Hertfordshire Dementia Care Standards for Residential and Nursing Care

Owner:

Commissioning for Older People Team, Adult Care Services Hertfordshire County Council

Objective:

- To ensure that all care providers in Hertfordshire provide a high standard of care for people living with dementia.
- To ensure all providers are clear on the expectations of Hertfordshire County Council.
- To ensure consistent standards are maintained across the county.
- For staff to be recognised and assisted to continually develop and train to provide the best dementia care.
- For carers to be recognised in their role and to be provided the opportunity to both engage and be supported.

Outcome:

For people living with dementia and their carers to be able to access care and support that provides a consistent, quality person centred service which enables people to live a satisfying and fulfilled life and enables the carer to be confident and reassured that this is the case.

Purpose

1. Assure Consistent Quality Across Providers
   Standards set clear expectations for all commissioned services, ensuring that people living with dementia receive safe, high-quality, and person centred care regardless of provider or setting. This consistency reduces variation and promotes equity in care delivery.
2. Provide a Framework for Commissioning and Monitoring
   They act as contractual benchmarks for commissioners to measure compliance and performance. This includes defining outcomes, indicators, and evidence requirements so providers can demonstrate adherence during audits or reviews.
3. Promote Person Centred and Rights-Based Care
   Standards embed principles of dignity, respect, and autonomy, aligning with legislation

such as the Care Act 2014 and Mental Capacity Act 2005. They ensure care planning reflects individual history, preferences, and life goals, while safeguarding rights under the Human Rights and Equality.

4. Drive Workforce Competence and Continuous Improvement
   They require providers to maintain skilled staffing, ongoing training, and leadership that fosters a well-led dementia culture. This supports safe practice, resilience, and adherence to evidence-based interventions.

5. Enable Accountability and Transparency
   By linking standards to contractual obligations, commissioners can hold providers accountable for delivering agreed outcomes, such as meaningful activities, nutrition, carer involvement, and safe medication practices.

6. Support Strategic Goals and Policy Compliance
   Standards reflect national frameworks (e.g., Skills for Care Dementia Core Skills) and local Dementia Care Strategy, ensuring alignment with statutory duties and quality improvement programmes.

Structure of standards

Summary Statement:

This is a concise overview that captures the essence of each standard. It describes the intended approach or philosophy of care, outlining what good practice should look like for that particular aspect of dementia care. The summary sets the tone and expectations for providers, focusing on person centred, dignified, and responsive care.

Indicators:

Indicators are specific criteria or benchmarks that providers must meet to demonstrate they are achieving the standard. They break down the summary statement into measurable actions or outcomes, detailing what should be in place for care to be considered good quality. Indicators guide providers on what to implement and help inspectors or commissioners assess compliance.

Standard 1- Person Centred Care

Summary Statement

Care plans are holistic and tailored to the individual's history, preferences, strengths, and abilities, ensuring dignity and meaningful engagement throughout the dementia journey.

Indicators

To meet this standard, providers must demonstrate that care plans:

1. Reflect the person's life history, interests, cultural background, and medical history.
2. Are anticipatory, addressing current and future care needs.
3. Include positive behaviour support strategies.
4. Are regularly reviewed and adapted in line with the progression of dementia to ensure they remain effective and appropriate.
5. Promote independence and incorporate activities of daily living.
6. Uphold the human value of individuals regardless of age or cognitive ability.
7. Include strategies for managing distressing symptoms and behaviours that express distress.
8. Refer to therapeutic interventions aimed at reducing distress.
9. Care plans identify clear, person centred goals and intended outcomes, and track and evaluate the impact of care interventions against these using robust record-keeping.
10. Communication plans reflect adjustments for sensory needs.

Standard 2 – Responsive Support for Changing Dependency

Summary Statement

Care is responsive to the evolving physical, cognitive, emotional and behavioural needs of people living with dementia. Support balances safety, enablement, dignity and quality of life through regular reassessment and personalised interventions.

Indicators

To meet this standard, providers must demonstrate that:

1. Dependency levels are assessed regularly using appropriate tools, professional judgement and knowledge of the individual, recognising changes in physical, cognitive, emotional and behavioural needs.
2. Support is adjusted promptly in response to changes in physical, cognitive, emotional and behavioural needs, including both gradual changes and day-to-day fluctuations.
3. Care promotes independence wherever possible, avoiding unnecessary dependency.
4. Staff are trained and supported to recognise, record and respond to fluctuations in physical, cognitive, emotional and behavioural presentation. Staff understand the importance of distinguishing between dementia progression, delirium, illness, pain, fatigue and other temporary changes.
5. Care plans reflect current dependency levels and are updated promptly.
6. Families and professionals are involved in reassessment and planning.
7. Risk-positive approaches are used to encourage safe autonomy.
8. Leadership role models balanced care that supports both safety and enablement.
9. Care plans identify the individual's strengths, personal goals and intended outcomes, with regular review of whether support is maintaining or improving their independence, wellbeing and quality of life.

Standard 3 - Carer and Family Involvement

Summary Statement

Carers, families, friends and other people important to the individual are recognised as potential partners in dementia care. Their involvement is supported, respected and tailored to the individual's wishes, rights, preferences, relationships and family dynamics throughout the dementia journey.

Indicators

To meet this standard, providers must demonstrate that:

1. Carers are identified at the earliest opportunity and their role is acknowledged and valued.
2. The rights of families are balanced with the individual's right to privacy and autonomy.
3. Family dynamics are understood and respected, with involvement tailored to how each person wishes to engage.
4. Carers are kept informed and involved in decision-making where appropriate.
5. Carers are assisted to access support services, education and guidance about dementia care.
6. Carers receive training to understand and respond to behaviours associated with dementia.
7. Communication with families is clear and consistent, including expectations across different stages of dementia.
8. Emotional support and interventions are available to address carer distress and promote self-esteem and self care.

Standard 4 - Respect and Dignity

Summary Statement

Care consistently upholds the respect and dignity of people living with dementia, recognising their autonomy, life history, and capacity, while ensuring comfort and emotional security throughout their journey.

Indicators

To meet this standard, providers must demonstrate that care:

1. Treats individuals with respect and dignity at all times.
2. Recognises and supports the autonomy of people living with dementia.
3. Assumes capacity unless proven otherwise, regardless of diagnosis.
4. Embeds a culture of presuming capacity across all staff and settings.
5. Considers the person's life history and personal values in care decisions.
6. Maintains emotional security and comfort, especially when verbal communication declines.

Standard 5 - Effective Communication

Summary Statement

Communication across the service is clear, compassionate, and inclusive, supporting meaningful interactions with individuals living with dementia, their families, professionals, and colleagues, while actively rejecting negative language and labelling.

Indicators

To meet this standard, providers must demonstrate that:

1. Language used across all interactions is respectful, clear, and compassionate.
2. There is zero tolerance for negative language, stereotypes, or labelling.
3. Communication methods are adapted to meet individual needs, including verbal, non-verbal, and alternative formats.
4. Technology is used appropriately to enhance communication with individuals, families, and professionals.
5. Staff are trained in dementia-sensitive communication and understand the impact of language on wellbeing and dignity.

Standard 6 - Skills and Competence

Summary Statement

Staff are equipped with evolving, dementia-specific knowledge and practical skills to deliver compassionate, person centred care, underpinned by reflective practice and leadership.

Indicators

To meet this standard, providers must demonstrate that:

1. All staff and leaders receive continuous dementia-specific training as per framework linked to these standards that is delivered at different stages for staff experience, only using e-learning as a blended tool to support training.
2. Staff are clear on the competent skills they require to deliver good dementia care and are supported to develop these through personal development plans.
3. There is a clear staffing structure based on the eight national role categories ensuring the service has a broad range of experience and development opportunities.
4. Training reflects the progressive nature of dementia and the need for evolving support and planning.
5. Staff are taught effective communication strategies and positive behaviour support.
6. Core training areas (e.g. medication, nutrition) are contextualised within dementia care, balancing enablement and compassion.
7. Training is regularly updated to reflect current best practice and research.
8. Management role models dementia leadership and demonstrates legal literacy in service delivery.
9. Staff are trained in multidisciplinary working, advance care planning, and engaging visiting professionals.
10. Life story work is embedded in training and practice.
11. Training includes practical approaches that encourage sharing of good practice and ideas.
12. A culture of reflective practice is actively promoted and supported.
13. Where rare forms and early onset of dementia are identified staff are provided with enhanced skills.

Standard 7 - Values and Behaviours

Summary Statement

Care is delivered by staff whose recruitment, development, and daily practice are rooted in values of empathy, compassion, and respect, with a clear understanding of the behaviours required to support people living with dementia.

Indicators

To meet this standard, providers must demonstrate that:

1. Recruitment and staff development prioritise values and behaviours aligned with high-quality dementia care.
2. A culture of empathy, patience, and understanding is actively fostered across the service.
3. Staff consistently demonstrate compassion and use appropriate, respectful language.
4. Staff understand the specific values required to support individuals living with dementia.
5. Staff understand unconscious bias and the impact that this could have on care planning and delivery.

Standard 8 - Comprehensive Healthcare

Summary Statement

Care is informed by current, holistic assessments that monitor dementia progression alongside other health conditions (such as a learning disability), ensuring timely interventions and preventing avoidable deterioration.

Indicators

To meet this standard, providers must demonstrate that:

1. Assessments are up-to-date and provide a comprehensive view of the individual's physical, emotional, and cognitive health.
2. Reviews actively avoid diagnostic overshadowing, recognising that changes may stem from conditions other than dementia.
3. Pain scales and other clinical tools are used effectively to assess wellbeing.
4. Systems are in place for early identification of deterioration, including timely reviews and access to specialist support.
5. Care planning incorporates strategies to prevent unnecessary hospital admissions.
6. Care homes work proactively with primary care, mental health, learning disability and other specialist services. Concerns and levels of urgency are communicated clearly, referrals are followed up and escalated where necessary, and interim actions are taken to manage risks and support the individual while specialist input is awaited.

Standard 9 - Supportive Environment

Summary Statement

Care is delivered in environments that are homely, risk-positive, and designed to reduce confusion and distress, while promoting emotional comfort, independence, and safety for people living with dementia.

Indicators

To meet this standard, providers must demonstrate that:

1. The environment is homely and risk-positive, promoting emotional comfort and security.
2. The social environment is used as a first-line intervention to reduce distress.
3. Familiar objects and layout are incorporated to minimise confusion.
4. Clear signage, appropriate lighting and flooring, are in place, with safe unrestricted movement, as appropriate.
5. Environmental design considers all senses, including sound and smell.
6. Individuals have access to outdoor spaces that are safe and therapeutic.
7. Evidence-based assistive technology is used to support independence and safety.
8. Contrasting colours are used to aid recognition and orientation.
9. Language, tone, and words used in care settings are appropriate and supportive.

Standard 10 - Meaningful Engagement, Activity and Occupation

Summary Statement

People living with dementia are supported throughout the day to experience meaningful engagement, activity and occupation that promote cognitive, physical, emotional, spiritual and social wellbeing. Opportunities are risk-positive and reflect the individual's interests, strengths, abilities, culture, relationships and life history.

Indicators

To meet this standard, providers must demonstrate that:

1. A range of one-to-one and group activities are offered, both indoors and outdoors, to support cognitive stimulation, physical health, and social interaction.
2. Activities are personalised, reflecting individual interests, abilities, culture, and life history.
3. Sensory engagement is embedded in activity planning to promote emotional connection and comfort.
4. Activities foster a sense of connection to the past and support being "in the moment".
5. Opportunities extend beyond immediate services, connecting individuals with wider community resources.
6. Activities are designed to support physical, emotional, and mental wellbeing, with the aim of reducing dementia risk factors and slowing progression.
7. Family and friend involvement is encouraged, including support for maintaining long-distance relationships.
8. Activities are adapted across all stages of dementia to promote connection and engagement, even where individuals may be withdrawn or disengaged.
9. Creative therapy approaches are used to enhance person-centred care and individual wellbeing, including the use of music therapy techniques.
10. All staff recognise and contribute to meaningful engagement and occupation as part of their role. Engagement is not solely the responsibility of designated activity or wellbeing staff.
11. Meaningful engagement is available throughout the day and is not dependent on the presence of an activity co-ordinator or a scheduled programme.

Standard 11 - Medication

Summary Statement

Care recognises the impact of dementia on medication management, ensuring that support is safe, effective, and responsive to the individual's changing needs. Care is delivered in a way that respects diversity, promotes equality, and is inclusive of all individuals, while preventing avoidable complications such as missed doses, medication errors, or adverse reactions. Non-pharmacological approaches are considered and prioritised wherever appropriate.

Indicators

To meet this standard, providers must demonstrate that:

1. Medication needs are assessed, reviewed, and monitored regularly, with care tailored to the individual's preferences, abilities, cultural background, and beliefs.
2. Care plans triangulate decisions, ensuring that non-pharmacological interventions are considered and applied before pharmacological solutions wherever appropriate.
3. Staff understand how dementia can affect medication adherence and response, and adapt support in a person centred, culturally sensitive, and inclusive manner.
4. Medicines are administered safely, in line with legal and clinical requirements, and in ways that respect the individual's dignity, identity, and choices.
5. Care is responsive to changes in the person's condition, including adjustments to timing, formulation, or route of administration, taking into account accessibility and individual needs.
6. The risks and consequences of missed doses, errors, or adverse reactions are recognised and actively addressed.
7. Support promotes dignity, independence, engagement in medication management, and equitable access to care for all individuals.

Standard 12 - Nutrition and Hydration

Summary Statement

Care recognises the impact of dementia on nutrition and hydration, ensuring that support is responsive, enabling, and adapted to the individual's changing needs, while preventing avoidable complications such as dehydration, delirium and malnutrition.

Indicators

To meet this standard, providers must demonstrate that:

1. Nutritional and hydration needs are screened for and monitored regularly, with care tailored to the individual's preferences, abilities and needs.
2. Staff understand how dementia affects appetite, eating, drinking, and swallowing, and adapt support accordingly including considering risk positive approaches.
3. Food (both meals and snacks) and drinks are presented in an appetising way to encourage intake, including for those who find it difficult to sit down to eat/who walk with purpose.
4. Care is intuitive and responsive to changes in the person's condition and preferences.
5. The risks and consequences of dehydration, including confusion, falls, UTIs, constipation, delirium are recognised and actively addressed.
6. The risks and consequences of malnutrition are recognised and actively managed as per the correct pathway.
7. Support is flexible and promotes dignity, independence, and enjoyment of food and drink.

Standard 13 - Advance Planning, including End of Life Care

Summary Statement

Care homes support individuals and their families to ensure that advance care planning is in place, regularly reviewed, and implemented in line with the progression of dementia, with a focus on comfort, advocacy, and quality of life.

Indicators

To meet this standard, providers must demonstrate that:

1. Advance care plans are developed collaboratively with individuals and their families.
2. Plans are reviewed regularly and updated to reflect changing needs and preferences.
3. Staff advocate on behalf of individuals when further support or intervention is required.
4. Families are signposted to appropriate advice and guidance in a timely manner.
5. Care prioritises comfort and quality of life throughout the dementia journey.

Standard 14 - Culture of Positive Behaviour Support

Summary Statement

Care uses Positive Behaviour Support principles and prioritises evidence-based, non-pharmacological approaches to understand, prevent and respond to behaviours that may communicate distress, discomfort, changes in wellbeing or unmet need. Support is person centred, strengths-based and informed by the individual's life history, communication and preferences. Medication is used only when necessary and remains under close review.

Robust, proportionate risk assessments and escalation plans are in place where behaviours may present a risk to the individual, other residents, staff or visitors. These plans include preventative approaches, early signs, known triggers, de-escalation strategies, actions to protect dignity and safety, and arrangements for seeking additional professional support. This includes situations involving aggression or sexual expressions that may present a risk.

Indicators

To meet this standard, providers must demonstrate that:

1. Evidence-based, non-pharmacological and person centred interventions are the first-line approach to preventing and responding to behaviours that communicate distress or unmet need.
2. Pharmacological interventions are considered only when clinically necessary and proportionate, after appropriate assessment and consideration of non-pharmacological approaches. Antipsychotic and psychotropic medicines are regularly reviewed, with a clear rationale, monitoring of effectiveness and side effects, and plans to reduce or discontinue them where appropriate.
3. Staff actively advocate for individuals to ensure non-pharmacological strategies are prioritised.
4. Medication is administered safely, with accurate dosage and monitoring for side effects.
5. Positive Behaviour Support is embedded in care planning, staff training, reflective practice, reviews and day-to-day care delivery. Staff understand that changes in behaviour may communicate distress, pain, illness, discomfort, environmental factors, emotional need or other changes in wellbeing.
6. Person centred Behaviour Support Plans and tools such as ABC charts are used where appropriate to understand the purpose or function of behaviour. They identify early

signs, potential triggers, unmet needs, preventative approaches, effective support strategies and the impact of interventions.

7. Staff record and review the period leading up to, during and following an expression of distress so that patterns, communication, triggers and effective approaches can be understood and incorporated into care planning.
8. The service can demonstrate that non-pharmacological approaches have been appropriately considered, tried, reviewed and evaluated before medication is requested or introduced, except where urgent clinical intervention is required.

Standard 15 - Collaborative Multidisciplinary Working

Summary Statement

Care is co-ordinated through timely engagement with the individual, people important to them and the right professionals. This ensures advocacy, effective communication, continuity and shared decision-making to deliver holistic, person centred dementia care.

Indicators

To meet this standard, providers must demonstrate that:

1. The service engages appropriate professionals at the right time to support the person living with dementia.
2. Staff advocate for individuals, supporting communication and challenging diagnostic overshadowing.
3. Multidisciplinary teams (MDTs) collaborate to develop and review personalised care strategies.
4. Medication is reviewed regularly by the MDT to ensure it remains necessary, effective, and appropriate.
5. Systems are in place to support effective data sharing among healthcare providers.
6. Care is co-ordinated across services and settings to ensure continuity and consistency.
7. Opportunities are provided for professionals to share knowledge, ideas, and best practice.
8. Referral information is clear, detailed, and supports appropriate placements and care planning.
9. The individual, their family, carers, advocates and other people important to them are recognised as contributors to multidisciplinary planning and shared decision-making, in accordance with the person's wishes, rights and capacity.

Standard 16 - Leadership for Dementia Excellence

Summary Statement

Strong leadership is essential to delivering high-quality dementia care. Leaders set the tone for a values-led culture, role model best practice, and ensure staff are supported, skilled, and aligned with the vision for person centred dementia care.

Indicators

To meet this standard, providers must demonstrate that:

1. Leaders have a clear understanding of dementia and its impact on individuals, families, and staff.
2. Leadership promotes a culture of dignity, empathy, and person centred care.
3. Managers are trained in dementia-specific leadership, including legal literacy and service governance.
4. Leaders actively role model good dementia care in their interactions, decision-making, and support for staff.
5. There is a clear vision for dementia care that aligns with national standards and local priorities.
6. Leadership ensures continuous improvement through supervision, feedback, and quality assurance.
7. Leaders facilitate access to training, resources, and multidisciplinary collaboration.
8. There is visible and proactive leadership to champion dementia care improvement present within the care setting.