cover both those carried out by the Authority as well as those carried out by any other competent authorities.

It was also suggested that point 8, referring to "residents who require change" be re-worded for clarity.

Annex III: it was suggested that the information in this Annex, relating to residents' rights and responsibilities when making use of the service of the residential care home, also be given to their relatives and legally appointed representatives. One organisation indicated the possibility that the residential care home may need to close for valid reasons other than emergencies (e.g. refurbishment), and that in case of emergency, six months' notice may not be given (as per points 2 and 3). It was also highlighted that pets (point 11) should be encouraged (while respecting the resident's individual choices) since these are therapeutic to persons living with dementia.

Annex V: it was suggested that the information in this Annex, relating to the financial costs of using the services of the residential care home, also be made available to prospective residents' relatives

and legally appointed representatives.

Annex VI: this Annex details the record of the personal care plan and individualised portfolio. Suggestions for potential additions to this record were made, namely:

- A brief personal history (hobbies, food preferences, enjoyable memories, etc.) of the individual living with dementia
- Information regarding the resident's personal, social, medical and drug history, including any allergies or specific dietary requirements

It was also suggested that the list of items included in this Annex be re-prioritised in order to keep the focus on the resident.

Annex VII: it was suggested that the list of indicative health and safety measures provided in this Annex also include regular maintenance of the outdoor environment/garden to ensure that safety is maintained

Annex VIII: suggestions were made for amendments to the composition of the interdisciplinary care team as follows:

- Chaplain: to include other faith leader where applicable
- Chiropractor: difficult to have on the team due to there being very few qualified chiropractors in Malta

To include:

- Cultural Mediator (where relevant)
- Nurse/Dementia Nurse
- General practitioner/Family doctor

Annex IX: While one respondent indicated that the list is very comprehensive, and made suggestions for additional topics which could be included (frailty; end of life care; the migrant with dementia), another respondent indicated that the topics included in the list are not all essential for dementia and thus could be included within the general guidelines.

More general comments indicated that ensuring all topics indicated in Annex IX are covered might create a burden for the service provider, both in terms of costs and in lost productivity. Furthermore, changes in behaviour and attitudes (awareness of equality and diversity, changing stereotypes) may require interventions other than training courses and which may require a longer-term approach by the service provider, particularly if changes to the workplace culture are required.

Annex X: Additional training topics for persons working directly with individuals living with dementia were suggested, namely:

- Communicating with persons living with dementia
- Dementia-friendly design
- Dysphagia
- Distinguishing between major cognitive types
- Ethics in dementia
- Pain and its assessment and management
- Therapeutic interventions in dementia

From the existing items in Annex X, one respondent suggested that the terms "Law" (point 11) and "Leadership" (point 13) have their meaning amplified.

Annex XI: Additional activities for individuals living with dementia were suggested, including:

- Animal-assisted therapy
- Cognitive Stimulation Therapy
- Dancing Therapy

One of the responding organisations also suggested that the personal care plan should indicate which activities are appropriate for the resident to participate in, given that certain activities may be dangerous for some residents.

Annex XII: Respondents suggested the below additions to the individual portfolio:

- A cognitive (e.g. MMSE) and functional (Barthel) assessment
- Health problems
- Things that are good for my health
- Things that are not good for my health

Annex XIII: One response indicated that, should the Authority consider involving a Clinical (Psychiatric) Director, this individual would also need to be informed as part of the process of responding to a change in a resident's needs.

8. Your assessment and the Government's decision (list the Government's decisions).

The SCSA has taken note of all feedback and is currently evaluating comments. The general comments regarding these Standards may, if taken on board, require significant changes to the existing version of these Social Regulatory Standards and will require careful evaluation to ascertain what is simultaneously within the Authority's remit and what will be feasible for individual service providers to enact. While considering possible changes, the Authority will keep the needs of service users at the forefront of these Standards, aiming to create a final document which acknowledges and respects the views presented during public consultation while meeting the needs of all individuals living with dementia who are currently living in or who may in future require the services of a residential care home.

Implementation

9. When you intend to implement the decisions

In the coming weeks, all necessary amendments to the guidelines and legal notices will be made. The legal notices are expected to be approved by Cabinet and the SCSA will then launch the final draft.

Contact Details

If you have any questions regarding this response, please contact: regulations.scsa@gov.mt