Hertfordshire Dementia Care Standards for Residential and Nursing Care

Support Guidance: Operational and Leadership

Purpose of this support guidance:

- To help commissioned residential and nursing services understand and apply Standards 6, 7, 15 and 16 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 6 – Skills and Competence

Summary Statement

Staff and leaders have evolving, role-appropriate dementia knowledge, practical skill and professional curiosity. Learning is blended with coaching, reflection and assessment so that staff can apply person-centred, rights-based and least-restrictive practice consistently and show improved outcomes for people living with dementia.

Indicators

1. The provider maintains a role-based dementia learning and competence framework covering induction, development, refreshers and reassessment.
2. Learning is blended and includes supervised practice, coaching and reflection; e-learning is not used as the sole preparation for complex dementia care.
3. Staff demonstrate person-centred communication, life-story use, positive behaviour support, consent and capacity practice, advocacy and least-restrictive positive risk-taking.
4. Staff recognise changes from the person's usual presentation, consider reversible causes and avoid diagnostic overshadowing, escalating within their role.
5. Dementia is contextualised across nutrition, hydration, medicines, mobility, pain, delirium, advance planning and end-of-life support.
6. Learning addresses progression, fluctuating needs, young-onset and rarer dementias where relevant to people using the service.
7. Staff understand internal and external multidisciplinary working, information sharing and their responsibility to advocate for the person.
8. Leaders assess competence in practice, respond to gaps and verify whether learning has improved the person's experience or outcomes.

Applying the Standard in Practice

Implementation must start with the person's wishes, rights, identity, culture, relationships, communication, strengths and quality of life. Evidence should show what changed for the person and distinguish provider action from action required of wider health and social-care partners.

Practical delivery

- **Indicators 1–2:** Map learning and reassessment to each role, including induction and refreshers. Combine taught or online learning with coaching, reflection and supervised practice before staff work independently on complex support.

- **Indicator 3:** Use life stories and communication preferences in daily support; observe consent, capacity, advocacy, positive behaviour support and least-restrictive positive risk-taking in practice.
- **Indicators 4–5:** Practise recognising changes from baseline, considering reversible causes and escalating within role. Apply dementia learning to nutrition, hydration, medicines, mobility, pain, delirium, advance planning and end-of-life support.
- **Indicators 6–7:** Tailor learning to progression, fluctuating needs, young-onset and rarer dementias present in the service. Rehearse multidisciplinary referrals, lawful information sharing and advocacy using the person's baseline and preferences.
- **Indicator 8:** Record observed competence, support required and reassessment; review whether learning changed the person's experience, not just training completion.

References

Mapping note: references identify relevant themes rather than an exclusive one-to-one relationship. A source may support several indicators. Resources support implementation and do not, by themselves, establish legal compliance, staff competence or achievement of an indicator. Local pathways and arrangements remain subject to Appendix 5 validation.

Reference	Relevant indicator(s)
Care Quality Commission staffing and governance expectations; Skills for Care Dementia Training Standards Framework — role-based learning and competence framework.	Indicator 1
Skills for Care dementia learning and workforce development guidance; NICE NG97 staff training and education — blended learning and supported application.	Indicator 2
Mental Capacity Act 2005 and Code of Practice; Human Rights Act 1998; Equality Act 2010; NICE NG97 — person-centred communication, rights and least-restrictive support.	Indicator 3
NICE dementia guidance and delirium guidance; professional escalation standards.	Indicator 4
NICE guidance relevant to medicines, nutrition, falls, pain and end-of-life care.	Indicator 5
NICE dementia guidance and diagnosis-specific evidence appropriate to current residents.	Indicator 6
Data Protection Act 2018/UK GDPR; Caldicott principles; NICE NG97 care coordination; professional codes — information sharing, partnership working and advocacy.	Indicator 7
CQC well-led and effective expectations; NMC Code where registered nurses are employed.	Indicator 8

Resources

The resources below are suggested tools that may help services apply and evidence the indicators. Existing tools can continue to be used where they achieve the intended outcome.

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

Indicator	Suggested resources and relevant themes
1. Role-based learning and competence	**Dementia Training Standards Framework** click here — Role-based dementia learning outcomes. **HCPA: Dementia pre-learning** click here — Preparation for further dementia training.
2. Blended and practical learning	**PocketMedic: Residential dementia care training films** click here — Films for discussion and practical learning. **Dementia Community: Behavioural Expressions of Need** click here — Needs-led language for describing distress.
3. Person-centred and rights-based practice	**Alzheimer's Society: This is me** click here — Personal routines and communication profile. **Dementia UK: My life story template** click here — Template for recording life history. **Dementia Community: Behavioural Expressions of Need** click here — Needs-led language for describing distress. **Alzheimer's Society: Dementia and the Mental Capacity Act 2005** click here — Capacity and supported decision-making guidance. **Dementia UK: LGBTQ+ support for people with dementia**

	click here — Inclusive care, identity and relationships. **Hertfordshire MCA Resource Pack — assessment, best-interests recording and reflective checklist** click here — Capacity assessment and best-interests recording tools. **Dementia UK: Managing distress in a person living with dementia** click here — Recognising triggers and offering reassurance.
4. Recognising change and reversible causes	**Hertfordshire Behavioural & Psychological Symptoms of Dementia checklist** click here — Structured checks for causes of distress. **RESTORE2 and RESTORE2 mini — official tools** click here — Deterioration recognition and structured escalation. **British Geriatrics Society: PINCH ME — delirium guidance** click here — Prompt for considering delirium causes. **Reviewing Patterns and Trends of Falls** click here — Individual and service-level falls review. **Alzheimer's Society: Sight and hearing loss with dementia** click here — Sensory needs and adapted support.
5. Dementia-contextualised core care	**Alzheimer's Association: Daily Care Guides** click here — Practical support for everyday care. **PocketMedic: Supporting eating and drinking; Supporting complexities** click here — Films supporting mealtimes and complex care. **Dementia UK: Advance Care Planning for Dementia** click here — Planning future care preferences.

	Marie Curie: Delirium in Palliative Care click here — Recognising delirium in palliative care. **Alzheimer's Research UK: Treatments for Dementia** click here — Overview of dementia treatment options. **Medicines competency assessment record — electronic** click here — Editable medicines competence assessment record. **Medicines competency assessment record — paper** click here — Printable medicines competence assessment record. **When Required Medication guidance — PRN/variable-dose template** click here — Individualised when-required medication protocol template. **Reviewing Patterns and Trends of Falls** click here — Individual and service-level falls review. **Resuscitation Council UK: ReSPECT for healthcare professionals** click here — Clinical recommendations for future emergencies.
6. Progression, fluctuating needs, young-onset and rarer dementias	**Rare Dementia Support: Posterior Cortical Atrophy (PCA)** click here — Visual-led dementia and support needs. **Alzheimer's Research UK: Primary Progressive Aphasia (PPA)** click here — Understanding language-led dementia. **Alzheimer's Association: Stages of Dementia and Behaviours** click here — Support as dementia needs change.

	Dementia UK: Young onset dementia — different symptoms (film and leaflet) click here — Film and leaflet on varied symptoms.
7. Multi-disciplinary working and advocacy	**Hertfordshire Behavioural & Psychological Symptoms of Dementia checklist** click here — Structured checks for causes of distress. **RESTORE2 and RESTORE2 mini — official tools** click here — Deterioration recognition and structured escalation. **Alzheimer's Society: This is me** click here — Personal routines and communication profile. **NICE NG97: Dementia assessment, management and support** click here — Dementia assessment, care and coordination guidance. **CQC: Meeting the Accessible Information Standard** click here — Identifying and meeting communication needs.
8. Competence assurance	**Dementia Training Standards Framework** click here — Role-based dementia learning outcomes. **Hertfordshire MCA Resource Pack — assessment, best-interests recording and reflective checklist** click here — Capacity assessment and best-interests recording tools. **Medicines competency assessment record — electronic** click here — Editable medicines competence assessment record. **Medicines competency assessment record — paper** click here — Printable medicines competence assessment record.

Learning and Development

Mapped indicator	Learning focus and method
Indicator 1	Design and maintain a role-based dementia learning and competence framework covering foundations, rights, identity, role boundaries, induction, development, refreshers and reassessment.
Indicator 2	Blend taught or online learning with coaching, reflection, practical communication, de-escalation, simulation and supervised application; do not rely on e-learning alone for complex dementia care.
Indicator 3	Person-centred communication, life story, strengths, positive behaviour support, consent, capacity, advocacy, positive risk-taking and least restriction.
Indicator 4	Recognising deterioration, delirium, pain and reversible causes; escalation practice.
Indicator 5	Dementia application in nutrition, hydration, medicines, mobility, pain, delirium, advance planning and end-of-life support.
Indicator 6	Progression, fluctuating needs, young-onset and rarer dementias relevant to people supported.
Indicator 7	Advocacy, MDT contribution, lawful information sharing and concise referral.
Indicator 8	Assessor skills, observation, feedback, coaching and outcome evaluation.

Suggested Learning Pathway

Role	Suggested learning and application
All staff	Foundations, rights, communication, recognising change and escalation.
Care and support staff	Role-specific practical dementia support, supervised practice and assessed communication/PBS competence.
Senior carers/shift leaders	Coaching, shift assurance, incident reflection, challenge and escalation.
Nurses/clinical leads	Clinical assessment, diagnostic overshadowing, medicines, delirium, capacity and professional accountability.

Managers/deputies/unit leaders	Workforce planning, legal literacy, quality assurance, learning transfer and culture.
Ancillary, temporary and agency staff	Before unsupervised work: service expectations, individual profiles, communication, rights, safeguarding and escalation.

Assessing and Reviewing Staff Competence

- Agree role-specific competence statements linked to the indicators.
- Use direct observation, scenario discussion, supervised practice and feedback from people and families.
- Assess judgement about consent, capacity, reversible causes, risk and escalation—not recall alone.
- Record the assessor, evidence, outcome, support required and review date.
- Reassess after incidents, changes in role or need, concerns, new evidence and relevant learning.
- Training attendance is supporting evidence only; competence is demonstrated through safe, person-centred practice and outcomes.
- Sample role-based competence across communication, life-story use, positive behaviour support, consent, capacity, advocacy, positive risk-taking, recognition of change, dementia-informed core care and multidisciplinary working. Include progression, fluctuating needs, young-onset and rarer dementias relevant to residents (Indicators 1–8).

Evidence

Type of evidence	Possible examples
Lived experience	Conversations, observation, accessible feedback, advocacy and family insight — What matters to the person; whether they feel known, safe, respected and involved; what changed for them.
Care records	Assessments, care plans, daily notes, reviews and decision records — A clear thread from wishes and needs to action, review and outcome.
Observation	Practice observation, walk-rounds, shadowing and spot checks — How staff communicate, uphold rights, enable choice and respond when leaders are absent.
Family and professional input	Reviews, correspondence, MDT records and feedback — Corroboration, challenge, shared decisions and continuity across settings.
Workforce competence	Observation, discussion, simulation, supervision and competency records — Applied knowledge and judgement—not training attendance alone.

Governance and outcomes	Audits, incidents, complaints, compliments, trends and improvement plans — Learning, sustained change, equity and measurable benefit or reduced harm.

Can the service show the full evidence cycle?

1. Understand	2. Plan	3. Deliver	4. Review	5. Improve
Identify the person's wishes, identity, strengths, communication, rights, risks and current outcomes.	Agree proportionate actions, roles, consent/capacity arrangements, timescales and evidence already available.	Provide consistent, least-restrictive support and record significant decisions or changes.	Bring together lived experience, records, observation, workforce and professional evidence.	Act on learning, update support and competence, share improvement and check that benefit is sustained.

Suggested care plan outcome tracker

Personal goal or desired outcome	Planned support or intervention	How impact will be measured	Review findings	Action following review
The outcome the person wants or would value, with a concise baseline using their words, observations or agreed proxy evidence.	The agreed support, responsible role and timescale. Separate provider actions from actions requested of partners.	The agreed signs of benefit or harm, evidence sources and review date; include the person's experience.	Date reviewed, evidence considered and what changed against baseline: benefit, no change or unintended effects.	The next action, owner and review date; record updates to the plan and how sustained benefit will be checked.

Leadership Assurance Questions

- Does the role-based framework cover every staff group, induction, development, refreshers and reassessment (Indicator 1)?
- Can staff demonstrate learning through coached practice rather than e-learning alone (Indicator 2)?
- Do observations show rights-based communication, recognition of change and dementia-informed core care (Indicators 3–5)?

- Does learning reflect current residents' dementia presentations and prepare staff to advocate and work with partners (Indicators 6–7)?
- What person-level evidence shows that assessed competence and resulting improvement are sustained (Indicator 8)?

Good Practice Examples

The examples below illustrate possible approaches. They are not intended to prescribe one way of working or require providers to replicate a particular intervention.

Indicator 1: Role-based learning and competence

What good practice may look like: A role matrix identifies a night-team gap; coached practice is arranged and reassessment confirms safer responses.

Possible evidence: Role matrix; observation; reassessment; person-level outcome.

Indicator 2: Blended and practical learning

What good practice may look like: After scenario practice, staff approach a distressed person slowly and reduce demands; distress decreases.

Possible evidence: Learning record; observation; daily-note trend.

Indicator 3: Person-centred and rights-based practice

What good practice may look like: Staff use a life-history cue to support consent and participation in personal care.

Possible evidence: Care plan; observation; feedback from the person or family.

Indicator 4: Recognising change and reversible causes

What good practice may look like: A change in walking and speech leads to prompt assessment rather than attribution to dementia.

Possible evidence: Baseline information; escalation record; professional outcome.

Indicator 5: Dementia-contextualised core care

What good practice may look like: Staff adapt medicines and mealtime support to the person's communication and routines.

Possible evidence: Care plans; medicines or food records; review.

Indicator 6: Progression, fluctuating needs, young-onset and rarer dementias

What good practice may look like: Focused learning about a younger person's rarer dementia and fluctuating support needs leads staff to adapt communication, pacing and routines as needs change.

Possible evidence: Professional advice; learning plan; observation; outcome.

Indicator 7: Multi-disciplinary working and advocacy

What good practice may look like: A referral includes baseline, triggers and strategies already tried; the person receives coordinated advice.

Possible evidence: Referral; MDT record; updated care plan.

Indicator 8: Competence assurance

What good practice may look like: A competence concern is coached and reassessed; respectful practice is sustained across shifts.

Possible evidence: Supervision; competency record; spot checks; feedback.

Standard 7 – Values and Behaviours

Summary Statement

Everyone working in the service demonstrates empathy, patience, respect, fairness and professional curiosity. Values are embedded in recruitment, induction, supervision and daily leadership so that each person's rights, identity, relationships, communication and strengths shape care, and discriminatory, stigmatising or task-led practice is challenged.

Indicators

1. Recruitment, induction, probation and deployment test and reinforce values and behaviours required for high-quality dementia care.
2. Staff consistently use respectful, non-stigmatising language and communication adapted to the individual.
3. Practice promotes autonomy, strengths, consent, privacy, relationships, identity, culture, faith, sexuality and quality of life.
4. Staff recognise and address unconscious bias, assumptions, diagnostic overshadowing and task-focused practice.
5. Staff support proportionate positive risk-taking and use the least-restrictive approach, recording capacity and best-interests decisions where required.
6. All leaders, including shift leaders, challenge poor practice promptly and support reflection, improvement and accountability.
7. The provider uses feedback and observation to understand culture across all shifts and demonstrates resulting improvements for people.

Applying the Standard in Practice

Implementation must start with the person's wishes, rights, identity, culture, relationships, communication, strengths and quality of life. Evidence should show what changed for the person and distinguish provider action from action required of wider health and social-care partners.

Practical delivery

- **Indicator 1:** Use values-based scenarios in recruitment and check the same behaviours during induction, probation and deployment, including temporary and agency placements.
- **Indicators 2–3:** Observe respectful language and individual communication in daily interactions. Check that support enables autonomy, strengths, consent, privacy, relationships, identity, culture, faith, sexuality and quality of life.

- **Indicators 4–5:** Use reflection to challenge bias, assumptions, diagnostic overshadowing and task-led routines. Support valued choices through proportionate safeguards and least-restrictive practice, recording capacity and best-interests decisions where required.
- **Indicators 6–7:** Give shift leaders clear responsibility to challenge poor practice promptly, support reflection and follow through. Compare feedback and observations across shifts and check what changed for people.

References

Mapping note: references identify relevant themes rather than an exclusive one-to-one relationship. A source may support several indicators. Resources support implementation and do not, by themselves, establish legal compliance, staff competence or achievement of an indicator. Local pathways and arrangements remain subject to Appendix 5 validation.

Reference	Relevant indicator(s)
Care Act 2014; CQC fit and proper persons and staffing expectations; Skills for Care values-based recruitment guidance.	Indicator 1
Human Rights Act 1998; Equality Act 2010; CQC dignity and respect requirements.	Indicator 2
Mental Capacity Act 2005; Equality Act 2010; Human Rights Act 1998; Care Act wellbeing principle — autonomy, identity, relationships, privacy and quality of life.	Indicator 3
NICE dementia guidance; Equality Act 2010; professional standards.	Indicator 4
Mental Capacity Act 2005 and Code of Practice; Human Rights Act 1998.	Indicator 5
CQC well-led expectations; organisational employment and safeguarding procedures; NMC Code where applicable — challenge, reflection and accountability.	Indicator 6
CQC assessment framework; organisational quality governance — feedback, observation across shifts and improvement. Duty of Candour where applicable to the circumstances.	Indicator 7

Resources

The resources below are suggested tools that may help services apply and evidence the indicators. Existing tools can continue to be used where they achieve the intended outcome.

Further resources: HCPA dementia page click here;

Indicator	Suggested resources and relevant themes
1. Values-based recruitment, induction,	**Dementia Training Standards Framework** click here — Role-based dementia learning outcomes.

probation and deployment	**PocketMedic: Residential dementia care training films** click here — Films for discussion and practical learning. **HCPA Best Practice Guide to Recruiting, Onboarding and Retaining Staff** click here — Values-based recruitment and staff onboarding. **HCPA: Dementia pre-learning** click here — Preparation for further dementia training.
2. Respectful language and communication	**Dementia Community: Behavioural Expressions of Need** click here — Needs-led language for describing distress. **Dementia UK: Communication tips** click here — Practical tips for individualised communication. **Alzheimer's Society: Positive language guide** click here — Guide to respectful dementia language.
3. Identity, relationships and quality of life	**Alzheimer's Society: This is me** click here — Personal routines and communication profile. **Dementia UK: LGBTQ+ support for people with dementia** click here — Inclusive care, identity and relationships. **Dementia UK: Meaningful activities for a person with dementia** click here — Person-led activities for meaningful engagement.
4. Bias and diagnostic overshadowing	**Dementia Community: Behavioural Expressions of Need** click here — Needs-led language for describing distress. **Hertfordshire dementia checklist** click here — Structured checks for causes of distress. **Alzheimer's Society: Sight and hearing loss with dementia** click here — Sensory needs and adapted support.
5. Positive risk and least restriction	**Alzheimer's Society: Dementia and the Mental Capacity Act 2005** click here — Capacity and supported decision-making guidance. **Alzheimer's Society: Dementia Statements and rights-based approaches** click here — Rights and person-focused care outcomes.

	Hertfordshire MCA Resource Pack — assessment, best-interests recording and reflective checklist click here — Capacity assessment and best-interests recording tools.
6. Challenge and accountability	**Dementia Training Standards Framework** click here — Role-based dementia learning outcomes. **Dementia Community: Behavioural Expressions of Need** click here — Needs-led language for describing distress. These resources support learning and respectful descriptions of need. Evidence of this indicator also requires observed challenge, reflection and follow-through using the service's safeguarding, supervision and accountability arrangements.
7. Culture and improvement	**Alzheimer's Society: Dementia Statements and rights-based approaches** click here — Rights and person-focused care outcomes. **Dementia UK: Communication tips** click here — Practical tips for individualised communication. Use these resources to frame rights-based feedback and communication. Compare actual feedback with observations across all shifts and record the resulting changes; the resources are not culture-measurement tools.

Learning and Development

Mapped indicator	Learning focus and method
Indicator 1	Values-based recruitment and fair selection, reinforced through induction, probation and deployment checks.
Indicator 2	Respectful dementia language, non-verbal communication and emotional validation.
Indicator 3	Autonomy, strengths, consent, privacy, relationships, identity, culture, faith, sexuality and quality of life.
Indicator 4	Unconscious bias, stigma, diagnostic overshadowing and reversible causes.
Indicator 5	Consent, capacity, best interests, advocacy, positive risk and least restriction.

Indicator 6	Constructive challenge, coaching, safeguarding and accountability.
Indicator 7	Culture measurement, triangulation and translating feedback into improvement.

Suggested Learning Pathway

Role	Suggested learning and application
All staff	Values, rights, respectful language, equality and speaking up.
Care and support staff	Applied communication, consent, strengths, identity and least-restrictive support.
Senior carers/shift leaders	Role modelling, immediate challenge, coaching and escalation.
Nurses/clinical leads	Clinical bias, capacity, consent, rights and person-centred clinical decisions.
Managers/deputies/unit leaders	Values-based recruitment, culture, accountability and workforce assurance.
Ancillary, temporary and agency staff	Clear expectations and individual guidance before each placement or shift.

Assessing and Reviewing Staff Competence

- Agree role-specific competence statements linked to the indicators.
- Use direct observation, scenario discussion, supervised practice and feedback from people and families.
- Assess judgement about consent, capacity, reversible causes, risk and escalation—not recall alone.
- Record the assessor, evidence, outcome, support required and review date.
- Reassess after incidents, changes in role or need, concerns, new evidence and relevant learning.
- Training attendance is supporting evidence only; competence is demonstrated through safe, person-centred practice and outcomes.
- Observe and discuss values in recruitment, induction, probation and deployment; respectful language; autonomy, privacy and identity; recognition of bias; positive risk and least restriction; constructive challenge; and response to feedback across shifts (Indicators 1–7).

Evidence

Type of evidence	Possible examples
Lived experience	Conversations, observation, accessible feedback, advocacy and family insight — What matters to the person; whether they feel known, safe, respected and involved; what changed for them.
Care records	Assessments, care plans, daily notes, reviews and decision records — A clear thread from wishes and needs to action, review and outcome.
Observation	Practice observation, walk-rounds, shadowing and spot checks — How staff communicate, uphold rights, enable choice and respond when leaders are absent.
Family and professional input	Reviews, correspondence, MDT records and feedback — Corroboration, challenge, shared decisions and continuity across settings.
Workforce competence	Observation, discussion, simulation, supervision and competency records — Applied knowledge and judgement—not training attendance alone.
Governance and outcomes	Audits, incidents, complaints, compliments, trends and improvement plans — Learning, sustained change, equity and measurable benefit or reduced harm.

Can the service show the full evidence cycle?

1. Understand	2. Plan	3. Deliver	4. Review	5. Improve
Identify the person's wishes, identity, strengths, communication, rights, risks and current outcomes.	Agree proportionate actions, roles, consent/capacity arrangements, timescales and evidence already available.	Provide consistent, least-restrictive support and record significant decisions or changes.	Bring together lived experience, records, observation, workforce and professional evidence.	Act on learning, update support and competence, share improvement and check that benefit is sustained.

Suggested care plan outcome tracker

Personal goal or desired outcome	Planned support or intervention	How impact will be measured	Review findings	Action following review
The outcome the person wants or would value, with	The agreed support, responsible role	The agreed signs of benefit or harm,	Date reviewed, evidence considered and	The next action, owner and review

a concise baseline using their words, observations or agreed proxy evidence.	and timescale. Separate provider actions from actions requested of partners.	evidence sources and review date; include the person's experience.	what changed against baseline: benefit, no change or unintended effects.	date; record updates to the plan and how sustained benefit will be checked.

Leadership Assurance Questions

- Are values tested throughout recruitment, induction, probation and deployment (Indicator 1)?
- Do everyday interactions and records demonstrate respectful language and each person's identity, rights, relationships and choices (Indicators 2–3)?
- How are bias, diagnostic overshadowing and unnecessary restrictions identified and addressed (Indicators 4–5)?
- Do leaders on every shift challenge poor practice and verify improvement after reflection and support (Indicator 6)?
- Does feedback from people, families and observations across all shifts show an improving culture (Indicator 7)?

Good Practice Examples

The examples below illustrate possible approaches. They are not intended to prescribe one way of working or require providers to replicate a particular intervention.

Indicator 1: Values-based recruitment, induction, probation and deployment

What good practice may look like: Values-based interview scenarios explore respectful, enabling responses. The same expectations are revisited during observed induction, probation and deployment checks, including temporary staff, with support or reassessment where gaps emerge.

Possible evidence: Interview criteria and decision rationale; observed induction; probation review; deployment or agency briefing; follow-up observation and feedback.

Indicator 2: Respectful language and communication

What good practice may look like: A team replaces labelling language with descriptions of need and response; records and interactions improve.

Possible evidence: Record audit; observation; feedback.

Indicator 3: Identity, relationships and quality of life

What good practice may look like: Staff enable a person's cultural routine and important relationship, improving comfort and engagement.

Possible evidence: Care plan; observation; person or family feedback.

Indicator 4: Bias and diagnostic overshadowing

What good practice may look like: A change attributed to decline is reviewed and hearing problems are addressed.

Possible evidence: Review; referral; outcome notes.

Indicator 5: Positive risk and least restriction

What good practice may look like: A person continues a valued activity with agreed safeguards and regular review.

Possible evidence: Capacity and risk decision; observation; outcome.

Indicator 6: Challenge and accountability

What good practice may look like: A shift leader challenges dismissive speech and follows through with coaching and reassessment.

Possible evidence: Incident or supervision record; competence evidence.

Indicator 7: Culture and improvement

What good practice may look like: Feedback shows people feel rushed at breakfast; rotas and routines change and mealtime experience improves.

Possible evidence: Feedback; action plan; follow-up observation.

Standard 15 – Collaborative and Multi-Disciplinary Working

Summary Statement

Care is co-ordinated through timely engagement with the individual, people important to them and the right professionals. The person and their chosen supporters contribute to

multidisciplinary planning and shared decision-making in accordance with the person's wishes, rights, capacity and legal authority. Advocacy, effective communication, internal review, timely referrals, lawful information sharing, review of complex interventions and coordinated transitions support holistic, person-centred dementia care. Provider actions and wider-system responsibilities are made explicit.

Indicators

1. The person, family or advocate are involved in coordinated decisions in line with consent, capacity, legal authority and best interests.
2. The service operates effective internal multidisciplinary review to identify changes, risks, gaps, referrals and agreed actions.
3. Staff make timely, sufficiently detailed referrals and escalations to appropriate professionals and follow up unresolved concerns.
4. Staff advocate for the person, communicate their baseline and preferences, and challenge diagnostic overshadowing or decisions that disregard known needs.
5. Relevant information is shared lawfully, accurately and accessibly across services and settings, with clear accountability and continuity.
6. Medication and other complex interventions are reviewed with appropriate professionals, including benefit, harm, consent and non-pharmacological options.
7. Transitions, admissions, hospital contacts and returns to the service are coordinated to reduce distress and prevent avoidable loss of information.
8. The provider distinguishes what it controls from actions required of health, social-care and commissioning partners, recording barriers and escalation without transferring system failure to the person.
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.

Applying the Standard in Practice

Implementation must start with the person's wishes, rights, identity, culture, relationships, communication, strengths and quality of life. Evidence should show what changed for the person and distinguish provider action from action required of wider health and social-care partners.

Practical delivery

- **Indicators 1 and 9:** Agree how the person wishes to participate, whom they want involved and what support or advocacy they need. Distinguish involvement in

individual decisions from recognition of the person and their chosen supporters as contributors throughout multidisciplinary planning. Record how their contributions affected the plan, in accordance with wishes, rights, capacity and legal authority.

- **Indicators 2–4:** Bring observations together in internal review, identify changes and agree named actions. Make timely referrals with baseline, preferences, urgency and strategies already tried; follow up unresolved concerns and advocate when known needs are overlooked.
- **Indicators 5–7:** Share relevant information lawfully and accessibly. Coordinate professional review of medicines and complex interventions, including benefit, harm, consent and non-pharmacological support. Preserve current plans, routines and communication needs through admissions, hospital contacts and returns.
- **Indicator 8:** Separate provider actions from requests to partners. Record barriers, escalation and interim support without presenting unverified local routes or response times as established arrangements.

References

Reference	Relevant indicator(s)
Mental Capacity Act 2005 and Code of Practice; Care Act 2014; Human Rights Act 1998; NICE NG97 involving people in decisions — involvement, advocacy and decision-making.	Indicator 1
CQC effective and well-led expectations; NICE NG97 care coordination — internal review, identified changes and agreed actions.	Indicator 2
NICE dementia and relevant clinical guidance; professional escalation standards.	Indicator 3
NICE dementia guidance; Equality Act 2010; professional codes.	Indicator 4
Data Protection Act 2018/UK GDPR; Caldicott principles; Accessible Information Standard — lawful, accurate and accessible information sharing.	Indicator 5
NICE medicines optimisation and dementia guidance; Mental Capacity Act 2005.	Indicator 6
NICE transition and medicines reconciliation principles; safeguarding requirements.	Indicator 7
Care Act 2014 partnership duties; commissioning/contractual arrangements – REQUIRES COMMISSIONER SIGN-OFF.	Indicator 8
NICE NG97: involving people in decisions, care coordination and supporting carers; Mental Capacity Act 2005 and Code of Practice, as relevant to the decision.	Indicator 9

Resources

The resources below are suggested tools that may help services apply and evidence the indicators. Existing tools can continue to be used where they achieve the intended outcome.

Further resources: HCPA dementia page click here;

Indicator	Suggested resources and relevant themes
1. Involving the person and those important to them	**Alzheimer's Society: This is me** click here — Personal routines and communication profile. **Alzheimer's Society: Dementia and the Mental Capacity Act 2005** click here — Capacity and supported decision-making guidance. **Dementia UK: Advance Care Planning for Dementia** click here — Planning future care preferences. **Hertfordshire MCA Resource Pack — assessment, best-interests recording and reflective checklist** click here — Capacity assessment and best-interests recording tools.
2. Internal multi-disciplinary review	**Hertfordshire Behavioural & Psychological Symptoms of Dementia checklist** click here — Structured checks for causes of distress. **NICE NG97: Dementia assessment, management and support** click here — Dementia assessment, care and coordination guidance. **Dementia UK: Managing distress in a person living with dementia** click here — Recognising triggers and offering reassurance.
3. Referral and escalation	**RESTORE2 and RESTORE2 mini — official tools** click here — Deterioration recognition and structured escalation. **Hertfordshire Behavioural & Psychological Symptoms of Dementia checklist** click here — Structured checks for causes of distress.
4. Advocacy and diagnostic overshadowing	**Dementia UK: Delirium and dementia — symptoms, causes and treatment** click here — Recognising delirium alongside dementia.

	Alzheimer's Society: This is me click here — Personal routines and communication profile. **Alzheimer's Society: Sight and hearing loss with dementia** click here — Sensory needs and adapted support.
5. Lawful information sharing	**CQC: Meeting the Accessible Information Standard** click here — Identifying and meeting communication needs. **Alzheimer's Society: Dementia and the Mental Capacity Act 2005** click here — Capacity and supported decision-making guidance.
6. Reviewing medication and complex interventions	**Alzheimer's Society: Antipsychotics and other drug approaches in dementia care** click here — Understanding non-drug approaches and medication risks. **NICE NG97: Dementia assessment, management and support** click here — Dementia assessment, care and coordination guidance. **Hertfordshire MCA Resource Pack — assessment, best-interests recording and reflective checklist** click here — Capacity assessment and best-interests recording tools. **Hertfordshire Medication Governance Standards for Care Homes — Manager Self-Assessment Checklist** click here — Medicines policy, competence and audit checklist. **When Required Medication guidance — PRN/variable-dose template** click here — Individualised when-required medication protocol template.
7. Coordinated transitions	**Alzheimer's Society: This is me** click here — Personal routines and communication profile. **Dementia UK: Advance Care Planning for Dementia** click here — Planning future care preferences. **NICE NG97: Dementia assessment, management and support**

	click here — Dementia assessment, care and coordination guidance. **Resuscitation Council UK: ReSPECT for healthcare professionals** click here — Clinical recommendations for future emergencies.
8. Provider and wider-system responsibilities	**NICE NG97: Dementia assessment, management and support** click here — Dementia assessment, care and coordination guidance. **RESTORE2 and RESTORE2 mini — official tools** click here — Deterioration recognition and structured escalation. **Memory Support Hertfordshire: Referral form** click here — Local dementia information and support referrals.
9. Contributions to multidisciplinary planning and shared decision-making	**Alzheimer's Society: This is me** click here — Supports the person and those important to them to contribute routines, preferences and communication needs. **NICE NG97: Dementia assessment, management and support** click here — Relevant sections: involving people in decisions, care coordination and supporting carers. **Hertfordshire MCA Resource Pack — assessment, best-interests recording and reflective checklist** click here — Use alongside wishes, capacity and legal-authority records where relevant; a completed form alone does not demonstrate meaningful contribution.

Learning and Development

Mapped indicator	Learning focus and method
Indicator 1	Consent, capacity, advocacy and supported decision-making.
Indicator 2	Integrated review, professional curiosity and team roles.
Indicator 3	Referral writing, urgency, escalation and closed-loop communication.
Indicator 4	Advocacy, diagnostic overshadowing and reversible causes.

Indicator 5	Lawful information sharing, confidentiality and accessible communication.
Indicator 6	Medicines review, non-pharmacological support and monitoring outcomes.
Indicator 7	Transitions, handover and continuity for people living with dementia.
Indicator 8	Systems leadership, boundaries, commissioning escalation and documenting barriers.
Indicator 9	Practise accessible review preparation, eliciting contributions from the person and those important to them, shared decision-making and recording how contributions affect agreed actions, within wishes, rights, capacity and legal authority.

Suggested Learning Pathway

Role	Suggested learning and application
All staff	Recognising change, reporting, consent and respectful information sharing.
Care and support staff	Accurate observations, baseline communication and supporting the person and chosen supporters to contribute to reviews (Indicators 1, 2, 4 and 9).
Senior carers/shift leaders	Coordinating inclusive internal review, recording contributions and agreed actions, referral follow-up and escalation (Indicators 1–4 and 9).
Nurses/clinical leads	Clinical assessment, professional handover, medicines and complex decision-making.
Managers/deputies/unit leaders	Partnership governance, unresolved-risk escalation and system accountability.
Ancillary, temporary and agency staff	Know whom to report to; access current individual guidance only as necessary.

Assessing and Reviewing Staff Competence

- Agree role-specific competence statements linked to the indicators.
- Use direct observation, scenario discussion, supervised practice and feedback from people and families.
- Assess judgement about consent, capacity, reversible causes, risk and escalation—not recall alone.
- Record the assessor, evidence, outcome, support required and review date.

- Reassess after incidents, changes in role or need, concerns, new evidence and relevant learning.
- Training attendance is supporting evidence only; competence is demonstrated through safe, person-centred practice and outcomes.
- For Indicators 1 and 9, observe review preparation and participation: check whose contributions were sought, how communication was supported, how wishes, capacity and legal authority were respected, and how contributions changed the plan.

Evidence

Type of evidence	Possible examples
Lived experience	Conversations, observation, accessible feedback, advocacy and family insight — What matters to the person; whether they feel known, safe, respected and involved; what changed for them.
Care records	Assessments, care plans, daily notes, reviews and decision records — A clear thread from wishes and needs to action, review and outcome.
Observation	Practice observation, walk-rounds, shadowing and spot checks — How staff communicate, uphold rights, enable choice and respond when leaders are absent.
Family and professional input	Reviews, correspondence, MDT records and feedback — Corroboration, challenge, shared decisions and continuity across settings.
Workforce competence	Observation, discussion, simulation, supervision and competency records — Applied knowledge and judgement—not training attendance alone.
Governance and outcomes	Audits, incidents, complaints, compliments, trends and improvement plans — Learning, sustained change, equity and measurable benefit or reduced harm.

Can the service show the full evidence cycle?

1. Understand	2. Plan	3. Deliver	4. Review	5. Improve
Identify the person's wishes, identity, strengths, communication, rights, risks and current outcomes.	Agree proportionate actions, roles, consent/capacity arrangements, timescales and evidence already available.	Provide consistent, least-restrictive support and record significant decisions or changes.	Bring together lived experience, records, observation, workforce and professional evidence.	Act on learning, update support and competence, share improvement and check that

				benefit is sustained.

Suggested care plan outcome tracker

Personal goal or desired outcome	Planned support or intervention	How impact will be measured	Review findings	Action following review
The outcome the person wants or would value, with a concise baseline using their words, observations or agreed proxy evidence.	The agreed support, responsible role and timescale. Separate provider actions from actions requested of partners.	The agreed signs of benefit or harm, evidence sources and review date; include the person's experience.	Date reviewed, evidence considered and what changed against baseline: benefit, no change or unintended effects.	The next action, owner and review date; record updates to the plan and how sustained benefit will be checked.

Leadership Assurance Questions

- Can the service show both lawful involvement in decisions and meaningful contribution to multidisciplinary planning by the person and those important to them (Indicators 1 and 9)?
- Do internal reviews lead to clear actions, timely referrals, follow-up and advocacy when needs are overlooked (Indicators 2–4)?
- Is information shared lawfully and accessibly, with professional review of complex interventions and continuity at transitions (Indicators 5–7)?
- Are provider actions, partner responsibilities, unresolved barriers and interim safeguards explicit (Indicator 8)?

Good Practice Examples

The examples below illustrate possible approaches. They are not intended to prescribe one way of working or require providers to replicate a particular intervention.

Indicator 1: Involving the person and those important to them

What good practice may look like: A person uses an advocate in a review and chooses who receives information.

Possible evidence: Consent or advocacy record; decision outcome.

Indicator 2: Internal multi-disciplinary review

What good practice may look like: An internal review links distress with constipation and changes the plan.

Possible evidence: Review action log; outcome trend.

Indicator 3: Referral and escalation

What good practice may look like: A referral includes baseline and urgency; follow-up secures timely assessment.

Possible evidence: Referral timeline and response.

Indicator 4: Advocacy and diagnostic overshadowing

What good practice may look like: Staff challenge diagnostic overshadowing and a treatable infection is identified.

Possible evidence: Escalation record; clinical outcome.

Indicator 5: Lawful information sharing

What good practice may look like: A professional reads the communication plan before meeting the person, reducing anxiety.

Possible evidence: Meeting record; observation.

Indicator 6: Reviewing medication and complex interventions

What good practice may look like: A review reduces sedating medicine after monitoring shows falls and limited benefit.

Possible evidence: Review; consent or best-interests record; outcome.

Indicator 7: Coordinated transitions

What good practice may look like: A transfer summary preserves the person's routines and sensory needs during admission.

Possible evidence: Transfer record; feedback.

Indicator 8: Provider and wider-system responsibilities

What good practice may look like: Delayed partner input is escalated while safe interim support is maintained.

Possible evidence: Action log; risk review; partner correspondence.

Indicator 9: Contributions to multidisciplinary planning and shared decision-making

What good practice may look like: The person helps set a review agenda using their preferred communication. At their request, a family member and advocate contribute knowledge of routines and priorities. The team records how these contributions shape agreed actions and checks the plan with the person in an accessible way.

Possible evidence: The person's wishes about involvement; accessible agenda; meeting contributions; consent, capacity or legal-authority records where relevant; agreed actions; updated care plan; feedback on involvement.

Standard 16 – Leadership for Dementia Excellence

Summary Statement

Visible, shared and accountable leadership makes person-centred dementia care reliable across every shift. A co-produced vision centres rights, identity, relationships, strengths and quality of life. Leaders understand dementia and the law, model expected values, assure workforce capacity and competence, enable partnership and speaking up, and use balanced evidence to improve. Clear authority, cover and escalation keep care safe, compassionate and rights-based during weekends and absences. Leaders address external barriers while maintaining interim support and verify that owned improvement actions deliver sustained benefit.

Indicators

1. The provider has a clear, co-produced vision for dementia care centred on rights, identity, relationships, strengths and quality of life.
2. Leaders at every level demonstrate sufficient dementia knowledge, legal literacy and understanding of residential, nursing and wider-system responsibilities.
3. Leadership responsibility is shared and explicit across shifts, weekends and absences, with authority to act, challenge and escalate.
4. Leaders visibly role model person-centred communication, consent, positive risk-taking, least restriction and professional curiosity.
5. Leaders assure workforce capacity and demonstrated competence against current needs, responding promptly to gaps and unsafe practice.
6. Governance combines lived experience, observation, records, workforce evidence, professional input and outcomes to identify inequity, risk and improvement.
7. Leaders create psychological safety for speaking up, reflection and learning while maintaining accountability and safeguarding duties.
8. Leaders maintain effective partnerships and escalate external barriers, while ensuring interim provider actions protect the person.
9. Improvement plans specify intended benefit for people, ownership and review measures, and leaders verify that changes are sustained.

Applying the Standard in Practice

Implementation must start with the person's wishes, rights, identity, culture, relationships, communication, strengths and quality of life. Evidence should show what changed for the person and distinguish provider action from action required of wider health and social-care partners.

Practical delivery

- **Indicators 1–2:** Develop the dementia-care vision with people and those important to them. Check that leaders understand dementia, relevant legal principles and the boundaries between residential, nursing and wider-system responsibilities.
- **Indicators 3–5:** Make delegated authority, cover and escalation clear across nights, weekends and absences. Observe leaders modelling person-centred communication, consent, positive risk-taking and least restriction; match workforce capacity and demonstrated competence to current needs.
- **Indicators 6–7:** Compare lived experience, observations, records, workforce evidence, professional input and outcomes to identify inequity, risk and improvement. Enable speaking up and reflection while following through on accountability and safeguarding.
- **Indicators 8–9:** Maintain partnerships and escalate external barriers while providing interim support. Give improvement actions an owner, intended benefit and review measures, then check that changes are sustained.

References

Reference	Relevant indicator(s)
Care Act 2014; Human Rights Act 1998; Equality Act 2010; CQC well-led expectations.	Indicator 1
Mental Capacity Act 2005; NICE dementia guidance; NMC Code where applicable.	Indicator 2
CQC staffing and governance requirements; business continuity and safeguarding duties.	Indicator 3
Mental Capacity Act 2005; NICE dementia guidance; least-restrictive principles.	Indicator 4
Health and Social Care Act 2008 regulations; Skills for Care guidance; NMC Code.	Indicator 5
CQC assessment framework; quality-governance requirements — triangulation, inequity, risk and outcomes. Duty of Candour where applicable to the circumstances.	Indicator 6
Freedom to Speak Up principles; safeguarding duties; employment procedures.	Indicator 7
Care Act partnership duties; local escalation arrangements – UNVERIFIED LOCAL ARRANGEMENT.	Indicator 8
CQC quality-improvement expectations; evidence-based practice principles.	Indicator 9

Resources

The resources below are suggested tools that may help services apply and evidence the indicators.

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

Indicator	Suggested resources and relevant themes
1. Co-produced vision	**Alzheimer's Society: Dementia Statements and rights-based approaches** click here — Rights and person-focused care outcomes. **Alzheimer's Society: This is me** click here — Personal routines and communication profile.
2. Leadership knowledge and legal literacy	**Dementia Training Standards Framework** click here — Role-based dementia learning outcomes. **Alzheimer's Society: Dementia and the Mental Capacity Act 2005** click here — Capacity and supported decision-making guidance. **NICE NG97: Dementia assessment, management and support** click here — Dementia assessment, care and coordination guidance. **Hertfordshire MCA Resource Pack — assessment, best-interests recording and reflective checklist** click here — Capacity assessment and best-interests recording tools.
3. Shared leadership	**Dementia Training Standards Framework** click here — Role-based dementia learning outcomes. Use the framework to inform role-appropriate learning. Demonstrate shared leadership separately through delegated responsibilities, cover arrangements and tested escalation across shifts, weekends and absences.
4. Visible role modelling	**Dementia UK: Communication tips** click here — Practical tips for individualised communication. **Dementia Community: Behavioural Expressions of Need** click here — Needs-led language for describing distress. **PocketMedic: Residential dementia care training films** click here — Films for discussion and practical learning.

	Hertfordshire MCA Resource Pack — assessment, best-interests recording and reflective checklist click here — Capacity assessment and best-interests recording tools. **Alzheimer's Society: Positive language guide** click here — Guide to respectful dementia language.
5. Workforce competence assurance	**Dementia Training Standards Framework** click here — Role-based dementia learning outcomes. **PocketMedic: Residential dementia care training films** click here — Films for discussion and practical learning. **HCPA Best Practice Guide to Recruiting, Onboarding and Retaining Staff** click here — Values-based recruitment and staff onboarding. **Medicines competency assessment record — electronic** click here — Editable medicines competence assessment record. **Medicines competency assessment record — paper** click here — Printable medicines competence assessment record. **HCPA: Dementia pre-learning** click here — Preparation for further dementia training.
6. Balanced governance evidence	**NICE QS184: Dementia quality standard** click here — Measurable priorities for improving dementia care. **Alzheimer's Society: Dementia Statements and rights-based approaches** click here — Rights and person-focused care outcomes. **CQC: Meeting the Accessible Information Standard** click here — Identifying and meeting communication needs. **Hertfordshire MCA Resource Pack — assessment, best-interests recording and reflective checklist** click here — Capacity assessment and best-interests recording tools. **Hertfordshire Medication Governance Standards for Care Homes — Manager Self-Assessment Checklist** click here — Medicines policy, competence and audit checklist. **Reviewing Patterns and Trends of Falls** click here — Individual and service-level falls review.

7. Speaking up and learning	**Dementia Training Standards Framework** click here — Role-based dementia learning outcomes. **Alzheimer's Society: Dementia Statements and rights-based approaches** click here — Rights and person-focused care outcomes. These resources support learning and rights-based reflection. Demonstrate speaking up through the service's reporting and safeguarding routes, response to concerns and follow-up with those raising them.
8. Partnership and escalation	**NICE NG97: Dementia assessment, management and support** click here — Dementia assessment, care and coordination guidance. **RESTORE2 and RESTORE2 mini — official tools** click here — Deterioration recognition and structured escalation. **Memory Support Hertfordshire: Referral form** click here — Local dementia information and support referrals.
9. Sustained improvement	**NICE QS184: Dementia quality standard** click here — Measurable priorities for improving dementia care. **Alzheimer's Society: Dementia Statements and rights-based approaches** click here — Rights and person-focused care outcomes. **Hertfordshire Medication Governance Standards for Care Homes — Manager Self-Assessment Checklist** click here — Medicines policy, competence and audit checklist. **Reviewing Patterns and Trends of Falls** click here — Individual and service-level falls review.

Learning and Development

Mapped indicator	Learning focus and method
Indicator 1	Co-production, rights-based leadership and quality of life.
Indicator 2	Dementia leadership, Mental Capacity Act, equality, governance and role boundaries.
Indicator 3	Delegation, succession, decision-making and escalation across all shifts.
Indicator 4	Role modelling, coaching, positive risk and least-restrictive leadership.

Indicator 5	Workforce planning, competence assurance and responding to poor practice.
Indicator 6	Evidence triangulation, inequalities, outcomes and quality improvement.
Indicator 7	Psychological safety, speaking up, safeguarding, fair accountability and reflection.
Indicator 8	Systems leadership, partnership challenge and escalation.
Indicator 9	Improvement methods, outcome measurement and sustainability.

Suggested Learning Pathway

Role	Suggested learning and application
All staff	Understand the vision, expectations, speaking-up route and rights-based practice.
Care and support staff	Apply the vision consistently and contribute observations and improvement ideas.
Senior carers/shift leaders	Lead shifts, coach, challenge, escalate and maintain standards during absence.
Nurses/clinical leads	Provide clinical leadership, supervision and governance within professional scope.
Managers/deputies/unit leaders	Set culture, assure competence and outcomes, manage partnerships and succession.
Ancillary, temporary and agency staff	Receive concise service expectations, escalation routes and individual guidance.

Assessing and Reviewing Staff Competence

- Agree role-specific competence statements linked to the indicators.
- Use direct observation, scenario discussion, supervised practice and feedback from people and families.
- Assess judgement about consent, capacity, reversible causes, risk and escalation—not recall alone.
- Record the assessor, evidence, outcome, support required and review date.
- Reassess after incidents, changes in role or need, concerns, new evidence and relevant learning.
- Training attendance is supporting evidence only; competence is demonstrated through safe, person-centred practice and outcomes.

- Assess leadership through scenarios and observation covering co-production, legal and role boundaries, delegated authority during absence, role modelling, workforce capacity, triangulation, speaking up, partner escalation and sustained improvement (Indicators 1–9).

Evidence

Type of evidence	Possible examples
Lived experience	Conversations, observation, accessible feedback, advocacy and family insight — What matters to the person; whether they feel known, safe, respected and involved; what changed for them.
Care records	Assessments, care plans, daily notes, reviews and decision records — A clear thread from wishes and needs to action, review and outcome.
Observation	Practice observation, walk-rounds, shadowing and spot checks — How staff communicate, uphold rights, enable choice and respond when leaders are absent.
Family and professional input	Reviews, correspondence, MDT records and feedback — Corroboration, challenge, shared decisions and continuity across settings.
Workforce competence	Observation, discussion, simulation, supervision and competency records — Applied knowledge and judgement—not training attendance alone.
Governance and outcomes	Audits, incidents, complaints, compliments, trends and improvement plans — Learning, sustained change, equity and measurable benefit or reduced harm.

Can the service show the full evidence cycle?

1. Understand	2. Plan	3. Deliver	4. Review	5. Improve
Identify the person's wishes, identity, strengths, communication, rights, risks and current outcomes.	Agree proportionate actions, roles, consent/capacity arrangements, timescales and evidence already available.	Provide consistent, least-restrictive support and record significant decisions or changes.	Bring together lived experience, records, observation, workforce and professional evidence.	Act on learning, update support and competence, share improvement and check that benefit is sustained.

Suggested care plan outcome tracker

Personal goal or desired outcome	Planned support or intervention	How impact will be measured	Review findings	Action following review
The outcome the person wants or would value, with a concise baseline using their words, observations or agreed proxy evidence.	The agreed support, responsible role and timescale. Separate provider actions from actions requested of partners.	The agreed signs of benefit or harm, evidence sources and review date; include the person's experience.	Date reviewed, evidence considered and what changed against baseline: benefit, no change or unintended effects.	The next action, owner and review date; record updates to the plan and how sustained benefit will be checked.

Leadership Assurance Questions

- Can people and those important to them recognise their priorities in the vision and daily care (Indicator 1)?
- Can leaders apply dementia knowledge, legal literacy and role boundaries in real decisions (Indicator 2)?
- Who can act, challenge and escalate on nights, weekends and during absence, and has this been tested (Indicator 3)?
- Do leaders model the expected approach and respond to workforce capacity or competence gaps (Indicators 4–5)?
- Does governance combine different evidence sources, identify inequity and respond safely to concerns (Indicators 6–7)?
- Are external barriers escalated without leaving the person unsupported (Indicator 8)?
- Do improvement plans specify ownership, benefit and measures, and do later checks demonstrate sustained change (Indicator 9)?

Good Practice Examples

The examples below illustrate possible approaches. They are not intended to prescribe one way of working or require providers to replicate a particular intervention.

Indicator 1: Co-produced vision

What good practice may look like: People and families reshape the vision to emphasise relationships and choice; care reviews use these outcomes.

Possible evidence: Co-production notes; revised vision; review sample.

Indicator 2: Leadership knowledge and legal literacy

What good practice may look like: A deputy identifies that a new health change requires registered clinical assessment and prompt escalation.

Possible evidence: Leadership competence record; clinical record.

Indicator 3: Shared leadership

What good practice may look like: An absence exercise finds uncertainty at night; delegation and escalation are clarified and retested.

Possible evidence: Exercise; action plan; retest.

Indicator 4: Visible role modelling

What good practice may look like: A leader models supported choice during personal care and staff replicate the approach.

Possible evidence: Observation; coaching; feedback.

Indicator 5: Workforce competence assurance

What good practice may look like: Training records are complete but observation shows a skill gap and the shift review identifies insufficient experienced cover for current needs. Leaders adjust deployment, provide coaching and reassess practice; follow-up checks show more consistent support.

Possible evidence: Current needs and staffing review; deployment changes; training record; competency assessment; outcome evidence.

Indicator 6: Balanced governance evidence

What good practice may look like: Governance detects higher distress on one unit; staffing and routine changes reduce it.

Possible evidence: Dashboard; person-level review; trend.

Indicator 7: Speaking up and learning

What good practice may look like: A concern about task-led care is raised safely and results in fair coaching and monitoring.

Possible evidence: Speak-up or action record; observations.

Indicator 8: Partnership and escalation

What good practice may look like: A specialist delay is escalated while the team provides agreed interim support.

Possible evidence: Escalation log; risk review; person outcome.

Indicator 9: Sustained improvement

What good practice may look like: A night-routine trial improves sleep; checks at two later reviews confirm sustainability.

Possible evidence: Improvement plan; outcome tracker.

Appendix 1: Glossary of Terms

Term	Meaning
Advocacy	Support that helps a person understand, express wishes and have their rights represented.
Best interests	A decision process required by the Mental Capacity Act when a person lacks capacity for the specific decision.
Competence	Demonstrated ability to apply knowledge, skill and judgement safely in practice.
Diagnostic overshadowing	Attributing a new symptom or change to dementia without considering other causes.
Lived experience	What the person experiences, communicates and values, including through behaviour and supported interpretation.
Least restrictive	The option that achieves the necessary purpose while restricting rights and freedom as little as possible.
Multi-disciplinary working	Coordinated contribution from the person, those important to them, care staff and relevant professions.
Positive behaviour support	Understanding distress and unmet need, preventing avoidable triggers and using personalised, least-restrictive support.
Positive risk-taking	Supporting meaningful choice and opportunity through proportionate assessment and safeguards.
Reversible causes	Potentially treatable contributors to change, such as pain, infection, constipation, dehydration, delirium, medicines or sensory loss.
Training attendance	Evidence that learning was accessed; it does not by itself demonstrate competence.

Appendix 2: Challenges, Barriers and Mitigations

The following themes synthesise and anonymise stakeholder feedback. They are evidence for improvement planning, not verified statements about every service or partner.

Challenge or barrier	Potential effect	Provider mitigation	System or commissioner consideration
Workforce turnover, agency use and time pressure	Inconsistent knowledge and relationships.	Concise individual profiles, buddying, observed induction and targeted competence checks.	Support sustainable workforce development and proportionate assurance.
Over-reliance on e-learning or attendance records	Knowledge may not transfer to practice.	Blend learning with coaching, observation and reassessment.	Clarify that competence and outcomes are expected, not a mandated course provider.
Difficulty extracting evidence from existing records	Good practice may be invisible or duplicated.	Use indicator indexes, sampling and short outcome narratives.	Align monitoring requests and avoid parallel templates.
Variable or delayed specialist and MDT input	Assessment, treatment or shared planning may be delayed.	Make clear referrals, follow up, mitigate risk and document escalation.	UNVERIFIED LOCAL PATHWAY – validate access, response and escalation arrangements.
Care-home knowledge not consistently used by visiting professionals	The person's baseline, triggers or communication may be missed.	Share concise current profiles and advocate respectfully.	Promote inclusion of providers and people in relevant discussions.
Unclear responsibility for complex or additional support	Delay, dispute or unmanaged risk.	Separate provider action from requested partner action and maintain interim support.	UNVERIFIED LOCAL ARRANGEMENT – confirm commissioning, funding and escalation responsibilities.
Good practice depends on one manager	Standards may drift across shifts or absence.	Shared leadership, delegation, scenario testing and	Consider leadership support and peer-learning opportunities.

		succession planning.	
Families need information and support	Distress, misunderstanding or conflict around decisions.	Offer accessible information, involvement and signposting within consent and capacity law.	UNVERIFIED LOCAL DETAIL – validate available local information and support.