Hertfordshire Dementia Care Standards for Residential and Nursing Care

Support Guidance: Skills and Knowledge of Staff

Purpose of this support guidance:

- To help commissioned residential and nursing services understand and apply Standards 2, 4, 5 and 14 in everyday practice.
- To translate the standards into practical, person-centred expectations for care delivery, workforce competence, partnership working and leadership.
- To support providers to use proportionate evidence from existing systems and demonstrate what changed for the person, rather than simply showing that a process, form or course was completed.
- To clarify the respective responsibilities of residential services, nursing services and wider health and social-care partners.
- To support reflection, assurance and continuous improvement without prescribing a particular system, template, course or local pathway.
- To provide, under each standard: a summary statement; measurable indicators; guidance for applying the standard in practice; mapped references, resources and learning; a role-based learning pathway; methods for assessing staff competence; balanced evidence examples; an evidence cycle and outcome tracker; leadership assurance questions; and a separate good-practice example for every indicator.

Intended outcome:

Providers can use this guidance to embed consistent, rights-based and person-centred dementia care, assess whether staff can apply learning in practice, identify improvement priorities and present balanced evidence of people's experiences and outcomes.

Purpose of the Standards

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 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.

Applying the Standard in Practice

Providers should show how information from assessments becomes timely, personalised action. A score or completed form is not enough: the evidence trail should connect the person's baseline, the change observed, action taken, involvement of others, the person's response and the next review.

Recognising fluctuations and meaningful change

- Record patterns across the day as well as longer-term change. A person may manage dressing with prompts in the morning but need more assistance when tired later.
- Distinguish usual fluctuation from deterioration by comparing observations across staff, shifts, family knowledge and assessment findings.
- Consider emotional and cognitive change alongside physical dependency. Changes in confidence, engagement, distress, sleep or behaviour may indicate changing need.
- Respond immediately when staff notice something is not right; do not wait for a scheduled monthly review.

Using tools proportionately

Depending on the person and service, evidence may include dependency assessments, mobility and moving-and-handling reviews, MUST and weight monitoring, skin-integrity assessment, pain tools, food and fluid records, dementia care mapping, incident trends and review of activities of daily living. Tools must be used by competent staff and interpreted alongside the person's usual presentation.

From assessment to action

Where a change is identified, records should show the immediate response: for example, adjusted prompting or assistance, an updated dietary or mobility plan, communication with catering or care teams, family involvement, equipment review, GP or therapy referral, and interim risk management while external input is awaited. Any local thresholds or named pathways require validation before publication.

What leaders should test

- Do staff know what the person can usually do and what varies?
- Can staff explain when to prompt, when to assist and when to escalate?
- Do electronic records and handovers join fragmented observations into a coherent picture?
- Are champions cascading learning, and is application checked through observation and supervision?
- Can the service demonstrate positive risk-taking and maintained quality of life, not only prevention of harm?

References

Reference	Relevant indicator(s)
Care Act 2014; Human Rights Act 1998; Equality Act 2010	1–9

Reference	Relevant indicator(s)
Mental Capacity Act 2005 and Code of Practice	3, 5–7 and 9
CQC Regulations 9, 11, 12, 17 and 18	1–9
NICE NG97 and QS184	1–9
Dementia Training Standards Framework (2026)	1–9
Local escalation and referral pathways	2, 4 and 6

Resources

Resources are organised against the nine current indicators. Some resources support more than one indicator; cross-references avoid unnecessary repetition.

HCPA: Dementia resources hub (topic resources and signposting)
click here

Indicator	Resources and practical tools
1. Regular assessment of dependency	CQC: Assessing needs click here SCIE: Fluctuating needs in assessment and eligibility click here Dementia UK: The care needs assessment and financial means test click here
2. Prompt adjustment to changing and fluctuating needs	Skills for Care: Spotting the signs when a person becomes unwell click here NHS England: PIER (prevention, identification, escalation, response) click here Dementia UK: Getting the best out of GP and other health appointments click here Use alongside the care-planning resources under indicator 5. Evidence should connect recognition of gradual or day-to-day change with prompt adjustment of support.

3. Independence and avoiding unnecessary dependency	NHS: Staying independent with dementia click here Alzheimer's Society: Keeping safe and independent at home click here In-document support: “Recognising fluctuations and meaningful change” and “What leaders should test”, including when to prompt and when to assist.
4. Staff recognition, recording and response to fluctuations	Alzheimer's Society: Stages of dementia and progression click here Dementia UK: Understanding dementia and pain click here Alzheimer’s Society: Help and support with dementia care click here NICE: Delirium quick guide for care homes click here RESTORE2 and RESTORE2 Mini tools for recognising deterioration and prompting reviews click here Use alongside “Suggested learning pathway” and competence assessment below. Include physical, cognitive, emotional and behavioural presentation, and distinguish progression from delirium, illness, pain, fatigue and other temporary changes.
5. Current and promptly updated care plans	CQC: Regulation 9 - person-centred care click here CQC: Good practice in caring for people with dementia (*updated 2026*) click here In-document support: “From assessment to action”. Show how the plan reflects current dependency and how changes are shared with staff.
6. Family and professional involvement in reassessment and planning	SCIE: Safeguarding and multi-agency working click here Research in Practice for Adults: Care co-ordination tool click here Memory Support Hertfordshire: Carer’s resources

	click here Alzheimer's Society: Care options - when is the right time to move someone into care? click here Alzheimer's Society: Improving access to a timely and accurate diagnosis of dementia in England, Wales and Northern Ireland click here NHS: Dementia, social services and the NHS click here The EMPOWER Dementia Network: Empowering a meaningful life for all click here
7. Risk-positive approaches and safe autonomy	SCIE: Freedom to choose and dignity in care click here Research in Practice for Adults: 10 questions to support positive risk assessments click here Use alongside the independence resources under indicator 3; connect risk decisions to the person's choices and intended outcomes.
8. Leadership modelling safety and enablement	Alzheimer's Society: Dementia experience toolkit click here Alzheimer's Society: The training gap: a hidden injustice in dementia care and how to fix it click here CQC: The state of health care and adult social care in England 2025/26 click here Skills for Care: GO online inspection toolkit click here In-document support: "What leaders should test". Use observation, supervision and reflection to test the balance between safety and enablement, not training attendance alone.

9. Strengths, personal goals, intended outcomes and review	CQC: Health and social care support for people with dementia click here Alzheimer's Society: Organising and reviewing care and support click here In-document support: "Suggested changing-dependency outcome tracker" and "Consolidated Evidence Framework". Department of Health and Social Care: Strengths-based social work: practice framework and handbook (2019) Open the official guidance and handbook
Cross-cutting: residential and nursing responsibilities	Skills for Care: Delegated healthcare activities click here NHS: Dementia and care homes click here Alzheimer's Society: Supporting a person with dementia in a care home click here
Relevant learning videos for Standard 2	Dementia UK: Videos about understanding changes in dementia watch here Dementia UK: Videos about maintaining health in dementia watch here PocketMedic: Dementia residential care training films (*informal guidance only*) watch here ReactTo Training Videos watch here

Learning and Development

Indicator	Learning and development
1	Knowing the person's baseline; regular dependency assessment using appropriate tools, professional judgement and knowledge of physical, cognitive, emotional and behavioural needs.

2	Recognising gradual change and day-to-day fluctuations; promptly adjusting prompting, assistance and other support; recording the action taken and the person's response.
3	Enablement in everyday care: allowing time, breaking tasks into steps, offering the least help needed and avoiding unnecessary dependency.
4	Recognising, recording and responding to fluctuations; distinguishing dementia progression from delirium, illness, pain, fatigue and other temporary changes; diagnostic overshadowing and escalation within role.
5	Keeping care plans aligned with current dependency; prompt updates following meaningful change; communicating revised support across shifts and reviewing its effect.
6	Involving the person, families and professionals in reassessment and planning; handover, MDT coordination, professional boundaries and residential/nursing responsibilities.
7	Positive risk-taking, safe autonomy, Mental Capacity Act principles and least-restrictive practice; documenting choices, benefits, risks and agreed support.
8	Leadership role modelling of safety and enablement; observation, coaching, supervision, reflective learning, audit and system escalation.
9	Strengths-based and outcome-focused care planning: identifying strengths, personal goals and intended outcomes; reviewing whether support maintains or improves independence, wellbeing and quality of life.

Suggested learning pathway

Staff group	Suggested pathway
All staff	Induction and dementia foundations: baseline, communication, dignity, recognition of fluctuations, escalation and supporting independence and personal choice.
Care staff and key workers	Extended practice learning in observation, recording, prompt adjustment of support, enablement, positive risk-taking, current care plans and the person's strengths, goals and outcomes.
Senior carers and nurses	Assessment, reversible causes, escalation, clinical monitoring within role, family and MDT coordination, prompt plan review and evaluation of independence, wellbeing and quality of life.
Dementia champions/practice leads	Coaching, observation, case reflection and audit; help staff translate strengths and goals into support and review whether intended outcomes are maintained or improved.

Staff group	Suggested pathway
Managers and clinical leaders	Governance, staffing capability and pathway escalation; model balanced safety and enablement and assure that reassessment, updated plans and outcome reviews change practice.

Evidence

Examples of evidence

Evidence domain	Possible evidence
Lived experience	The person's words, choices, mood and non-verbal response; family or advocate feedback.
Records	Baseline, assessments, care plans, daily notes, handovers, referral and review records.
Observation	Staff notice change, allow processing time, promote participation and use agreed support.
Professional input	GP, nurse, pharmacist, OT, physiotherapist, SALT, dietitian or mental-health advice, as relevant.
Workforce competence	Observation, supervision, scenarios, reflective accounts and improvement following feedback.
Governance and outcomes	Audits, incident themes, referral delays, maintained function, reduced distress, timely treatment or safer support.

Can the service show the full evidence cycle?

1. Understand	2. Plan	3. Deliver	4. Review	5. Improve
What is usual and what changed?	Agree outcome, risks and involvement.	Adjust support and escalate.	Identify what changed for the person.	Continue, change, stop or escalate.

Suggested changing-dependency outcome tracker

Desired outcome	Support/action	Measure	Review finding	Next action
Maintain safe walking and confidence	Prompting, pain check, equipment and referral	Comfort, participation and assistance required	Record improvement or deterioration	Continue, adjust, refer or review restrictions

Good Practice Examples

2.1 Regular assessment of dependency

Staff regularly review usual ability, preferred support and fluctuations across physical, cognitive, emotional and behavioural needs, using appropriate tools and professional judgement alongside assessment findings and knowledge of the person.

Possible evidence: Baseline profile; dependency assessment; person/family account; observation; reassessment record.

2.2 Prompt adjustment to changing and fluctuating needs

Staff adjust prompting or assistance when the person is tired later in the day, and respond to gradual change without waiting for the scheduled review. They record the response and check whether the adjustment helps.

Possible evidence: Daily notes; handover; adjusted support; action and response record; review.

2.3 Independence and avoiding unnecessary dependency

Staff break dressing into manageable steps, allow processing time and offer only the help needed, rather than taking over a task the person can still do.

Possible evidence: Observation; strengths-based care plan; level of prompting or assistance; evidence of maintained participation.

2.4 Staff recognition, recording and response to fluctuations

Staff compare a quieter or sleepier presentation with the person's baseline rather than assuming dementia progression. They record the change, consider pain, illness, delirium, fatigue and other temporary causes, and escalate within their role.

Possible evidence: Baseline comparison; daily notes; handover; assessment prompts; GP or nurse contact; action and outcome record; competency observation.

2.5 Current and promptly updated care plans

Following illness or a meaningful change in dependency, staff promptly update the care plan and risk assessment, identify the support now needed and share the revised guidance across shifts.

Possible evidence: Updated care plan and risk assessment; date of change; staff communication; review date; observation of revised support.

2.6 Family and professional involvement in reassessment and planning

The person, family and relevant professionals contribute observations to reassessment and agree support with staff, with actions communicated consistently across shifts.

Possible evidence: Review notes; person/family feedback; professional advice; agreed actions; handover; MDT record.

2.7 Risk-positive approaches and safe autonomy

The person is supported to continue a valued walking routine. Staff consider the benefits, preferences and risks, agree proportionate support and review whether restrictions remain necessary.

Possible evidence: Positive risk assessment; person's choices; agreed support; observation; review of autonomy, safety and restrictions.

2.8 Leadership modelling safety and enablement

Leaders model when to prompt and when to assist, coach staff to avoid unnecessary dependency and use observation and reflection to check that safety measures preserve autonomy and quality of life.

Possible evidence: Leadership observation; coaching and supervision; positive risk review; audit; action plan; re-observation.

2.9 Strengths, personal goals, intended outcomes and review

The care plan identifies what the person can still do and a personal goal, such as continuing to dress with prompts. Staff agree the intended outcome and support, then review participation, assistance required and the person's experience to establish whether independence, wellbeing and quality of life are maintained or improved.

Possible evidence: Strengths and baseline profile; recorded personal goal and intended outcome; care plan; person/family feedback; observation; outcome tracker; review finding and next action.

Standard 4 – Respect and Dignity

Summary Statement

Care consistently upholds each person's inherent worth, privacy, autonomy, identity and rights. Staff presume capacity, support decision-making, seek consent and maintain emotional security and comfort, including when communication or dependency changes.

Indicators

1. **Respectful everyday practice.** Staff protect privacy, modesty, confidentiality and personal space and use adult, compassionate, non-stigmatising language.
2. **Identity, culture and relationships.** Care reflects the person's history, strengths, faith, culture, sexuality, gender identity, relationships, routines and personal expression.
3. **Choice, autonomy and consent.** The person is offered genuine choices, given time and support to decide, and refusal or changed preference is respected and explored.
4. **Capacity and best interests.** Capacity is presumed and assessed only for the specific decision and time. Where capacity is lacking, decisions follow the Mental Capacity Act, include the person and relevant others, and use the least restrictive option.
5. **Independence and positive risk-taking.** Staff balance safety with the benefits of autonomy, participation, movement, intimacy, occupation and quality of life.
6. **Emotional security and comfort.** Staff recognise distress, avoid rushed or coercive care and use familiar, trauma-informed and personalised approaches.
7. **Advocacy and challenge.** Staff confidently challenge disrespectful language, discriminatory assumptions or practice by colleagues, visitors or professionals and escalate concerns appropriately.
8. **Leadership and assurance.** Leaders model dignity, observe practice, respond to feedback and ensure agency and new staff understand each person's preferences and rights.

Applying the Standard in Practice

Respect and dignity should be visible in small, repeated interactions and in how the service responds when routines, professional priorities or family expectations conflict with the person's wishes.

Everyday dignity and emotional security

- Personal care is not rushed. Staff explain each step, seek consent, respect refusal and preserve privacy and modesty.

- Care follows the person's preferred routines, clothing, appearance, washing arrangements, sleep habits, faith, relationships and cultural identity wherever possible.
- When the person is distressed, staff protect privacy from unnecessary observation and use a calm, familiar approach rather than treating distress as spectacle or misconduct.
- Life-history information is translated into practical action. For example, a repeated wish to walk at a familiar time may reflect a former routine and can be supported safely.

Capacity, consent and family involvement

Staff should presume capacity and support the person to decide using an appropriate time, environment and communication method. Capacity is assessed only where there is reason to doubt it and for the specific decision. Families provide valuable knowledge but do not automatically make decisions; records should show how disagreements were handled, what authority was checked, how the person was involved and why a best-interest decision was necessary.

Challenging practice respectfully

Care-home staff are expected to advocate for the person when visiting professionals, relatives or colleagues use undignified language, discuss sensitive matters publicly, interrupt important routines without justification or propose care that does not reflect the person's rights. Evidence may include a contemporaneous note, email, corrected document, MDT discussion, escalation or subsequent change in practice.

What leaders should test

- Do care-plan audits examine respectful language and person-led wording?
- Can new and agency staff quickly find the person's key preferences?
- Do staff know how to respond to refusal without pressure or coercion?
- Do induction, probation and targeted supervision address observed dignity gaps?
- Are walkarounds, feedback, complaints and compliments used to improve culture?

References

Reference	Relevant indicator(s)
Human Rights Act 1998; Equality Act 2010; Care Act 2014	1–8
Mental Capacity Act 2005 and Code of Practice	3–7
CQC Regulations 9, 10, 11, 13, 17 and 18	1–8

Reference	Relevant indicator(s)
NICE NG97	2–6
Skills for Care Dementia Training Standards Framework	1–8

Resources

The resources below are mapped to this standard's indicators and practical guidance. Select complementary resources for the person and the service; use existing records rather than creating duplicate paperwork. Resource types and relevant limitations are identified.
HCPA: Dementia resources hub (topic resources and signposting)
click here

Indicator	Resources and practical tools
1. Respectful everyday practice	Care Quality Commission: Regulation 10, dignity and respect click here Skills for Care: Kindness, compassion and dignity in residential and nursing homes click here Care Quality Commission: Fundamental standards of care click here KYN: Inclusive language guide "Talking about dementia" click here
2. Identity, culture and relationships	Royal College of Nursing: Older people in care homes, sex, sexuality and intimate relationships click here Skills for Care: Understanding spirituality in dementia care click here Alzheimer's Society: Cultural sensitivity and awareness click here Dementia UK: Dementia in the LGBT+ community click here
3. Choice, autonomy and consent	Forward with Dementia: Supporting everyday decisions click here Forward with Dementia: supporting people living with dementia to engage with care click here CQC: Regulation 11 - need for consent click here SCIE: Dignity: Information and good communication - practice guidance click here

Indicator	Resources and practical tools
	NHS: Mental Capacity Act click here Dementia UK: Mental capacity and decision-making for people with dementia click here
4. Capacity and best interests	GOV.UK: Mental capacity act code of practice click here Alzheimer's Society: Making decisions for a person with dementia who lacks mental capacity click here NICE: Decision-making and mental capacity click here SCIE: MCA and the best interests principle click here
5. Independence and positive risk-taking	Alzheimer's Society: Living with dementia click here My Home Life England: Thriving in residential care click here Dementia Carers Count: Supporting safer walking for people with dementia click here Alzheimer's Association: Driving and dementia (including videos) click here
6. Emotional security and comfort	GOV.UK: Working definition of trauma-informed practice click here Alzheimer's Society: The psychological and emotional impact of dementia click here Dementia Services Development Centre: Understand dementia - the power of validating emotion (*guidance only*) click here
7. Advocacy and challenge	HCC: Advocacy services - get your voice heard click here HILS: Advocacy service click here Rethink Advocacy: Older people and people with dementia click here
8. Leadership and assurance	Dignity in Care: Champion service click here Skills for Health: Dignity in care click here

Indicator	Resources and practical tools
	Alzheimer's Society: Dementia "We" statements click here
Relevant learning videos for standard 4	Dementia Carers Count: Create a comfort box watch here Dementia UK: How culture shapes dementia support - dementia care for Black, African and Caribbean communities watch here SCIE: Dignity in care - privacy watch here

Learning and Development

Indicator	Learning and development
1–2	Rights, dignity, equality, culture, identity, relationships, privacy and respectful language.
3–4	Consent, the five Mental Capacity Act principles, supported decision-making, best interests, advocacy and least restriction.
5–6	Positive risk-taking, personal care, emotional validation, trauma-informed approaches and responding to refusal or distress.
7–8	Professional challenge, safeguarding, unconscious bias, supervision, observation and dignity governance.

Suggested learning pathway

Staff group	Suggested pathway
All staff	Induction and dementia foundations covering dignity, privacy, consent, identity and communication.
Direct-care staff	Practice learning in supported choice, personal care, refusal, emotional security and positive risk-taking.
Senior staff and nurses	Decision-specific capacity, best interests, safeguarding, advocacy, coaching and escalation.
Champions and managers	Culture, observation, professional challenge, complaints learning and governance.

Evidence

Examples of evidence

Evidence domain	Possible evidence
Lived experience	The person's choices, comfort, non-verbal responses, feedback, complaints, compliments and advocacy input.
Records	Preferences, consent, capacity and best-interest records, personal-care guidance and positive risk assessments.
Observation	Privacy, tone, pace, introductions, supported choice, non-rushed care and response to refusal.
Professional/family input	Advocate, family and professional contributions without overriding the person's rights.
Workforce competence	Observation, scenarios, supervision, reflective accounts and action following concerns.
Governance and outcomes	Dignity audits, complaints themes, safeguarding learning and improved comfort, choice or participation.

Can the service show the full evidence cycle?

1. Understand	2. Plan	3. Deliver	4. Review	5. Improve
What matters to the person and what communicates comfort or refusal?	Agree rights-based support, consent and risk arrangements.	Provide respectful, paced and least-restrictive care.	What changed for the person?	Continue, adapt, challenge or escalate.

Suggested respect and dignity outcome tracker

Desired outcome	Support	Measure	Review	Next action
Feel in control during personal care	Preferred staff, explanation, privacy, choice and time	Consent, participation and signs of comfort/distress	Record the person's experience and any refusal	Continue or change the approach

Good Practice Examples

4.1 Respectful everyday practice

Staff knock, introduce themselves, respect personal space, protect modesty and speak with the person rather than over them, using adult, compassionate and non-stigmatising language. They discuss sensitive information privately and protect confidentiality.

Possible evidence: Observation; feedback; privacy audit; supervision.

4.2 Identity, culture and relationships

The person's history, strengths, preferred clothing, faith, culture, language, sexuality, gender identity, relationships, routines and personal expression visibly shape daily care. Staff use what they know about the person to support choices about appearance, valued relationships and everyday activities rather than making assumptions.

Possible evidence: Life history; care plan; person/family feedback; observation.

4.3 Choice, autonomy and consent

A person who declines care is offered time, explanation and an alternative approach rather than being pressured.

Possible evidence: Consent and refusal records; updated plan; staff reflection; outcome.

4.4 Capacity and best interests

Staff presume capacity and offer time, accessible information and communication support before concluding that the person cannot decide. Where there is reason to doubt capacity, assessment concerns the particular decision at the time it is needed. Where the person lacks capacity for that decision, a best-interest decision follows the Mental Capacity Act, involves the person and relevant others, and records why the chosen option is the least restrictive.

Possible evidence: Decision-specific assessment; best-interest record; advocacy; least-restrictive rationale.

4.5 Independence and positive risk-taking

The person chooses clothing, food, movement or routines with proportionate support despite manageable risk.

Possible evidence: Positive risk assessment; observation; maintained independence and wellbeing.

4.6 Emotional security and comfort

Personal care is paced around the person and trauma or distress cues shape who supports them and how.

Possible evidence: Comfort profile; observation; reduced distress; review.

4.7 Advocacy and challenge

Staff respectfully challenge disrespectful, discriminatory or infantilising language, assumptions or practice by colleagues, visitors or professionals. They explain the person's preferences and rights, seek correction or a change in approach, and record and escalate concerns appropriately.

Possible evidence: Escalation/email record; supervision; corrected documentation; feedback.

4.8 Leadership and assurance

Leaders model dignity in everyday interactions and use walkarounds, observation and feedback to identify dignity gaps, respond to concerns and check that improvement is sustained. They ensure new and agency staff can find each person's key preferences and rights, explain the agreed approach and demonstrate it in practice.

Possible evidence: Leadership observation; audit; complaint/compliment themes; action plan; induction and agency briefing; staff understanding checks; re-observation.

Standard 5 – Effective Communication

Summary Statement

Communication throughout the service is clear, compassionate, adult, inclusive and tailored to the individual. Staff enable meaningful interaction and decision-making, understand verbal and non-verbal communication, make reasonable adjustments and actively reject negative language, stereotypes and labels.

Indicators

1. **Individual communication profile.** The person's preferred name, language, communication style, processing time, understanding, expression and helpful or unhelpful approaches are known and recorded.
2. **Sensory and physical needs.** Hearing, vision, speech, pain, oral health and other factors affecting communication are identified, addressed and reviewed.
3. **Accessible interaction.** Staff introduce themselves, explain what is happening, use appropriate pace, positioning, tone, words, visual or movement cues and allow sufficient response time.
4. **Communication as behaviour.** Staff recognise changes in expression, movement, withdrawal or distress as possible communication and investigate meaning and reversible causes.
5. **Respectful language.** Communication with and about people is adult, strengths-based and non-stigmatising; labels, infantilising language and discriminatory assumptions are challenged.
6. **Supported decision-making and consent.** Information is given in accessible formats and staff check understanding, consent and preference rather than assuming agreement.
7. **Consistency and information sharing.** Effective approaches and changes are communicated across shifts, agency staff, families and professionals in line with consent and confidentiality.
8. **Technology and communication aids.** Technology or aids are used only when useful to the person, with consent, accessibility, privacy and effectiveness considered.
9. **Workforce competence and governance.** Leaders observe communication, review feedback and incidents, address bias and verify that learning changes practice.

Applying the Standard in Practice

Effective communication is both how staff communicate and how they interpret what the person communicates. Providers should evidence patient observation, adaptation and shared learning, not only the existence of a communication passport.

Verbal, non-verbal and cultural communication

- Staff understand the person's words, phrases, gestures, facial expression, tone, movement and behaviour. Colloquial phrases and culturally specific expressions may need to be explained during induction.
- For a person who does not use speech, staff may learn consistent meanings from sounds or gestures, offer writing materials, objects, flashcards, pictures or simple signs, and record what has been learnt.
- Picture menus, showing plated options, demonstrations and one choice at a time can support meaningful decisions where written menus are not accessible.
- Communication in another language may require agreed phrases, interpreters or suitable technology. Digital translation must be used carefully, with privacy, accuracy and risk considered.

Communication, pain and physical health

Changes in posture, facial expression, vocalisation, withdrawal, sleep, appetite or movement may communicate pain, constipation, infection or another health problem. Staff should know the person's individual signs and use an appropriate pain or clinical assessment tool within competence, escalating findings rather than recording the behaviour alone.

Recording and sharing what works

Care records should show the process of observation, trial, response and refinement. If staff discover that a particular noise means discomfort, that a writing gesture means the person wants pen and paper, or that approaching from one side prevents startling, this must be added to accessible guidance and shared with all shifts, agency staff and professionals.

Language, labelling and bias

Records should describe what was observed, its context and the person's likely need instead of using labels. Services should audit handovers and care records for infantilising, judgemental or gendered language and challenge inaccurate labels before they become embedded in future decisions.

What leaders should test

- Can staff demonstrate communication methods rather than only describe training?
- Are aids working, available and actually used?
- Does observation show an adult, natural conversation rather than a patronising tone?
- Are communication discoveries reviewed when needs change?
- Can staff explain how communication supports consent, dignity, safety and wellbeing?

References

Reference	Relevant indicator(s)
Equality Act 2010; Human Rights Act 1998; Care Act 2014	1–9
Mental Capacity Act 2005 and Code of Practice	3, 6–8
CQC Regulations 9, 10, 11, 12, 17 and 18	1–9
NICE NG97: Dementia: assessment, management and support for people living with dementia and their carers	1–9; indicator 9: staff training and education, not the full governance requirement
Skills for Care Dementia Training Standards Framework	1–9

Resources

The resources below are mapped to this standard's indicators and practical guidance. Select complementary resources for the person and the service; use existing records rather than creating duplicate paperwork.

HCPA: Dementia resources hub (topic resources and signposting)

click here

Indicator	Resources and practical tools
1. Individual communication profile	Alzheimer's Society: "This is Me" document click here Dementia UK: Life story template click here
2. Sensory and physical needs	Dementia UK: Health advice topics click here Dementia UK: Dementia and personal hygiene click here Alzheimer's society: Dental and mouth care click here Alzheimer's Society: Dementia, sensory impairment and communicating click here RNIB: Dementia and sight loss - guide with optometrist-visit checklist click here RNID: Supporting people who are deaf, having hearing loss or tinnitus click here

Indicator	Resources and practical tools
3. Accessible interaction	Dementia Carers Count: Using visual aids to support communication click here Dementia UK: Tips for better communication - practical leaflet click here Alzheimer's Society: How to communicate with a person with dementia click here Hearing Dogs for Deaf People click here Institute of Translation and Interpreting click here Royal College of Speech and Language Therapists click here
4. Communication as behaviour	Hertfordshire Behavioural and psychological symptoms of dementia checklist click here St Oswald's Hospice: DisDAT tools - distress passport and monitoring resources click here *Originally developed in learning-disability/palliative care. Records individual content/distress cues, not a numerical pain score or diagnosis.* Dementia Services Development Centre: Behaviour and communication (*guidance only*) click here
5. Respectful language	Dementia Community: "Behavioural expressions of need" and the use of appropriate language click here KYN: Inclusive language guide "Talking about dementia" click here DEEP: Dementia words matter click here
6. Supported decision-making and consent	Innovations in Dementia: How to write and produce better information for people with dementia click here Forward with Dementia: Support shared decision making and planning ahead click here Care Handbook: Communication techniques click here

Indicator	Resources and practical tools
7. Consistency and information sharing	NHS: Accessible Information Standard click here NHS: Information sharing in social care click here CQC Logic: Confidentiality in care - what it means, the Caldicott principles and when information can be shared click here
8. Technology and communication aids	Talking Mats: Digital talking mats and dementia click here Dementia UK: Living aids and assistive technology click here DemTalk: Communication toolkit (*developed by Newcastle University, but nationally useful*) click here
9. Workforce competence and governance	Care Professional Academy: Dementia Tool Workbook click here *Use alongside training, supervision and observed practice, completion alone does not certify competence.*
Relevant learning videos for standard 5	SCIE: Dignity in care - communication (*not dementia specific but contains useful tips*) watch here Alzheimer's Society: "The World Turned Upside Down" short film about dementia and communication watch here

Learning and Development

Indicator	Learning and development
1–3	Dementia-sensitive verbal and non-verbal communication; listening, processing time, positioning, validation, sensory loss and accessible information.
4	Distress as communication; pain, delirium and diagnostic overshadowing; professional curiosity and escalation.
5–6	Respectful terminology, unconscious bias, supported decision-making, consent and the Mental Capacity Act.
7–8	Handover, confidentiality, family/professional communication, communication aids and proportionate technology.
9	Coaching, observation, reflective practice, audit and governance.

Suggested learning pathway

Staff group	Suggested pathway
All staff	Induction and dementia foundations in respectful, accessible communication.
Direct-care and activity staff	Practice-based learning in non-verbal approaches, validation, sensory support and supported choice.
Senior staff and nurses	Assessment of communication change, escalation, consent, care planning and coaching.
Champions and managers	Observation, documentation audit, bias challenge, feedback and governance.

Evidence

Evidence domain	Possible evidence
Lived experience	The person's words, choices, engagement and non-verbal responses; family, advocate, complaint and compliment feedback.
Records	Communication passport, sensory checks, accessible information, consent records, handovers and care-plan reviews.
Observation	Introductions, calm tone, suitable pace, positioning, cues, response time and checking understanding.
Professional input	SALT, audiology, optometry, dental, GP, nursing or advocacy advice where relevant.
Workforce competence	Observation, scenarios, supervision, reflective accounts and response to feedback.
Governance and outcomes	Documentation audits, incident themes, improved participation, reduced distress or more successful decision-making.

Can the service show the full evidence cycle?

1. Understand	2. Plan	3. Deliver	4. Review	5. Improve
How does the person communicate and what are the barriers?	Agree accessible approaches and desired outcome.	Use the approach consistently.	What did the person understand or communicate?	Keep, adapt, replace or escalate.

Suggested communication outcome tracker

Desired outcome	Approach	Measure	Review	Next action
Express meal choice	Show two options, use pictures and allow response time	Choice expressed and meal accepted	Record verbal and non-verbal response	Continue or test another accessible method

Good Practice Examples

5.1 Individual communication profile

Staff know and record the person's preferred name, language, communication style, processing time, understanding, expression, gestures and meaningful expressions. The communication profile identifies helpful and unhelpful approaches, and staff use and review this guidance during everyday interactions.

Possible evidence: Profile; observation; family input; review.

5.2 Sensory and physical needs

Glasses and hearing aids are available and working; hearing, vision, speech, positioning, pain, oral health and other factors affecting communication are identified and addressed. Staff review whether the support helps, record changes and seek relevant professional advice where needed.

Possible evidence: Checks; professional advice; equipment records; outcome.

5.3 Accessible interaction

Staff approach from the person's visible side, introduce themselves, use one idea at a time and wait for a response.

Possible evidence: Observation; supervision; person's response; spot check.

5.4 Communication as behaviour

Withdrawal or pacing prompts exploration of pain, toileting, noise, fear or another unmet need.

Possible evidence: ABC or observation record; physical-health check; changed support; outcome.

5.5 Respectful language

Staff replace labels with factual descriptions of what happened, likely meaning and support required.

Possible evidence: Care-record audit; corrected handover; supervision; feedback.

5.6 Supported decision-making and consent

Pictures, objects, demonstrations or simplified information enable the person to choose or consent. Staff allow response time and check understanding, consent and preference using the person's communication methods rather than assuming agreement; they adapt the explanation or approach where needed.

Possible evidence: Accessible material; consent record; observation; decision outcome.

5.7 Consistency and information sharing

A successful approach and any subsequent changes are added to the care plan and shared across shifts, including night and agency staff, and with families and visiting professionals in line with consent and confidentiality. Staff check that those providing support understand and use the agreed approach.

Possible evidence: Updated plan; handover; agency briefing; audit.

5.8 Technology and aids

A video call, translation tool or communication device is used only where it helps the person, with consent, accessibility and privacy considered. Staff check that the person can use the aid with appropriate support and review its effectiveness through the person's response, adapting or replacing it if it does not help.

Possible evidence: Consent; risk/privacy review; usage record; impact review.

5.9 Workforce competence and governance

Leaders observe communication, review feedback and incidents, identify language or access barriers and address bias. They use coaching and agreed actions to improve practice, then confirm through re-observation and follow-up that learning has changed everyday interactions and that improvements are sustained.

Possible evidence: Competency record; audit; action plan; sustained outcome.

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

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.

Applying the Standard in Practice

Positive Behaviour Support is not a form, label or risk-control system. It is a continuing process of understanding the function and meaning of distress, improving quality of life and changing support so that distress is less likely and the person recovers safely when it occurs.

Structured assessment before intervention

Staff should first consider physical and clinical causes, including pain, delirium, infection, constipation, dehydration, hunger, medicine effects and sensory impairment. They should then consider communication, environment, noise, temperature, demands, relationships, routine, boredom, trauma, grief and other unmet needs. Assessment must be based on the person's baseline, life history and current context.

Using ABC records as support tools

- Record what happened well before the event, not merely the action immediately preceding it.
- Describe observable behaviour without judgement, including intensity, duration and impact.
- Record staff responses, changes to demand or environment, the person's response and recovery period.
- Analyse repeated records for patterns and convert learning into proactive and reactive guidance.
- Avoid entries such as "agitated—calmed down", which provide too little information to guide support.

Plans, terminology and review

Services may call the document a PBS plan, emotional-support plan or another person-centred name. Whatever the title, it should identify the specific expressions being understood, likely function, early signs, primary prevention, skilled response, safety measures, recovery support and review arrangements. A general emotional-care plan alone may not provide sufficient functional analysis.

Medication and professional challenge

Medication is considered only when clinically necessary and proportionate, following appropriate assessment and consideration of non-pharmacological approaches. Before medication is requested or introduced, records should show which approaches were considered, tried, reviewed and evaluated, including unsuccessful approaches and the person's response, except where urgent clinical intervention is required; record the reason for that exception. Where psychotropic or PRN medicine is prescribed, evidence should show the target symptom, rationale, reason for administration, accurate dosage and administration record, effect, side effects and planned review. Staff administer medicines safely within their role and competence and communicate concerns to the prescriber. Staff should actively advocate for non-pharmacological support, use their day-to-day knowledge to challenge ineffective or over-sedating treatment, and record communication with prescribers. Regular reviews should consider effectiveness, side effects and reduction or discontinuation where appropriate, in partnership with the prescriber. Any stated local review interval or pharmacy arrangement must be validated before publication.

Safety, restrictions and positive risk

Safety plans should protect the person, other residents and staff while preserving movement, occupation, relationships and quality of life. Where restriction is unavoidable, record the legal basis, decision-making process, alternatives considered, authorisation where required, duration and plan to reduce it.

What leaders should test

- Are ABC records analysed, or merely completed?
- Do incidents, safeguarding, PRN use and complaints lead to changes in support?
- Can staff identify triggers and early signs and explain personalised responses?
- Are MDT discussions and family knowledge translated into care guidance?
- Do audits show outcomes such as improved engagement, nutrition, mobility, comfort, fewer incidents, reduced medication or better recovery?
- Is personalised, evidence-based non-pharmacological support the first-line approach, and can staff show how they advocate for it?
- Before medication was requested or introduced, can the service show what was considered, tried, reviewed and evaluated, including unsuccessful approaches and the person's response? Where urgent clinical intervention was required, is the reason recorded?
- Do medication reviews show clinical necessity, proportionality, rationale, effectiveness, side effects and consideration of reduction or discontinuation where appropriate?

- Do staff responsible for medicines demonstrate safe administration, accurate dosage and recording, side-effect monitoring and communication of concerns to the prescriber?
- Is PBS embedded across care planning, staff training, reflection, reviews and daily care, with competence checked across shifts?

References

Reference	Relevant indicator(s)
Human Rights Act 1998; Equality Act 2010; Care Act 2014	1–8
Mental Capacity Act 2005, Code of Practice and applicable deprivation-of-liberty safeguards	2–6 and 8
CQC Regulations 9, 10, 11, 12, 13, 17 and 18	1–8
NICE NG97: Dementia: assessment, management and support for people living with dementia and their carers	1–8
NICE QS184: Dementia — quality statement 6: Managing distress	6; 1, 2 and 8.
NICE decision aid: Antipsychotic medicines for treating agitation, aggression and distress in people living with dementia	2, 3 and 8
Skills for Care Dementia Training Standards Framework	1–8

Resources

Resources are organised against the eight current indicators. Some resources support more than one indicator

HCPA: Dementia resources hub (topic resources and signposting)
click here

Indicator	Resources and practical tools
1. First-line non-pharmacological, person centred interventions	Alzheimer's Society: Managing behaviour changes click here Skills for Care: Distressed behaviour click here HCPA: Positive Behaviour Support (PBS) - framework guidance and resource links click here Includes learning-disability material and older guidance - always use dementia-specific assessment and follow local and national guidance.

Indicator	Resources and practical tools
	The PBS Academy click here Dementia UK: Coping with distress - practical guidance leaflet click here Use alongside the structured-assessment and planning resources under indicator 6. Connect personalised non-pharmacological support to the person's life history, communication, preferences and quality of life.
2. Clinically necessary medication and regular review	NICE: Antipsychotic medicines for treating agitation, aggression and distress in people living with dementia (*this is a decision aid document only, application of the content should always be discussed and monitored in partnership with the prescriber*) click here Alzheimer's Research UK: Antipsychotics for dementia linked to more harms than previously acknowledged click here HWEICB: Antipsychotics and dementia webinar slides (guidance only, last updated 31st March 2026) click here HWEICB: Medication and compliance in adult social care (*guidance only, last updated 31st March 2026*) click here HWEICB: Medication compliance FAQ and resources click here Use these medication resources with the prescriber to support rationale, effectiveness and side-effect review, and consideration of reduction or discontinuation where appropriate. They also support safe administration under indicator 4.
3. Advocacy for non-pharmacological strategies	Rare Dementia Support click here Young Dementia Network click here Memory Support Hertfordshire click here Dementia UK: Admiral nurse dementia helpline click here *Not an emergency or local referral pathway. Professionals may seek advice, but the Helpline does not take third-party referrals.* In-document support: "Medication and professional challenge" and "What leaders should test". Use the person's and family's knowledge, recorded non-pharmacological approaches and outcomes to advocate during professional discussions. The

Indicator	Resources and practical tools
	services above provide advice or support; they are not a substitute for validated local referral and escalation arrangements.
4. Safe medication administration and side-effect monitoring	Use the medication resources under indicator 2, including the medication and compliance webinar, FAQ and resources. In-document support: "Medication and professional challenge" and the medication/PRN evidence examples. Connect accurate administration records with the reason for use, effect, side effects and communication with the prescriber.
5. PBS embedded in culture, learning and everyday care	Alzheimer's Society: Dementia "We" statements click here Restraint Reduction Network click here GOV.UK: Changes to the definition of deprivation of liberty click here Mental Health Foundation: Dementia, rights, and the social model of disability click here Skills for Care: Positive behavioural support resources and case studies click here PBS Academy: Positive behavioural support competence framework click here *Not specifically validated for dementia, select relevant competencies and seek specialist input.* PBS Academy: Behaviour support plan content appraisal tool (BSP-CAT) and user's manual click here *Developed for learning disabilities in community settings, not a validated dementia-care appraisal instrument. Requires relevant PBS experience and you must observe non-commercial/no-derivatives licence terms.* Use alongside the learning pathway and competence assessment below. Check how PBS is embedded in care planning, training, reflection, reviews and everyday support, including recognition that behaviour may communicate pain, illness, discomfort or other unmet need.
6. Person centred Behaviour Support Plans and appropriate tools	Hertfordshire Behavioural and psychological symptoms of dementia checklist click here CQC: Functional assessment of behaviour (brief guide) click here

Indicator	Resources and practical tools
	Alzheimer's Society: Dementia care mapping information click here PASS: ABC charts (guidance only) click here Challenging Behaviour Foundation: Positive Behaviour Support Planning: Part 3 - practical guide with examples click here *Written for children/adults with learning disabilities and family carers. Adapt the planning structure with dementia expertise and do not assume behaviour is learned or teach replacement skills without individual assessment.* In-document support: "Structured assessment before intervention", "Using ABC records as support tools" and "Plans, terminology and review". Use appropriate tools to identify early signs, triggers, possible function, unmet needs, preventative approaches, support strategies and intervention impact.
7. Recording and reviewing before, during and after distress	SCIE: Listening to learn - what a residential service visit reminded me about personalisation, power and possibility click here Use alongside the ABC guidance under indicator 6. In-document support: "Using ABC records as support tools", the full evidence cycle and the Positive Behaviour Support outcome tracker. Record the wider lead-up, observable distress, staff response and recovery; analyse patterns and update care guidance.
8. Considering, trying and evaluating non-pharmacological approaches	Use the non-pharmacological resources under indicator 1 and assessment and planning resources under indicator 6, alongside the medication decision aid under indicator 2. In-document support: "Medication and professional challenge", the full evidence cycle and the Positive Behaviour Support outcome tracker. Show what was considered, tried, reviewed and evaluated, including unsuccessful approaches and the person's response, before medication was requested or introduced. Record the reason where urgent clinical intervention was required.
Relevant learning videos for standard 14	PBS Together: What is PBS? watch here Restraint Reduction Network: We need to talk about restraint watch here Dementia Community: Responding to people with dementia in distress webinar recording

Indicator	Resources and practical tools
	watch here Alzheimer's Research UK: Urvashi's story - living with frontotemporal dementia watch here Alzheimer's Research UK: A walk through dementia - at the supermarket (*lived experience video*) watch here Alzheimer's Research UK: A walk through dementia - walking home (*lived experience video*) watch here SCIE: Dementia from the inside (*lived experience video*) watch here

Learning and Development

Indicator	Learning and development
1	Evidence-based, non-pharmacological and person centred interventions as the first-line approach; distress as communication; life history, trauma-informed care, proactive support and quality of life.
2	Clinically necessary and proportionate medication following appropriate assessment and consideration of non-pharmacological approaches; psychotropic and antipsychotic governance, target symptoms, rationale, effectiveness, side effects, regular prescriber review and consideration of reduction or discontinuation.
3	Advocacy for personalised non-pharmacological strategies; using the person's and family's knowledge, recorded approaches and outcomes in MDT discussions and professional challenge; partnership working and escalation within role.
4	Safe medication administration, accurate dosage and recording; psychotropic/PRN protocols, reasons for administration, monitoring of effects and side effects, and communication of concerns to the prescriber.
5	Embedding PBS in care planning, training, reflective practice, reviews and everyday care; recognising distress, pain, illness, discomfort, environmental and emotional needs; coaching, observation, audit and service improvement.
6	Person centred Behaviour Support Plans and appropriate tools, including ABC charts; structured assessment of pain, delirium, infection, constipation, dehydration, nutrition, medicines, sensory needs and diagnostic overshadowing; functional thinking, early signs, triggers, unmet needs, prevention, de-escalation, safety and intervention impact. Include positive

Indicator	Learning and development
	risk-taking, consent, capacity, best interests, least-restrictive practice and safeguarding in planning.
7	Recording and reviewing the wider lead-up, observable distress, staff responses and recovery period; ABC and incident-pattern analysis, communication, triggers and effective approaches; reflective case review and incorporating learning into care planning.
8	Demonstrating which non-pharmacological approaches were considered, tried, reviewed and evaluated before medication was requested or introduced; recording the person's response, unsuccessful approaches, outcomes and learning; documenting the reason where urgent clinical intervention was required.

Suggested learning pathway

Staff group	Suggested pathway
All staff	Dementia foundations: compassionate language, distress as communication, recognition of changes in wellbeing, first-line personalised non-pharmacological support, advocacy and immediate safety; recording and escalation within role.
Direct-care staff	PBS fundamentals, observation before, during and after distress, proactive support, de-escalation and recovery; applying Behaviour Support Plans, recording responses and outcomes, contributing to review of non-pharmacological approaches and advocating for what helps the person. Medication administration learning and assessment apply only where included in the staff member's role and competence.
Senior carers and nurses	Structured assessment, clinical escalation, capacity, restrictions and Behaviour Support Plan review; coordinating ABC analysis, family and MDT input, advocacy and evaluation of non-pharmacological approaches before medication requests. Where responsible for medicines, demonstrate safe administration, accurate dosage, recording, monitoring and communication with prescribers; support regular review of necessity, effectiveness, side effects and reduction or discontinuation where appropriate. Record reasons for urgent clinical intervention.
Champions/practice leads	Functional review, coaching, data analysis and case reflection; help staff analyse lead-up, distress and recovery, translate findings into support plans, advocate for non-pharmacological strategies and evaluate their impact, including unsuccessful approaches.

Staff group	Suggested pathway
Managers and clinical leaders	Governance, staffing, restrictive-practice oversight, prescribing challenge and system escalation; assure PBS is embedded across planning, training, reflection, reviews and daily care. Check role-specific competence, safe administration and medication-review records, evidence of non-pharmacological approaches considered, tried and evaluated before medication requests, and recorded urgent clinical exceptions.

Evidence

Examples of evidence

Evidence domain	Possible evidence
Lived experience	The person's comfort, quality of life, choices and verbal/non-verbal response; family or advocate feedback.
Records	PBS plan, ABC records covering before, during and after distress, health checks, risk and capacity records, medicine/PRN records and reviews. Existing records show non-pharmacological approaches considered, tried, reviewed and evaluated, including unsuccessful approaches and the person's response, before medication was requested or introduced; record the reason for any urgent clinical exception. Medication records show accurate dosage and administration, rationale, effects, side effects and review arrangements.
Observation	Calm approach, early support, de-escalation, least restriction, safety and post-event recovery.
Professional input	GP, pharmacist, nurse, mental-health, psychology, OT or safeguarding input where relevant; advocacy and professional-discussion records showing how the person's and family's knowledge informed prioritisation of non-pharmacological strategies; prescriber reviews of clinical necessity, proportionality, effectiveness, side effects and reduction or discontinuation where appropriate.
Workforce competence	Observation, scenarios, coaching, supervision, reflection and learning after incidents; demonstrated advocacy, use of support plans and evaluation of non-pharmacological approaches. Role-specific medication competence includes safe administration, accurate dosage, recording and side-effect monitoring.
Governance and outcomes	Trends in distress, injuries, safeguarding, restrictions, PRN use, wellbeing and quality of life; audits of PBS across shifts, advocacy, medication safety and reviews, and evidence of non-pharmacological

Evidence domain	Possible evidence
	evaluation before medication requests or recorded urgent clinical exceptions.

Can the service show the full evidence cycle?

1. Understand	2. Plan	3. Deliver	4. Review	5. Improve
What is the person communicating and what may be causing distress?	Agree quality-of-life outcomes and proactive/response strategies.	Use personalised, least-restrictive support.	What changed, including unintended effects?	Keep, adapt, stop, escalate or reduce restriction/medicine.

Suggested Positive Behaviour Support outcome tracker

Desired outcome	Support	Measure	Review	Next action
Feel safe and less distressed during personal care	Familiar staff, pain check, explanation, retreat-and-return and preferred routine	Early signs, duration/intensity of distress, participation and recovery	Record what helped and any adverse effect	Continue, adjust, seek clinical input or review medication/restriction

Good Practice Examples

14.1 First-line non-pharmacological, person centred interventions

When a person becomes distressed during care, staff consider pain, illness, communication, the environment and other unmet needs rather than reducing the person to a label. Using the person's life history and preferences, they reduce demands, offer space, validate feelings, use a familiar activity and follow the agreed safety plan. They record the person's response and review whether this first-line support improves comfort and quality of life.

Possible evidence: Assessment and clinical contact where needed; life history; agreed non-pharmacological support; observation; response and recovery record; review.

14.2 Clinically necessary medication and regular review

Where medication is considered, staff contribute assessment findings, alternatives considered and the person's response to the prescriber's decision. Records explain why treatment is clinically necessary and proportionate. Psychotropic and antipsychotic reviews document the rationale, target symptoms, effectiveness, side effects and plans to reduce or discontinue treatment where appropriate. Staff raise concerns about ineffective or over-sedating treatment and record the agreed response.

Possible evidence: Assessment; non-pharmacological approaches considered; prescribing rationale; target symptoms; effect and side-effect monitoring; prescriber review; reduction or discontinuation plan where appropriate.

14.3 Advocacy for non-pharmacological strategies

Staff bring the person's preferences, family knowledge and recorded responses to professional discussions and actively advocate for personalised non-pharmacological strategies to be prioritised. They explain what helps, seek timely specialist advice where needed, and record agreed actions, follow-up, delays and interim risk management rather than allowing the person's needs to be lost between services.

Possible evidence: Person/family feedback; recorded approaches and outcomes; advocacy or MDT discussion; referral and follow-up; escalation timeline; agreed actions and revised guidance.

14.4 Safe medication administration and side-effect monitoring

Staff whose role and competence include medicines administer the prescribed dose safely and maintain an accurate administration record. Where PRN medicine is prescribed, they follow the person's protocol and record the target symptom, reason for administration, effect and any side effects. Concerns are communicated to the prescriber and followed up.

Possible evidence: Role-specific competency observation; prescription and PRN protocol; medication administration record (MAR); dosage checks; effect and side-effect monitoring; prescriber communication and follow-up.

14.5 PBS embedded in culture, learning and everyday care

Leaders embed PBS in care planning, staff training, reflective practice, reviews and daily care. They coach staff to describe observable events and possible meaning, recognising pain, illness, discomfort, environmental factors and emotional need rather than using labels. Plans are tested on different shifts; observation, supervision and audit identify inconsistency or unsafe practice, and leaders check that agreed changes are sustained.

Possible evidence: Care plans; learning and competency records; observation across shifts; supervision and reflection; records audit; feedback; staffing/action review; re-observation.

14.6 Person centred Behaviour Support Plans and appropriate tools

A Behaviour Support Plan draws on the person's baseline, life history, preferences, family knowledge and assessment. A sudden change prompts checks for pain, delirium, infection, constipation, hydration, medicines and environmental causes, with clinical input as needed. ABC charts and other appropriate tools help identify possible function, early signs, triggers and unmet needs. The plan sets out good-day routines, prevention, calming approaches, what staff should avoid, safety measures and recovery support; intervention impact informs review. Any restriction is justified, authorised where required, time-limited and reviewed for reduction.

Possible evidence: Behaviour Support Plan; life history; person/family input; assessment and clinical contact; ABC analysis; risk and capacity/best-interest records; restriction register; alternatives tried; intervention outcomes and review.

14.7 Recording and reviewing before, during and after distress

Staff record the wider period leading up to distress, what was observed during it, staff responses and the person's recovery afterwards. ABC and incident records are analysed for patterns, communication, triggers and effective approaches, not simply filed. Findings change routines, environments or support guidance, and review checks the person's response.

Possible evidence: ABC and incident records covering lead-up, distress and recovery; pattern analysis; case review; updated care plan; action plan; before/after trend and person's response.

14.8 Considering, trying and evaluating non-pharmacological approaches

Before medication is requested or introduced, the service can show which personalised non-pharmacological approaches were considered, tried, reviewed and evaluated. Records include what did not help, the person's response, effects on comfort and quality of life, and the next action. PRN use is linked to a defined target and appropriate alternatives. Where urgent clinical intervention is required, staff record the reason for the exception, action taken and subsequent review.

Possible evidence: Dated support and trial records; approaches considered and tried; successful and unsuccessful responses; outcome tracker; review findings; medication request or prescribing record; PRN protocol; urgent clinical rationale where applicable; follow-up review.

Appendix 1: Glossary of Terms

Term	Definition
ABC record	A structured record of what happened before, during and after an event, used with other evidence to identify patterns; it is not a complete assessment by itself.
Capacity	The ability to make a particular decision at the time it must be made. It is decision-specific and time-specific.
Diagnostic overshadowing	Attributing a new symptom or change to dementia without adequately considering physical illness, pain, delirium, sensory loss, medicine effects or another cause.
Distress	Discomfort or upset shown through words, emotion, movement, behaviour, withdrawal or a change in presentation.
Evidence cycle	Understand, plan, deliver, review and improve: a process connecting what matters to action and outcome.
Least restrictive option	The approach that meets need and manages risk while limiting rights, freedom and choice as little as possible.
Non-pharmacological approach	Personalised support that does not rely on medication, such as communication, activity, routine, sensory or environmental adjustment.
Outcome	The difference care or support makes to comfort, safety, independence, communication, wellbeing, connection or quality of life.
Positive Behaviour Support	A person-centred, evidence-informed approach that seeks to understand distress or behaviour as communication and improve quality of life through proactive, least-restrictive support.
Positive risk-taking	Supporting meaningful choice and participation while assessing and managing risk proportionately.
Proportionate evidence	Sufficient, meaningful evidence from suitable existing sources without avoidable duplication or excessive recording.
Reversible cause	A treatable factor that may change presentation, such as pain, infection, constipation, dehydration, delirium, sensory loss or medicine effects.
Trauma-informed care	Support that recognises the possible effect of past or current trauma and promotes safety, choice, trust, collaboration and control.

Appendix 2: Anonymised Challenges, Barriers and Mitigations

Challenge or barrier	Mitigation or improvement action
Gradual change is missed or fragmented across records.	Maintain a clear baseline, use structured handover and review small changes across sources.
Good care occurs but recording does not show impact.	Record the desired outcome, response and next action; use observation and feedback as well as records.
Staff turnover, agency use or shift variation affects consistency.	Use concise profiles, induction, buddying, observation, competency checks and targeted supervision.
External professional input is delayed or referral routes are unclear.	Record referral and follow-up, use interim safety plans, escalate delays and review system themes with commissioners.
Family expectations differ from the person's wishes.	Clarify consent, capacity and legal authority; use compassionate explanation, advocacy and documented review.
Disrespectful or outdated language appears in practice or external records.	Agree respectful terminology, coach staff, challenge and request correction, and record escalation where needed.
Course completion is mistaken for competence.	Use observation, scenarios, record review, reflection, feedback and reassessment.
ABC, incident or PRN data is collected without analysis.	Review patterns, causes, restrictions and outcomes; assign actions and re-audit.
Residential services are asked to evidence clinical judgement beyond their role.	Define observation, immediate action and escalation duties separately from nursing assessment and clinical oversight.
Day-to-day fluctuations are mistaken for permanent loss of ability.	Record time-of-day patterns and individual fatigue; brief staff to offer the least help required and review before increasing dependency.
Family members are unprepared for progression or fluctuating need.	Use regular reviews, accessible education and compassionate conversations; record information shared, questions, disagreement and agreed actions.
Good practice is buried in archived or lengthy electronic records.	Maintain a concise evidence map or anonymised case-study index that points to existing records and states the outcome and learning.

Communication barriers arise from language, culture, accent or unfamiliar colloquial phrases.	Include culturally informed communication in induction; use agreed phrases, visual aids and suitable interpretation while checking understanding and privacy.
Pain or illness is interpreted as dementia-related behaviour.	Document individual non-verbal pain signs, use an appropriate tool within competence and escalate changes promptly.
Visiting professionals disrupt routines or propose care in public areas.	Empower staff to protect privacy, explain the person's needs, request a suitable time/place and record any challenge or escalation.
PBS terminology is misunderstood as controlling behaviour.	Define PBS locally as a quality-of-life and least-restrictive approach; ensure plans focus on function, proactive support and recovery.
Behaviour-support plans do not capture the lead-up or recovery period.	Record early signs, wider antecedents, staff responses, outcome and recovery; analyse patterns and update guidance.
Psychotropic medication effects are not linked to wider outcomes.	Review alertness, mobility, nutrition, engagement, distress and quality of life; record concerns and professional challenge.
Leadership and good practice depend on one manager or champion.	Distribute responsibility across deputies, senior staff and champions; verify standards across nights, weekends and manager absence.