Hertfordshire Dementia Care Standards for Residential and Nursing Care

Support Guidance: Physical Health

Purpose of this support guidance:

- To help commissioned residential and nursing services understand and apply Standards 8, 11, 12 and 13 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 8 – Comprehensive Health Care

Summary Statement

Care is informed by current, holistic assessment of the person's physical, emotional, cognitive, sensory and mental health, alongside dementia progression, frailty, disability and other long-term conditions. Changes are recognised early, investigated without diagnostic overshadowing and responded to through timely, coordinated and least-restrictive support that prevents avoidable deterioration and hospital admission.

Indicators

To meet this standard, providers must demonstrate that:

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

Applying the Standard in Practice

Providers should show how assessment and observation lead to timely, coordinated action. A completed tool or referral is not enough: the evidence trail should connect the person's usual baseline, the change identified, possible causes considered, action and escalation, the person's response and the next review.

Responsibilities in residential and nursing services: Residential staff recognise and record change, provide support within competence, seek clinical input and follow up agreed actions. Nursing staff and clinical leads undertake clinical assessment and monitoring within their professional competence. Primary care and specialist partners provide the relevant clinical advice and treatment plans. Managers assure clear responsibilities, access arrangements, escalation and implementation across shifts.

Recognising change and avoiding diagnostic overshadowing

- Ensure staff know the person's usual physical, cognitive, emotional, communication and functional presentation.
- Compare subtle changes across shifts, records and information from people who know the person well.
- Consider pain, infection, constipation, dehydration, delirium, medicines, sensory loss, depression and environmental factors before attributing change to dementia.
- Escalate promptly when something is not right rather than waiting for a routine review.

Using assessment tools proportionately

Use locally approved tools within staff competence and alongside clinical judgement. Records should show why a tool was selected, the result, action taken, any repeat assessment and whether the intervention improved the person's outcome.

From assessment to coordinated action

Work proactively with primary care, mental health, learning disability and other specialist services. Communicate the person's baseline, change, concerns, risks and level of urgency clearly. Record each attempt to obtain GP, mental health, learning disability, frailty, hospital-at-home or other specialist support, including the response, referral follow-up, escalation and interim actions while input is awaited. Translate professional recommendations into clear shift-level instructions, named responsibility and review dates. Support treatment at home where safe and consistent with the person's wishes, without delaying necessary hospital care. Records should distinguish actions within the provider's control from delays or barriers requiring wider system action.

What leaders should test

- Indicator 1: Are assessments current and comprehensive across physical, emotional and cognitive health, and can staff describe the person's baseline?
- Indicator 2: Do reviews consider causes other than dementia, record the action taken and avoid diagnostic overshadowing?
- Indicator 3: Can staff explain why a pain scale or other clinical tool was selected, use it within competence, act on the findings and reassess the person's response?
- Indicator 4: Do systems identify deterioration early and lead to timely review and access to specialist support?
- Indicator 5: Do care plans identify early warning signs, contact arrangements and safe treatment-at-home options to prevent unnecessary admission without delaying necessary hospital care?

- Indicator 6: Does the service work proactively with primary care, mental health, learning disability and other specialist services, communicate urgency clearly, follow up referrals, escalate delays and maintain interim support?
- Are professional recommendations implemented consistently across shifts?
- Can the service show what changed for the person?
- Can staff, including at night or when managers are absent, escalate confidently when they know something is not right?

References

Reference	Relevant indicator(s)
Mental Capacity Act 2005 and Code of Practice	1–6
Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulations 9, 11 and 12	1–6
NICE NG97: Dementia: assessment, management and support for people living with dementia and their carers	1–6
Skills for Care Dementia Training Standards Framework	1–6
For review: current Hertfordshire deterioration, delirium, constipation, community and specialist referral pathways	2–6

Resources

Resources complement existing assessments, care plans and records. The table groups the existing resources under the six updated indicators, with supporting topics identified within each row.

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

Indicator	Suggested resources and practical tools
1. Comprehensive	**Holistic baseline** Alzheimer's Society: This is Me click here

assessment and review	Alzheimer's Society: Understanding and supporting a person with dementia click here Dementia UK: Life Story Template click here **Keeping assessments current** NICE Guideline NG97: Dementia assessment & care planning click here Alzheimer's Society: Organising and reviewing care and support click here HPFT: Guidelines for the pharmacological management of dementia click here CQC: Good practice in caring for people with dementia click here
2. Avoiding diagnostic overshadowing	**Considering reversible causes** Dementia UK: Delirium and dementia click here Royal College of Psychiatry: Delirium click here Sepsis Alliance: Sepsis and dementia click here Dementia UK: Understanding dementia and pain click here NICE: Delirium quick guide for care homes click here
3. Pain scales and other clinical tools	**Selecting and using assessment tools** Hertfordshire Behavioural and psychological symptoms of dementia checklist click here British Geriatrics Society: PINCH ME tool click here RESTORE2 and RESTORE2 Mini tools for recognising deterioration and prompting reviews click here Abbey Pain Scale Online Tool click here NHS Frailty Toolkit click here British Geriatrics Society: Rockwood clinical frailty scale click here (*use only with training, appropriate permission and local clinical arrangements*)
4. Early identification of deterioration	**Recognising change and prompting timely review** Skills for Care: Spotting the signs when a person becomes unwell click here

	NHS: Supporting care homes to identify deterioration click here NHS: Recognising deterioration and Martha's rule click here Alzheimer's Society: How to know when a person with dementia is nearing the end of their life click here
5. Preventing unnecessary hospital admissions	**Prevention and contingency planning** Carers UK: Creating a contingency plan click here Alzheimer's Society: Being prepared for changes and emergencies when you're caring for a person with dementia click here UCL: Breaking the cycle of hospital admissions in people with dementia impact study click here Alzheimer's Disease International: Advice for carers, humanitarian agencies, communities and people living with dementia during times of crisis click here
6. Proactive partnership working, escalation and interim support	**Escalation and referral follow-up** Alzheimer's Society: Support and services from the GP click here Dementia UK: Getting the best out of GP and other health appointments click here **Equitable access and advocacy** Alzheimer's Society: Know your risks, know your rights click here NHS England: Reasonable adjustments click here POhWER: Hertfordshire advocacy services click here Memory Support Hertfordshire: For professionals click here Hertfordshire County Council: Dementia support click here **Coordinating and implementing professional advice** NICE: Coordinating care for people with dementia click here CQC: Good practice in caring for people with dementia click here
Relevant learning videos for standard 8	NHS: 3 soft signs of deterioration watch here NHS: Introduction to sepsis and serious illness

	watch here NHS: Delirium awareness watch here Alzheimer's Society: The many voices of dementia advocacy watch here

Learning and Development

Learning should be proportionate to each staff member's role, responsibilities and competence,

HCPA learning mapped to Standard 8

Standard 8 indicator	Relevant HCPA learning and development
1. Comprehensive assessment and review	Tier 1: Foundations of Dementia Care should establish person-centred assessment, life history, communication and recognition of usual presentation. Tier 2: Extended Knowledge should develop understanding of dementia progression, frailty, sensory loss, co-existing conditions and review after illness, falls, transfer or medication change. Care-plan learning should help staff translate assessments into current, practical instructions.
2. Avoiding diagnostic overshadowing	Learning should address pain, infection, constipation, dehydration, hunger, medicine effects, sensory loss, depression, sleep and environmental causes of distress. Scenario-based discussion should require staff to consider multiple causes rather than attributing change to dementia. Three D's: Dementia, Delirium and Depression should help staff distinguish gradual dementia progression from acute change and consider conditions other than dementia. Exact current HCPA titles and availability should be validated.
3. Pain scales and other clinical tools	Role-specific learning should cover the purpose, limitations and escalation thresholds of RESTORE2 or the locally approved deterioration tool, pain tools such as Abbey Pain Scale or PAINAD, frailty assessment and delirium prompts. Staff should practise selecting a tool, completing it accurately, interpreting findings within competence and repeating assessment after intervention.
4. Early identification of deterioration	Three D's: Dementia, Delirium and Depression, together with locally approved deterioration-recognition learning, should help staff distinguish gradual dementia progression from acute change, identify red flags, compare presentation with baseline and seek timely clinical advice. Exact current HCPA titles and availability should be validated. Staff should practise recognising subtle change from baseline, arranging timely review and accessing specialist support, rather than waiting for a routine review when something is not right.
5. Preventing unnecessary hospital admissions	Tier 3 and Tier 4 learning should support anticipatory planning, positive risk-taking, treatment at home where safe, recognition of limits and prompt transfer when clinically necessary. Managers should review pathways, escalation delays and avoidable admissions as part of governance.

6. Proactive partnership working, escalation and interim support	Staff should learn structured communication such as SBARD, documentation of baseline and risk, referral follow-up, safety-netting and interim risk management. Senior staff should practise challenging delayed or unclear responses and escalating through local pathways. Learning should cover reasonable adjustments, accessible communication, advocacy, hospital passports, referral pathways and translating professional recommendations into shift-level actions with named responsibility and review dates. Dementia Champion learning should support coordination and evaluation across disciplines. Learning should cover proactive work with primary care, mental health, learning disability and other specialist services; clear communication of urgency; referral follow-up and escalation; and interim actions to manage risks and support the person while specialist input is awaited.

Suggested learning pathway

Staff group	Suggested learning and application
All staff	Pre-learning and Tier 1, plus induction on the person's baseline, recognising change, immediate reporting, clear recording and emergency procedures.
Care staff and senior carers	Tier 2, Three D's and practical learning on pain, hydration, constipation, infection, observation tools and SBARD, supported by supervised scenarios and observation in practice.
Nurses and clinical leads	Advanced clinical assessment, medicines contribution, delirium and frailty, referral quality, monitoring plans, professional challenge and coordinated review.
Dementia champions and practice leads	Tier 3: Dementia Champion, with responsibility for coaching staff, reviewing complex changes, reducing diagnostic overshadowing and evidencing improved outcomes.
Registered managers and deputies	Tier 4: Managers, focused on pathway mapping, competency assurance, audit, learning from deterioration and admissions, and escalation of system barriers.
Staff requiring targeted development	Coaching, simulation, reflective review and repeated competency observation linked to the identified gap, followed by a documented review of improvement.

Evidence

Evidence for this standard should be meaningful, proportionate and drawn from a balanced range of sources.

Examples of evidence

Type of evidence	Possible examples for Standard 8
Voice and lived experience	The person's verbal or non-verbal response to assessment and intervention; accessible feedback, family or carer knowledge, complaints, compliments and advocacy about recognition of change and access to support.
Care documentation	Current holistic assessments and baseline profiles; reviews of possible causes other than dementia; pain or deterioration-tool findings; contingency plans; referral, escalation and interim-support records.
Observation of practice	Staff comparing presentation with baseline, selecting tools within competence, communicating urgency and implementing personalised recommendations across shifts.
Professional input	Medical, nursing, pharmacy, therapy, dietetic, mental health, learning disability, palliative-care or multidisciplinary advice, including referral responses and follow-up.
Workforce evidence	Observed use of pain and deterioration tools, structured escalation scenarios, supervision, reflection and coaching linked to the six indicators.
Quality assurance and governance	Audits of assessment currency, recognition-to-action trails, referral delays and admissions; complaints, incident themes, action plans and checks that improvements were sustained.
Outcomes and impact	What changed against baseline following intervention: comfort, distress, wellbeing, timely treatment, safety, independence and wishes followed; whether unnecessary admission was prevented without delaying necessary care.

Can the service show the full evidence cycle?

1. Know the person	2. Notice and understand	3. Act	4. Review impact	5. Learn and sustain
What matters	What needs to happen, why and by whom?	What personalised support or	What changed and what was	What should continue,

1. Know the person	2. Notice and understand	3. Act	4. Review impact	5. Learn and sustain
and what is usual?		intervention was provided?	the person's response?	change or stop?

Suggested outcome tracker

Concern or change	Baseline	Action	Outcome or impact	Next review
Record the person-centred issue or desired outcome.	Describe the starting position and relevant wishes.	Record the agreed personalised response and responsibility.	Record what changed for the person, including benefit or burden.	State what will continue, change or stop and when it will be reviewed.

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: Comprehensive assessment and review

What good practice may look like:

- On admission, staff record the person's usual cognition, mood, mobility, pain expression, communication, continence, sleep, appetite and sensory needs, drawing on the person and those who know them well.
- Support is personalised to the person's wishes, communication, strengths, risks and current needs.
- Staff record the action taken, review the person's response and adapt the approach where needed.

Illustrative practice example: At admission, the person and those who know them help staff build a baseline profile covering cognition, mood, mobility, pain expression, communication, continence, sleep, appetite and sensory needs. Staff compare day-to-day observations with this profile and update assessment and support when presentation changes.

Possible evidence: holistic assessment, baseline profile, feedback and handover observation.

Timely assessment review — supports indicator 1

What good practice may look like:

- After a fall or hospital attendance, the assessment and care plan are reviewed promptly and any new support is communicated across shifts.
- Support is personalised to the person's wishes, communication, strengths, risks and current needs.
- Staff record the action taken, review the person's response and adapt the approach where needed.

Illustrative practice example: Following hospital attendance after a fall, staff compare the discharge advice with the existing assessment and care plan. They record the review, communicate changed support across shifts and check the person's response at follow-up.

Possible evidence: dated review, updated plan, handover and follow-up outcome.

Indicator 2: Avoiding diagnostic overshadowing

What good practice may look like:

- When distress increases, staff consider pain, constipation, dehydration, infection, hunger, medicines, sensory loss and environmental factors.
- Support is personalised to the person's wishes, communication, strengths, risks and current needs.
- Staff record the action taken, review the person's response and adapt the approach where needed.

Illustrative practice example: Increased distress prompts a structured review rather than an assumption of dementia progression. Staff consider pain, constipation, dehydration, infection, hunger, medicines, sensory loss and environmental factors, record the action taken and review the response using relevant bowel, fluid and observation records.

Possible evidence: structured review, bowel or fluid record and outcome note.

Indicator 3: Pain scales and other clinical tools

What good practice may look like:

- Staff use an appropriate pain or deterioration tool within their competence, act on the result and repeat the assessment to establish whether the response helped.
- Support is personalised to the person's wishes, communication, strengths, risks and current needs.
- Staff record the action taken, review the person's response and adapt the approach where needed.

Illustrative practice example: A person cannot readily explain their discomfort. A competent staff member selects an appropriate pain or deterioration tool, records the

findings and resulting action, then repeats the assessment to compare the person's response.

Possible evidence: completed tool, action record and reassessment.

Indicator 4: Early identification of deterioration

What good practice may look like:

- A usually sociable person becomes withdrawn; staff treat this as a change requiring investigation rather than assuming dementia progression.
- Support is personalised to the person's wishes, communication, strengths, risks and current needs.
- Staff record the action taken, review the person's response and adapt the approach where needed.

Illustrative practice example: Withdrawal from usual social contact is recognised at handover as a change from baseline. Staff record observations, seek a timely clinical review and arrange specialist input where indicated. They follow up the response and review the person's presentation rather than assuming dementia progression.

Possible evidence: baseline and change observations, a dated clinical review, specialist referral and follow-up where indicated, escalation records and the person's response.

Indicator 5: Preventing unnecessary hospital admissions

What good practice may look like:

- The plan identifies early warning signs, who to contact and safe treatment-at-home options while making clear when hospital care is necessary.
- Support is personalised to the person's wishes, communication, strengths, risks and current needs.
- Staff record the action taken, review the person's response and adapt the approach where needed.

Illustrative practice example: During a care-plan review, staff and relevant professionals agree the person's early warning signs, contact arrangements and safe treatment-at-home options. The plan also identifies when hospital care is necessary; after an episode, staff review whether escalation and the resulting care matched the plan and the person's wishes.

Possible evidence: contingency plan, escalation records and review of admissions.

Indicator 6: Proactive partnership working, escalation and interim support

What good practice may look like:

- Partnership arrangements and referrals identify the relevant service, baseline, change, observations, risks and urgency; staff follow up and escalate where necessary while maintaining an interim safety plan.
- Support is personalised to the person's wishes, communication, strengths, risks and current needs.
- Staff record the action taken, review the person's response and adapt the approach where needed.

Illustrative practice example: Staff identify a change from the person's usual presentation and contact the relevant primary care, mental health, learning disability or other specialist service. They communicate the baseline, change, observations, risks and urgency clearly. While awaiting a response, they maintain an interim safety plan, record follow-up contacts and escalate delays where necessary. When advice is received, they update shift-level instructions and review the person's response.

Possible evidence: SBARD record, partnership and referral log showing urgency, follow-up and escalation, interim plan, implemented professional advice and review of the person's response.

Equitable access and advocacy — supports indicator 6 and avoiding diagnostic overshadowing in indicator 2

What good practice may look like:

- Staff arrange communication and sensory adjustments for a health appointment and advocate when symptoms risk being attributed solely to dementia.
- Support is personalised to the person's wishes, communication, strengths, risks and current needs.
- Staff record the action taken, review the person's response and adapt the approach where needed.

Illustrative practice example: Before a health appointment, staff use the person's communication and sensory profile to arrange adjustments and prepare a hospital passport where relevant. They describe new symptoms without attributing them solely to dementia and check that professional advice is understood and followed up.

Possible evidence: reasonable-adjustment plan, hospital passport and professional feedback.

Implementing professional advice — supports indicator 6

What good practice may look like:

- MDT recommendations are converted into clear shift-level instructions, with a named person and date for reviewing impact.

- Support is personalised to the person's wishes, communication, strengths, risks and current needs.
- Staff record the action taken, review the person's response and adapt the approach where needed.

Illustrative practice example: Following an MDT review, the named coordinator records each recommendation as a shift-level action with responsibility and a review date. Handover checks whether the actions are in place, and the next review records their impact on the person.

Possible evidence: MDT actions, updated care plan and outcome review.

Standard 11 – Medication

Summary Statement

Medication support is safe, effective, person-centred and responsive to changing needs. People are supported to understand, consent to and participate in medication decisions as far as possible. Benefits, burdens, side effects and interactions are monitored, with non-pharmacological approaches considered first where appropriate and restrictive practices avoided.

Indicators

To meet this standard, providers must demonstrate that:

- Medication needs, allergies, preferences, routines, cultural or religious considerations, communication needs and ability to self-administer are assessed and reviewed.
- Medicines reconciliation is completed at admission and transfer, including prescribed, over-the-counter and homely remedies.
- The person is supported to make informed decisions; capacity is assessed for the specific decision where necessary and lawful best-interests processes are followed.
- Medicines are administered safely and exactly as prescribed, using person-centred approaches that protect privacy, dignity and choice.
- PRN protocols state the indication, non-pharmacological approaches to try where appropriate, dose, interval, maximum dose, review arrangements and how effectiveness and adverse effects will be evaluated.
- Non-pharmacological responses to distress are personalised, recorded and evaluated before psychotropic medication is requested or used, except where urgent clinical treatment is required.
- New, changed and high-risk medicines are monitored for intended benefit, sedation, falls, appetite or hydration changes, anticholinergic burden, distress and other adverse effects; concerns are escalated promptly.
- Refused, omitted, delayed or missed doses and medication incidents are responded to, reported, reviewed and used for learning.
- Medication reviews involve the person and relevant professionals, consider deprescribing and polypharmacy, and result in documented actions and follow-up.
- Self-administration is enabled where desired and safe, with proportionate assessment, storage and review.
- Covert administration occurs only following a decision-specific capacity assessment, best-interests decision and pharmacist or prescriber input, with a current management plan and review.

Applying the Standard in Practice

Providers should show how medication decisions remain lawful, person-centred and outcome-focused. Administration records alone are not enough: evidence should connect the indication, the person's wishes and capacity, the medicine or alternative used, monitoring of benefit and harm, and review.

Responsibilities in residential and nursing services: All staff report changes and concerns within their role. Only staff trained, assessed as competent and authorised under the service's medicines arrangements provide the relevant medication support. Nurses and clinical leads undertake clinical monitoring within competence; prescribers and pharmacists advise on prescriptions, formulations and reviews. Residential and nursing managers assure reconciliation, records, competency, follow-up and learning rather than assuming that another service has completed an action.

Admission and family-held medicines

At admission or transfer, discuss previous routines, over-the-counter products, homely remedies, medicines previously given by family and expectations about PRN use. Explain the service's responsibilities and how changes, refusals, reviews and concerns will be communicated, recognising that families may need support when relinquishing day-to-day control of medicines.

Person-centred administration and consent

- Record routines, preferences, communication needs, allergies, swallowing needs and the person's ability and wish to self-administer.
- Explain medicines accessibly, respect and explore refusal, and assess capacity for the specific decision where required.
- Use privacy, sufficient time and the least restrictive approach during administration.

PRN and non-pharmacological approaches

PRN protocols should be individualised and current, stating the indication, alternatives to try where appropriate, dose limits, monitoring and review. Personalised non-pharmacological responses should be used and evaluated before psychotropic medication is requested or administered, unless urgent treatment is clinically necessary.

Monitoring benefit, harm and incidents

After starting or changing a medicine, compare alertness, mobility, falls, appetite, hydration, distress and other relevant effects with the person's baseline. Missed, delayed, refused or omitted doses and incidents should lead to timely advice, proportionate disclosure, review and learning.

What leaders should test

- Are reconciliation and transfer checks complete and discrepancies resolved?
- Can staff explain why each PRN medicine is used and how effectiveness is reviewed?
- Do monitoring records show benefit as well as adverse effects?
- Are covert-administration and self-administration plans lawful, current and reviewed?
- Do medication reviews produce tracked actions and follow-up?
- Indicator 1: Is the medication assessment current and does it reflect allergies, preferences, routines, cultural or religious considerations, communication and ability to self-administer?
- Indicator 3: Is the person supported to make informed medication decisions, with decision-specific capacity assessment where necessary and recorded lawful best-interests processes?
- Indicator 4: Does observed administration follow the prescription while protecting privacy, dignity and choice?
- Indicator 6: Are personalised non-pharmacological responses recorded and evaluated before psychotropic medication is requested or used, except where urgent clinical treatment is required?
- Indicator 8: Are refused, omitted, delayed and missed doses and medication incidents acted on, reported, reviewed and used for learning?

References

Reference	Relevant indicator(s)
NICE SC1: Managing medicines in care homes	1–11
NICE QS85: Medicines management in care homes	2, 5, 7, 9–11:
NICE NG97: Dementia	3, 5–9
Mental Capacity Act 2005 and Code of Practice	3, 10–11
Health and Social Care Act 2008 Regulations 9, 11 and 12	1–11

Resources

Indicator	Suggested resources and practical tools
1. Individual medication assessment	CQC: Medicines care plans click here Dementia UK: Managing medication for a person with dementia click here CQC: Medicines optimisation quality statement

	click here BNF: Dementia treatment summaries click here
2. Medicines reconciliation	CQC: Medicines reconciliation click here NICE: Medicines management in care homes quality statements click here CQC: Learning from safety incidents click here
3. Consent, capacity and best interests	Alzheimer's Society: Dementia and the Mental Capacity Act 2005 click here GOV.UK: Making decisions - a guide for people who work in health and social care click here SCIE: Consent, capacity and best interests assessment for health and social care interventions click here
4. Safe person-centred administration	NICE Guideline SC1: Managing medicines in care homes click here Skills for Care: Medicines management resources click here
5. PRN protocols	HWEICB: "When required medication" good practice guidance webinar slides (guidance only, last updated 31st March 2026) click here CQC: "When required" medicines in adult social care click here
6. Non-pharmacological responses to distress	Alzheimer's Society: Non-drug approaches to changes in mood and behaviour click here Alzheimer's Society: Optimising treatment and care for people with behavioural and psychological symptoms of dementia (guidance only, last updated 2018) click here
7. Monitoring benefit and harm	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: Anticholinergic burden webinar slides (guidance only, last updated 31st March 2026) click here Dementia UK: Understanding statins and dementia click here

	Dementia UK: Medication for dementia click here Alzheimer's Association: Medication safety click here
8. Refusals, missed doses and incidents	Alzheimer's Society: Refusing to take medication click here CQC: Medicines administration records in adult social care click here HCC: Recording of non-safeguarding medication errors form click here HCC: Reporting a concern about an adult click here HCC: Safeguarding form click here CQC: Allegations and safeguarding notification form click here NHS: Controlled drug reporting form (care homes have a strict statutory obligation to report all incidents, discrepancies, near misses, or stock concerns directly to the local NHS England Controlled Drugs Accountable Officer using this form) click here
9. Medication review	TRiB1 Medicare: Medication and compliance in adult social care webinar slides click here CQC: Good governance of medicines click here British Geriatrics Society: Medication history and review click here
10. Self-administration	CQC: Self-administered medicines in care homes click here Alzheimer's Society: Taking medications with dementia click here HWEICB: Self-administration webinar slides (guidance only, last updated 31st March 2026) click here
11. Covert administration	NICE: Giving medicines covertly quick guide click here HWEICB: Covert medication administration and medications at end-of-life webinar slides (guidance only, last updated 31st March 2026) click here
Relevant learning videos for standard 11	Skills for Care: Care topic videos (*including "Dementia care: enabling people to live well" and "Managing meds with confidence")* watch here

	Dementia Community: Non-pharmacological prescribing in a care home liaison service webinar recording watch here

Learning and Development

Learning must reflect the person's role, local medicines policy and delegated responsibilities. It should connect legal and technical knowledge with person-centred administration, recognition of benefit and harm, non-pharmacological support, accurate records and timely escalation. Staff should understand the boundaries of their competence and know when advice from a prescriber, pharmacist, nurse or manager is required.

HCPA learning mapped to Standard 11

Standard 11 indicator	Relevant HCPA learning and development
1. Individual medication assessment	Tier 1 and Tier 2 dementia learning should support communication, preferences, routines, cultural needs and the effect of dementia on understanding and self-management. Medication learning should cover allergies, formulation, swallowing, sensory needs, reasonable adjustments and assessment of self-administration.
2. Medicines reconciliation	Medication-trained staff should learn how to obtain and compare reliable medicines information at admission and transfer, including prescribed, over-the-counter and homely remedies; resolve discrepancies; document sources; and escalate omissions or uncertainty promptly.
3. Consent, capacity and best interests	Mental Capacity Act learning should cover accessible information, decision-specific capacity, respect for refusal, consultation, best interests, restraint and legal authority. Staff should practise explaining medicines and recording the decision-making process clearly. Exact current HCPA course titles should be validated.
4–5. Safe administration and PRN medicines	Medication administration and competency learning should cover the rights of administration, infection prevention, privacy, dignity, timing, crushing or altering medicines only with authority, MAR or eMAR recording, refusal, PRN indications, dose limits, intervals, alternatives, effectiveness and adverse-effect review.
6. Non-pharmacological approaches	Tier 2, Tier 3 and Positive Behaviour Support learning should help staff identify pain, fear, boredom, communication difficulty and environmental triggers; plan personalised responses; document what was tried; and avoid using psychotropic medication as a substitute for understanding unmet need.

Standard 11 indicator	Relevant HCPA learning and development
7. Monitoring benefit and harm	Role-specific learning should cover intended outcomes, sedation, falls, appetite, hydration, mobility, constipation, anticholinergic burden and changes in distress. Staff should compare findings with baseline, use approved monitoring plans and escalate promptly.
8–9. Incidents and medication review	Learning should cover missed, delayed, refused or omitted doses; immediate advice; incident reporting; duty of candour where applicable; root-cause learning; preparation for multidisciplinary review; polypharmacy; deprescribing; and tracking agreed actions.
10. Self-administration	Staff should understand enablement, consent, proportionate risk assessment, secure storage, access, documentation and triggers for review, preserving independence wherever safely possible.
11. Covert administration	Senior staff and nurses require detailed learning on decision-specific capacity, best interests, prescriber or pharmacist advice, least-restrictive options, safe formulation, current management plans and scheduled review. Covert administration must never become routine.

Suggested learning pathway

Staff group	Suggested learning and application
All staff	Awareness of consent, common effects and adverse effects, the importance of reporting change, safe boundaries and emergency action.
Medication-trained staff	Current medication administration programme followed by supervised rounds, reconciliation, PRN decision-making, refusal management, MAR or eMAR recording and incident response.
Senior carers and key workers	Monitoring benefit and harm, person-centred routines, non-pharmacological approaches, review preparation and communication with the person, family and professionals.
Nurses and clinical leads	Clinical monitoring, high-risk medicines, psychotropics, covert administration, swallowing or formulation issues, polypharmacy, deprescribing and professional escalation.
Dementia champions	Tier 3 learning to coach personalised non-drug approaches, challenge restrictive practice and help teams evidence outcomes rather than administration alone.

Staff group	Suggested learning and application
Registered managers and deputies	Competency systems, governance, audits, incident learning, controlled-drug oversight, external pharmacy links and assurance that policy is applied in practice.

Evidence

Evidence for medication should combine the person's experience, MAR or eMAR records, observed administration, capacity and best-interests documentation, PRN and monitoring records, professional review, incident learning and outcome information.

Examples of evidence

Type of evidence	Possible examples for Standard 11
Voice and lived experience	The person's verbal or non-verbal experience of medication support; accessible feedback, family or carer feedback, advocacy, complaints and compliments about choice, privacy, benefits or burdens.
Care documentation	Medication assessments, reconciled lists, MAR/eMAR, PRN protocols, refusal and incident records, monitoring charts, consent/capacity and best-interests records, self-administration and covert-administration plans.
Observation of practice	Observed medication rounds showing prescription checks, person-centred explanation, privacy, dignity, choice, safe recording and response to refusal.
Professional input	Prescriber, pharmacist, nursing, therapy or multidisciplinary advice on medicines, formulation and swallowing, intended benefit, adverse effects, review and follow-up.
Workforce evidence	Observed rounds, reconciliation and PRN exercises, knowledge checks, supervision, reflection and competency reassessment following errors or identified concerns.
Quality assurance and governance	MAR/eMAR and PRN audits; refused, omitted, delayed or missed-dose and incident trends; review action trackers, complaints, improvement plans and sustained follow-up.
Outcomes and impact	Evidence of intended benefit and adverse effects against baseline, including alertness, falls, intake, mobility and distress; independence, treatment burden and wishes being followed.

Can the service show the full evidence cycle?

1. Know the person	2. Identify need or risk	3. Act safely	4. Review benefit and harm	5. Improve and sustain
What matters and what is usual?	What needs to happen, why and by whom?	What personalised support or intervention was provided?	What changed and what was the person's response?	What should continue, change or stop?

Suggested outcome tracker

Medication concern	Baseline or indication	Action	Benefit or adverse effect	Next review
Record the person-centred issue or desired outcome.	Describe the starting position and relevant wishes.	Record the agreed personalised response and responsibility.	Record what changed for the person, including benefit or burden.	State what will continue, change or stop and when it will be reviewed.

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: Individual medication assessment

What good practice may look like:

- The medication profile records allergies, preferred drinks, communication, cultural considerations, routines and the person's wish and ability to manage medicines.
- Support is personalised to the person's wishes, communication, strengths, risks and current needs.
- Staff record the action taken, review the person's response and adapt the approach where needed.

Illustrative practice example: When preparing a medication profile, staff ask about allergies, preferred drinks, communication, cultural considerations, routines and the person's wish and ability to manage medicines. They use this information during administration and revisit the profile with the person when needs change.

Possible evidence: medication profile, review and person's feedback.

Indicator 2: Medicines reconciliation

What good practice may look like:

- On admission, staff check prescribed medicines, creams, inhalers, supplements, over-the-counter products and homely remedies with the appropriate professionals.
- Support is personalised to the person's wishes, communication, strengths, risks and current needs.
- Staff record the action taken, review the person's response and adapt the approach where needed.

Illustrative practice example: A person arrives with tablets, creams, inhalers, supplements and non-prescription products. Medication-trained staff compare these with reliable prescribing information and clarify discrepancies with the appropriate professionals before relying on the list for ongoing support.

Possible evidence: reconciliation checklist and verified medicines list.

Indicator 3: Consent and capacity

What good practice may look like:

- Information is explained accessibly; refusal is respected and explored. Where capacity is in doubt, it is assessed for the specific medication decision.
- Support is personalised to the person's wishes, communication, strengths, risks and current needs.
- Staff record the action taken, review the person's response and adapt the approach where needed.

Illustrative practice example: A person declines a medicine after an explanation. Staff respect and explore the refusal, adapt the information and seek advice as needed. If capacity is in doubt, the specific medication decision is assessed and any best-interests process recorded.

Possible evidence: consent record, capacity assessment and best-interests record.

Indicator 4: Safe person-centred administration

What good practice may look like:

- Medicines are offered privately, one tablet at a time with the person's preferred drink and sufficient processing time, exactly as prescribed.
- Support is personalised to the person's wishes, communication, strengths, risks and current needs.

- Staff record the action taken, review the person's response and adapt the approach where needed.

Illustrative practice example: The administration plan identifies a private setting, the person's preferred drink and time to process explanations. Staff follow the prescription and offer tablets at the person's pace, recording administration and any change requiring review.

Possible evidence: administration plan, MAR and observed practice.

Indicator 5: PRN protocols

What good practice may look like:

- A PRN protocol defines signs, indication, alternatives to try where appropriate, dose, interval, maximum dose, review arrangements and how benefit and adverse effects will be evaluated.
- Support is personalised to the person's wishes, communication, strengths, risks and current needs.
- Staff record the action taken, review the person's response and adapt the approach where needed.

Illustrative practice example: Before giving a PRN medicine, staff check the individual indication, non-pharmacological alternatives where appropriate, prescribed dose, interval and maximum dose. They record why it was used, review benefit and adverse effects and follow the protocol's review arrangements.

Possible evidence: PRN protocol, MAR and effectiveness review.

Indicator 6: Non-pharmacological approaches

What good practice may look like:

- Staff identify possible pain, fear, boredom or environmental triggers and use personalised responses before requesting psychotropic medication unless urgent treatment is required.
- Support is personalised to the person's wishes, communication, strengths, risks and current needs.
- Staff record the action taken, review the person's response and adapt the approach where needed.

Illustrative practice example: When distress occurs, staff use the person's formulation and ABC record to consider pain, fear, boredom, communication and environmental triggers. They try and evaluate personalised support before requesting psychotropic medication, unless urgent clinical treatment is required.

Possible evidence: distress formulation, ABC record and review of outcomes.

Indicator 7: Monitoring effects

What good practice may look like:

- Following a new medicine, staff monitor alertness, falls, intake, mobility and distress against the person's baseline and report concerns promptly.
- Support is personalised to the person's wishes, communication, strengths, risks and current needs.
- Staff record the action taken, review the person's response and adapt the approach where needed.

Illustrative practice example: After a medicine is started, staff use the agreed monitoring plan to compare alertness, falls, intake, mobility and distress with baseline. They report concerns promptly and bring the observations to the medication review to assess benefit and harm.

Possible evidence: monitoring chart, clinical contact and medication review.

Indicator 8: Missed doses and incidents

What good practice may look like:

- Refused, omitted, delayed or missed doses and medication incidents prompt timely advice, recording, reporting, disclosure where applicable and review of why they happened, with actions shared across the team.
- Support is personalised to the person's wishes, communication, strengths, risks and current needs.
- Staff record the action taken, review the person's response and adapt the approach where needed.

Illustrative practice example: A refused, omitted, delayed or missed dose triggers timely advice and the appropriate recording, reporting and disclosure. The review identifies why it happened, shares agreed actions and checks whether the change prevents recurrence.

Possible evidence: incident report, duty-of-candour record where applicable and action plan.

Indicator 9: Medication review

What good practice may look like:

- The review includes the person, considers benefit, polypharmacy, anticholinergic burden and deprescribing, and records follow-up actions.

- Support is personalised to the person's wishes, communication, strengths, risks and current needs.
- Staff record the action taken, review the person's response and adapt the approach where needed.

Illustrative practice example: Staff prepare a medication review with the person's views and monitoring records. The multidisciplinary discussion considers benefit, polypharmacy, anticholinergic burden and deprescribing, with each agreed action tracked through to follow-up.

Possible evidence: multidisciplinary review and completed action tracker.

Indicator 10: Self-administration

What good practice may look like:

- A person who wishes to self-administer is supported with secure storage and a proportionate risk assessment that is reviewed when ability changes.
- Support is personalised to the person's wishes, communication, strengths, risks and current needs.
- Staff record the action taken, review the person's response and adapt the approach where needed.

Illustrative practice example: A person asks to manage their own medicines. Staff coordinate a proportionate assessment, consent and secure storage arrangements, record the support needed and review the plan when ability or circumstances change.

Possible evidence: risk assessment, consent and review.

Indicator 11: Covert administration

What good practice may look like:

- Covert administration is used only after decision-specific capacity and best-interests processes, with prescriber or pharmacist advice and a scheduled review.
- Support is personalised to the person's wishes, communication, strengths, risks and current needs.
- Staff record the action taken, review the person's response and adapt the approach where needed.

Illustrative practice example: When covert administration is proposed, senior staff check that the specific capacity and best-interests processes are complete and obtain prescriber or pharmacist advice. They record the authorised management plan and review date and check that practice remains consistent with it.

Possible evidence: capacity assessment, meeting record, management plan and review.

Standard 12 – Nutrition and Hydration

Summary Statement

Care recognises how dementia, illness, disability, medicines, sensory changes and swallowing difficulties can affect eating and drinking. Support is flexible, enabling and enjoyable, reflects the person's identity and preferences, and responds promptly to prevent avoidable dehydration, malnutrition, delirium and loss of function.

Indicators

To meet this standard, providers must demonstrate that:

- Nutrition and hydration needs and risks are assessed on admission, monitored regularly and reviewed after relevant change, using appropriate screening and professional advice.
- Care plans describe preferences, cultural and religious needs, allergies, routines, abilities, communication, equipment, positioning and the level of support required.
- Staff understand how dementia may affect appetite, thirst, recognition, initiation, coordination, sensory processing and swallowing, and adapt support accordingly.
- People have timely access to appealing food, snacks and drinks that reflect their preferences, including outside set mealtimes and where they walk with purpose or cannot remain seated.
- Support maximises independence, dignity and enjoyment, using prompts, demonstration, adapted crockery, a calm environment and sufficient time.
- Changes in intake, weight, swallowing, oral health, alertness or presentation are recognised, recorded, investigated and escalated promptly.
- Dehydration risks and consequences are actively prevented and managed through personalised approaches rather than relying on one type of drink.
- Malnutrition risk is managed through the current approved pathway, including food-first approaches, fortification, monitoring and referral when indicated.
- Swallowing concerns are managed promptly with appropriate professional advice; texture modification follows current recommendations and is not introduced solely for staff convenience.
- Consent, capacity, positive risk-taking and best interests are considered for significant nutrition or hydration decisions, including clinically assisted nutrition and hydration.
- Family and carers are involved, with consent or lawful authority, to share knowledge and support continuity without overriding the person's wishes.

Applying the Standard in Practice

Providers should show how assessment, preferences and observation shape flexible support with eating and drinking. A completed screening score or intake chart is not enough: evidence should connect the person's baseline and wishes, the concern identified, personalised action, professional input where required, the person's response and review.

Responsibilities in residential and nursing services: Care staff provide personalised eating and drinking support and report changes. Catering and hospitality staff implement shared preferences, allergies, texture and fortification instructions. Nurses and senior staff monitor trends and coordinate escalation within competence; dietetic, speech and language therapy and primary-care partners provide individual professional advice. Managers assure communication, equipment, competence and follow-up across residential and nursing services.

Maintaining a dedicated focus throughout the day

Nutrition and hydration should be treated as skilled dementia care, not merely a routine task. Services should identify how responsibility for drinks, snacks and mealtime support is maintained throughout the day, including during busy periods, and may use named staff, champions or planned rounds where these improve intake and experience.

Flexible, enabling support

- Offer preferred food and drinks, snacks and alternatives outside fixed mealtimes where needed.
- Use prompts, demonstration, adapted equipment, suitable positioning, a calm environment and sufficient time.
- Support people who walk with purpose or cannot remain seated without restricting access to food or drink.
- Share current information consistently across care, nursing, catering and hospitality teams.

Purposeful screening and monitoring

Use screening, weight and intake monitoring for a defined reason and at a frequency proportionate to risk. Records should identify triggers, action thresholds, review dates and a stopping point, and should demonstrate what changed following intervention.

Responding to swallowing, dehydration and malnutrition risk

Recognise reduced intake, weight loss, coughing, fatigue, altered alertness, constipation and other changes promptly. Follow current local pathways, obtain professional advice,

implement texture or food-first recommendations accurately and review their effect on safety, comfort and enjoyment.

What leaders should test

- Do staff know each person's preferences, risks and required support?
- Are food and drinks available flexibly rather than only at set times?
- Are monitoring charts reviewed and linked to action?
- Is current dysphagia and texture information consistent across teams?
- Can the service evidence improved intake, comfort, weight stability or safer swallowing?
- Indicator 10: Do significant nutrition and hydration decisions address consent, decision-specific capacity, best interests and positive risk-taking, including clinically assisted nutrition and hydration?
- Indicator 11: Are family and carers involved with consent or lawful authority, without overriding the person's wishes?

References

Reference	Relevant indicator(s)
Health and Social Care Act 2008 Regulations 9, 11, 12 and 14	1–11
NICE CG32: Nutrition support for adults	1, 6, 8–10
NICE NG97: Dementia	2–5, 9–11
Mental Capacity Act 2005 and Code of Practice	10–11
For review: current Hertfordshire malnutrition and dysphagia pathways	6, 8–9

Resources

Indicator	Suggested resources and practical tools
1. Screening and monitoring	BAPEN: Malnutrition Universal Screening Tool (MUST) guide click here Nursing Older People: Improving nutrition and hydration in older people with dementia in care homes (open access article - published October 2026) click here CQC: Regulation 14 - Meeting nutritional and hydration needs click here

2. Personalised care planning	Dementia UK: Life story template (editable version) click here British Geriatrics Society: Best practice approaches to deliver good nutritional care for people with dementia click here Age UK: Training articles - communicating, eating/drinking and environments click here NHS: 10 key characteristics of "good nutrition and hydration care" click here
3. Dementia-related changes	Alzheimer's Society: Eating and drinking click here Dementia UK: Eating and drinking with dementia click here British Dietetic Association: Dementia and diet click here British Nutrition Foundation: Diet and dementia click here
4. Flexible access	Carers UK: Dementia and nutrition - supporting the person you care for click here Barchester Healthcare: Nutritious snacks for people living with dementia (guide only, personalised clinical advice and partnership work is still required) click here Barchester Healthcare: Finger food ideas for people living with dementia (as above, intended as a guide only) click here
5. Independence and enjoyment	Alzheimer's Society: Supporting someone with dementia to eat and drink click here
6. Recognising and escalating change	HWEICB: Care home malnutrition management pathway resources (guidance only, last updated 31st March 2026) click here HCT: Nutrition and dietetic service click here
7. Preventing dehydration	Dementia UK: Dementia and hydration click here Jelly Drops: Sweets to support hydration — commercial product information, not independent clinical guidance. Any use must be consistent with the person's current swallowing and clinical plan; seek professional advice where suitability is uncertain. click here Alzheimer's Society: Drinking, hydration and dementia click here

8. Managing malnutrition	BAPEN: The MUST toolkit click here Alzheimer's Society: Appetite and dementia click here NICE Clinical Knowledge Summaries: Management of malnutrition click here NICE: Enteral (tube) feeding for people living with severe dementia (*decision guide only*) click here
9. Swallowing concerns	HCT: Swallowing difficulties click here NHS Inform: Dysphagia (swallowing problems) click here Royal College of Speech and Language Therapists: Dysphagia fact sheet click here
10. Consent and positive risk-taking	Care Talk: Finding the balance in dementia care click here Royal College of Speech and Language Therapists: Eating and drinking with acknowledged risks guidance click here British Dietetic Association: Supporting people who have eating and drinking difficulties click here **Clinically assisted nutrition and hydration decisions:** The NICE tube-feeding decision aid is also listed under indicator 8. Use it to support discussion alongside the person's current clinical advice and decision-making arrangements. NICE: Enteral (tube) feeding for people living with severe dementia (*decision guide only*) click here
11. Family and carer involvement	Age UK: Eating and drinking well with dementia - a guide for family carers and friends by the University of Bournemouth click here
Relevant learning videos for standard 12	Dementia Community: Support for people facing eating, swallowing & communication challenges webinar recording watch here NHS: 10 key characteristics of "good nutrition and hydration care" accompanying video watch here

Learning and Development

Learning should help staff understand how dementia, illness, disability, medicines, sensory change, oral health and swallowing difficulty affect eating and drinking

HCPA learning mapped to Standard 12

Standard 12 indicator	Relevant HCPA learning and development
1. Screening, monitoring and review	Role-specific nutrition and hydration learning should cover MUST or the locally approved pathway, weight trends, intake monitoring, review triggers and referral thresholds. Staff should understand that screening supports judgement and action rather than replacing assessment.
2. Personalised care planning	Tier 1 and Tier 2 dementia learning should support life history, communication, culture, religion, allergies, routines, preferences, positioning, equipment and independence. Staff should practise creating concise instructions shared consistently across care and catering teams.
3. Dementia-related changes	Learning should explain changes in appetite, thirst, recognition, initiation, coordination, sensory processing and communication across dementia progression. Practical scenarios should require staff to adapt cues, pace, presentation and the environment.
4–5. Flexible access, independence and enjoyment	Staff should learn to offer preferred drinks, snacks, finger foods, dessert first and food outside fixed mealtimes; use demonstration and adapted equipment; reduce distraction; support people who walk with purpose; and avoid taking over tasks the person can still do.
6–7. Recognising change and preventing dehydration	Learning should cover red flags such as reduced intake, weight loss, coughing, fatigue, dry mouth, constipation, confusion and reduced urine. Staff should practise targeted monitoring, offering varied preferred fluids, escalation and evaluating response against baseline.
8. Managing malnutrition	The HCPA nutrition and hydration programme and Nutrition and Hydration Champion learning should cover food-first approaches, fortification, energy and protein enrichment, monitoring, referral and review. Exact tier and course titles should be confirmed.
9. Dysphagia and texture modification	Dysphagia learning should cover recognition of swallowing concerns, immediate action, speech and language therapy referral, positioning, pace, supervision, oral care and implementation of current texture recommendations.

Standard 12 indicator	Relevant HCPA learning and development
	Competence should include practical observation; exact HCPA course title requires validation.
10. Consent, capacity and positive risk-taking	Mental Capacity Act learning should address accessible choices, decision-specific capacity, best interests, clinically assisted nutrition and hydration, and eating and drinking with acknowledged risk. Staff should balance safety, rights, comfort and enjoyment.
11. Family and carer involvement	Staff should learn to gather knowledge about successful routines and preferences, involve others lawfully, manage disagreement and keep the person's current wishes central.

Suggested learning pathway

Staff group	Suggested learning and application
All staff	Induction and awareness on hunger, thirst, common dementia-related changes, respectful offers, immediate reporting and the person's preferences.
Care staff, activity staff and key workers	Tier 1 and practical nutrition and hydration learning on prompts, independence, flexible access, mealtime observation, targeted records and communicating change.
Catering, hospitality and housekeeping staff	Allergies, cultural and religious needs, appetising presentation, fortification, texture information, snack and drink availability, environmental cues and communication with care teams.
Senior carers and nurses	Screening, weight and intake trends, dehydration and malnutrition pathways, dysphagia escalation, oral health, medicines contribution, consent and best interests.
Nutrition and hydration champions	Champion learning with responsibility for coaching, mealtime observation, environmental review, audit, referral-pathway awareness and evidencing impact.
Registered managers and deputies	Governance of screening, catering-care communication, competency, equipment, incidents, referral delays and outcomes such as weight stability, safer swallowing and enjoyment.
Staff requiring targeted development	Practical coaching, simulation, observed support and reassessment linked to a specific gap, including advanced dementia, fluctuating intake or dysphagia.

Evidence

Evidence for nutrition and hydration should combine the person's experience and enjoyment, care and catering records, direct observation, screening and monitoring, professional advice, family or carer knowledge, staff competence and outcomes.

Examples of evidence

Type of evidence	Possible examples for Standard 12
Voice and lived experience	The person's enjoyment, verbal or non-verbal choices and responses at meals; accessible feedback, family or carer knowledge, advocacy, complaints and compliments about food, drinks and support.
Care documentation	Screening, weight and targeted intake trends; preference, allergy and communication profiles; care and catering instructions, food-first and SLT plans; escalation, consent/capacity, best-interests and family communication records.
Observation of practice	Mealtime observation of prompts, demonstration, positioning, adapted equipment, calm surroundings, sufficient time, flexible access and independence.
Professional input	Dietetic, speech and language therapy, medical, nursing, pharmacy, mental health or palliative-care advice on intake, swallowing, oral health or relevant medicines, with implementation and follow-up.
Workforce evidence	Observed mealtime support, screening exercises, fortification and texture checks, dysphagia scenarios, supervision, reflection and coaching.
Quality assurance and governance	Review of weight and intake trends, choking or dehydration concerns, monitoring-chart actions, catering-care communication and referral delays; complaints, action plans and sustained improvement.
Outcomes and impact	Changes in intake, comfort, alertness, weight stability, swallowing safety, independence, enjoyment, distress and wishes followed; benefit or burden of the agreed approach.

Can the service show the full evidence cycle?

1. Know preferences and risk	2. Plan support	3. Provide support	4. Review intake and experience	5. Adapt and sustain
What matters and what is usual?	What needs to happen, why and by whom?	What personalised support or intervention was provided?	What changed and what was the person's response?	What should continue, change or stop?

Suggested outcome tracker

Nutrition or hydration concern	Baseline	Action	Outcome or impact	Next review
Record the person-centred issue or desired outcome.	Describe the starting position and relevant wishes.	Record the agreed personalised response and responsibility.	Record what changed for the person, including benefit or burden.	State what will continue, change or stop and when it will be reviewed.

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: Screening and monitoring

What good practice may look like:

- Nutrition and hydration risk is screened on admission and reviewed after illness, weight change or reduced intake, with action proportionate to risk.
- Support is personalised to the person's wishes, communication, strengths, risks and current needs.
- Staff record the action taken, review the person's response and adapt the approach where needed.

Illustrative practice example: Reduced intake after illness prompts staff to revisit nutrition and hydration screening and compare weight and intake with baseline. They record risk-proportionate actions and a review point rather than treating the screening score as the outcome.

Possible evidence: screening trend, weight record and review action.

Indicator 2: Personalised care planning

What good practice may look like:

- The plan records preferred foods and drinks, cultural and religious needs, allergies, routines, abilities, communication, positioning, equipment and required support.
- Support is personalised to the person's wishes, communication, strengths, risks and current needs.
- Staff record the action taken, review the person's response and adapt the approach where needed.

Illustrative practice example: The person and those who know them help staff record preferred foods and drinks, cultural and religious needs, allergies and routines. The plan also describes abilities, communication, positioning, equipment and required support so that care and catering teams can apply the same personalised approach.

Possible evidence: preference profile, care plan and person or family feedback.

Indicator 3: Understanding dementia-related changes

What good practice may look like:

- Staff recognise that a person may feel hungry or thirsty but be unable to identify, communicate or initiate eating or drinking, and adapt prompts accordingly.
- Support is personalised to the person's wishes, communication, strengths, risks and current needs.
- Staff record the action taken, review the person's response and adapt the approach where needed.

Illustrative practice example: A person does not begin eating when the meal arrives. Staff check how the person recognises and initiates the task, adapt prompts and demonstration, then observe whether the person can continue and record the response.

Possible evidence: observed practice, supervision and intake outcome.

Indicator 4: Flexible access

What good practice may look like:

- Preferred drinks, snacks, finger foods or dessert first are offered outside fixed times, including to a person who walks with purpose.
- Support is personalised to the person's wishes, communication, strengths, risks and current needs.
- Staff record the action taken, review the person's response and adapt the approach where needed.

Illustrative practice example: A person who walks with purpose does not settle for a fixed mealtime. Staff offer preferred drinks, suitable snacks or finger foods and dessert first where wanted, within the person's current plan, then review access, intake and enjoyment.

Possible evidence: menus, availability checks, observation and feedback.

Indicator 5: Independence and enjoyment

What good practice may look like:

- Staff demonstrate the first action, provide adapted crockery and sufficient time, allowing the person to continue independently rather than taking over.
- Support is personalised to the person's wishes, communication, strengths, risks and current needs.
- Staff record the action taken, review the person's response and adapt the approach where needed.

Illustrative practice example: During a meal, staff demonstrate the first action and provide adapted crockery and sufficient time. They observe how much the person can do independently before offering further help and review whether the equipment and approach support enjoyment.

Possible evidence: mealtime observation, equipment trial and feedback.

Indicator 6: Recognising and escalating change

What good practice may look like:

- Coughing at meals, reduced alertness or unexpected weight loss prompts immediate review, targeted monitoring and professional referral.
- Support is personalised to the person's wishes, communication, strengths, risks and current needs.
- Staff record the action taken, review the person's response and adapt the approach where needed.

Illustrative practice example: Coughing during meals, reduced alertness or unexpected weight loss is recorded as a change requiring prompt action. Staff obtain professional advice, arrange targeted monitoring and follow up the referral and the effect of the agreed plan.

Possible evidence: change record, referral and follow-up outcome.

Indicator 7: Preventing dehydration

What good practice may look like:

- Small amounts of the person's preferred drink are offered frequently using suitable cups and visual prompts, rather than relying only on water rounds.
- Support is personalised to the person's wishes, communication, strengths, risks and current needs.
- Staff record the action taken, review the person's response and adapt the approach where needed.

Illustrative practice example: Staff notice that a person rarely initiates drinking and identify preferred drinks and suitable cups. They offer small amounts frequently with visual prompts, use targeted monitoring where needed and review the person's response rather than relying only on water rounds.

Possible evidence: targeted fluid record, observation and improvement in wellbeing.

Indicator 8: Managing malnutrition

What good practice may look like:

- A food-first plan adds energy and protein to familiar foods, with weight and intake reviewed before escalation to supplements or specialist advice as indicated.
- Support is personalised to the person's wishes, communication, strengths, risks and current needs.
- Staff record the action taken, review the person's response and adapt the approach where needed.

Illustrative practice example: A malnutrition review leads to an individual food-first plan using familiar foods with energy and protein enrichment. Staff follow the approved pathway, monitor weight and intake and obtain supplements or specialist advice when indicated, checking benefit and burden at review.

Possible evidence: pathway record, food-first plan and weight trend.

Indicator 9: Swallowing concerns

What good practice may look like:

- Staff follow current speech and language therapy advice on texture, positioning, pace and supervision and seek review when swallowing changes.
- Support is personalised to the person's wishes, communication, strengths, risks and current needs.
- Staff record the action taken, review the person's response and adapt the approach where needed.

Illustrative practice example: A swallowing plan is checked at handover and with catering staff so texture, positioning, pace and supervision are consistent. When swallowing

changes, staff seek professional review and update instructions rather than continuing an outdated plan.

Possible evidence: professional plan, competency observation and incident monitoring.

Indicator 10: Consent and positive risk-taking

What good practice may look like:

- A decision about eating and drinking with acknowledged risk includes the person as far as possible, records capacity and balances safety with enjoyment and rights.
- Support is personalised to the person's wishes, communication, strengths, risks and current needs.
- Staff record the action taken, review the person's response and adapt the approach where needed.

Illustrative practice example: Before a significant decision about eating and drinking with acknowledged risk or clinically assisted nutrition and hydration, staff support the person's involvement and establish the relevant consent or capacity and best-interests arrangements. The agreed plan records safety, enjoyment, rights and review.

Possible evidence: capacity or best-interests record, risk plan and review.

Indicator 11: Family and carer involvement

What good practice may look like:

- With consent or lawful authority, family share successful routines and favourite foods, but the person's current wishes remain central.
- Support is personalised to the person's wishes, communication, strengths, risks and current needs.
- Staff record the action taken, review the person's response and adapt the approach where needed.

Illustrative practice example: With consent or lawful authority, relatives describe favourite foods and routines that previously worked. Staff try suitable options while observing the person's current wishes and response, and record any agreed adaptation rather than allowing family preference to override the person.

Possible evidence: family knowledge profile, agreed plan and the person's response.

Standard 13 – Advance Planning including End of Life

Summary Statement

People living with dementia are supported, from an appropriate early stage and throughout changing circumstances, to express what matters to them and plan for future care. Plans are voluntary, accessible, legally informed, regularly reviewed and used in practice, with comfort, relationships, spiritual and cultural needs, advocacy and quality of life central through to the end of life.

Indicators

To meet this standard, providers must demonstrate that:

- The person is offered timely, sensitive opportunities to discuss future care, treatment, place of care, relationships, spiritual or cultural wishes and what gives life meaning, without pressure to participate.
- Communication is adapted and the person is supported to decide who should be involved and what information may be shared.
- Advance care planning distinguishes preferences from legally binding decisions and accurately records relevant advance decisions, health and welfare lasting powers of attorney and emergency care recommendations.
- Capacity is presumed and assessed for the specific decision when required; best-interests decisions follow the Mental Capacity Act and give proper weight to known wishes, feelings, beliefs and values.
- Plans are reviewed at agreed intervals and following significant change, and any change of mind is respected and communicated.
- Current plans are accessible to staff and shared with relevant professionals and services lawfully, including at transfer or in an emergency.
- Staff recognise deterioration and possible last days of life, seek timely clinical input and continue to review because the person may deteriorate, stabilise or recover.
- Individualised end-of-life care prioritises comfort, dignity, privacy, meaningful connection, symptom control, oral care, nutrition and hydration decisions, and emotional, spiritual and cultural support.
- Anticipatory medicines and clinical plans have clear individual indications, dose, route, monitoring and escalation arrangements and are used only by competent staff.
- Family, carers and people important to the person receive clear information, involvement consistent with consent and legal authority, and timely signposting to support, including bereavement support.

- The person's quality of life remains central; being on an end-of-life pathway does not automatically mean withdrawal from relationships, activity or ordinary pleasures.
- After a death, the provider reviews whether wishes were followed, identifies learning and supports staff.

Applying the Standard in Practice

Providers should show how voluntary conversations and recorded wishes are translated into current, lawful and compassionate care. Possessing an advance plan is not enough: evidence should show that it was accessible, reviewed, understood and used when decisions, transfers or deterioration occurred.

Responsibilities in residential and nursing services: Residential staff support voluntary conversations, record and share current wishes lawfully, provide comfort within competence and seek timely clinical input. Nurses and clinical leads undertake clinical assessment, monitoring and symptom support within their professional competence. Primary care, hospice and community palliative-care partners provide relevant clinical plans and prescribing. Managers assure current documentation, access, competency, family support and after-death learning; a residential placement does not itself confer nursing or prescribing responsibilities.

Starting and revisiting conversations

- Offer sensitive opportunities to discuss what matters before crisis, while respecting a person's wish not to participate.
- Adapt communication and agree who the person wants involved and what may be shared.
- Review plans after changes in health, capacity, wishes, treatment options or place of care.
- Withdraw superseded versions clearly and communicate any change of mind promptly.

Legal clarity and access

Distinguish wishes and preferences from advance decisions, lasting powers of attorney, DNACPR and emergency care recommendations. Verify scope and validity, record where current documents are held and ensure access during evenings, weekends, transfers and emergencies.

Advocacy, family preparation and emergency decisions

Help families and people important to the person understand dementia progression, possible changes in communication, function, eating and drinking, medication decisions and future decision points. When ambulance crews, GPs, frailty teams, hospital-at-home

services or other professionals are involved, staff should communicate the person's wishes, baseline, risks and legal arrangements clearly. Plans cannot cover every scenario, so records should show the judgement used, who was consulted, why a decision was made and how the person's rights and quality of life remained central.

Comfort, uncertainty and quality of life

When a person may be approaching the last days of life, seek timely clinical input and continue review because they may deteriorate, stabilise or recover. Individualised care should address symptoms, mouth care, positioning, nutrition and hydration decisions, privacy, relationships, culture and spirituality while preserving ordinary pleasures for as long as wanted and comfortable.

What leaders should test

- Can staff find and explain the current plan and its legal status?
- Are review triggers and changes of mind recorded and communicated?
- Do transfer records carry the information needed to follow the person's wishes?
- Are anticipatory medicines used only to individual instructions by competent staff?
- Do after-death reviews examine whether wishes were followed and identify learning?
- Indicator 1: Are future-care conversations offered sensitively and voluntarily, with the person free to decline or revisit them?
- Indicator 2: Is communication adapted, with the person supported to choose who is involved and what may be shared?
- Indicator 4: Is capacity presumed, assessed for the specific decision when required, and any best-interests decision informed by known wishes, feelings, beliefs and values?
- Indicators 8 and 11: Does care prioritise individual comfort, dignity, culture and relationships while preserving wanted and comfortable activities and ordinary pleasures?
- Indicator 10: Do family, carers and people important to the person receive clear information, lawful involvement and timely practical, emotional and bereavement signposting?

References

Reference	Relevant indicator(s)
Mental Capacity Act 2005 and Code of Practice	1–6, 10
NICE NG97: Dementia	1–8, 10–11

NICE NG31: Care of dying adults in the last days of life	7–11
NICE QS144: Care of dying adults in the last days of life	7–10
Health and Social Care Act 2008 Regulations 9, 10, 11, 12 and 14	1–12
For review: Hertfordshire ReSPECT and local hospice/community palliative-care pathways	3, 6–10

Resources

Indicator	Suggested resources and practical tools
1. Timely voluntary conversations	Dementia UK: Advance care planning for dementia click here Dementia UK: My advance care plan template (editable version) click here
2. Accessible communication and involvement	Skills for Care: End-of-life resources click here Alzheimer's Society: End-of-life care - communication and physical needs click here NHS: Accessible Information Standard click here
3. Legal clarity	Alzheimer's Society: Advance decisions and advance statements click here Gold Standards Framework: Advance care planning click here GOV.UK: Make, register or end a lasting power of attorney click here Resuscitation Council UK: ReSPECT form click here (must be implemented with clinical input)
4. Capacity and best interests	SCIE: Mental Capacity Act 2005 at a glance click here Alzheimer's Society: Making decisions about end-of-life care click here CQC: Regulation 11 - Need for consent click here
5. Review and changing wishes	NICE: Advance care planning and review of needs recommendations click here Dementia UK: Advance care planning leaflet click here
6. Access and information sharing	NICE: End of life care for adults - service delivery click here

	Marie Curie: Palliative care team click here NHS: Enhanced health in care homes framework click here
7. Recognising possible dying	Gold Standards Framework: Proactive identification guidance click here Dementia UK: Recognising the later stages of dementia and moving towards end-of-life care click here Marie Curie: End-of-life dementia care click here Crossroads Hospice: 10 signs death is near click here
8. Individualised comfort care	Marie Curie: Mouth care in palliative care click here NICE: Care of dying adults in the last days of life click here NHS: Managing pain and other symptoms during end-of-life care click here Alzheimer's Society: End-of-life factsheet click here
9. Anticipatory medicines	Marie Curie: Anticipatory medications at the end of life click here NICE: Anticipatory prescribing recommendations click here
10. Supporting family and carers	Alzheimer's Society: Coping with the death of a person with dementia click here Dementia UK: Grief, bereavement and loss click here Marie Curie: Support for carers at end-of-life click here The Compassionate Friends: Supporting bereaved parents and their families — specialist bereavement support for this audience, not general dementia bereavement support. click here Cruse: Bereavement support click here The Cinnamon Trust: The national charity for older people, the terminally ill and their pets click here Widowed and Young: Helping to navigate life after loss click here Rennie Grove Peace Hospice: Easy-read resources

	click here
11. Quality of life until death	British Geriatric Society: End-of-life care in frailty and dementia click here Dementia UK: "A better death" - fixing palliative and end-of-life care for dementia click here
12. Learning after death	Hospice UK: Care after death guidance click here CQC: Learning, candour and accountability click here
Relevant learning videos for standard 13	ReSPECT: How to write an advance care plan (*must be completed in partnership with primary care*) watch here Alzheimer's Society: "The long goodbye" anticipatory grief video watch here Hospice UK: The way we talk about dying matters watch here Dr Katryn Mannix: Dying for beginners watch here Dying Matters: I didn't want that watch here

Learning and Development

HCPA learning mapped to Standard 13

Standard 13 indicator	Relevant HCPA learning and development
1–2. Timely conversations and accessible involvement	Tier 1 and Tier 2 dementia learning should support person-centred communication, life history, culture, spirituality and advance care planning. Staff should practise opening conversations sensitively, recognising readiness, respecting refusal, adapting communication and agreeing who may be involved.
3. Legal clarity and documentation	Advance care planning and Mental Capacity Act learning should distinguish wishes and preferences, advance decisions to refuse treatment, health and welfare lasting powers of attorney, DNACPR and ReSPECT where locally adopted. Staff should know how to verify scope, validity and document location. Exact HCPA titles require validation.
4. Capacity and best interests	Role-specific learning should cover presumption of capacity, decision-specific assessment, support to decide, consultation, past and present wishes, beliefs and values, advocacy, least-

Standard 13 indicator	Relevant HCPA learning and development
	restrictive options and recording defensible best-interests decisions.
5–6. Review, access and lawful sharing	Staff should learn review triggers, version control, documenting a change of mind, lawful information sharing, transfer summaries and ensuring current plans are accessible during evenings, weekends and emergencies.
7. Recognising deterioration and possible dying	End-of-life learning should cover uncertainty, reversible causes, signs of deterioration, timely clinical input, ongoing review and communication that a person may deteriorate, stabilise or recover. Links with local hospice and community pathways should be included.
8. Individualised comfort care	Learning should cover pain and symptom observation, mouth care, skin care, positioning, privacy, nutrition and hydration decisions, meaningful connection, emotional and spiritual support, cultural practice and care after death.
9. Anticipatory medicines	Nurses and authorised staff require competency-based learning on individual indications, dose, route, administration, monitoring, documentation, storage and escalation of unresolved symptoms, aligned with local policy and prescriber instructions.
10. Supporting family and carers	Staff should practise honest compassionate communication, managing uncertainty and disagreement, involving people within consent and legal authority, explaining changes and signposting practical, emotional and bereavement support.
11. Quality of life until death	Tier 3 and champion learning should reinforce that end-of-life status does not automatically mean withdrawal of ordinary pleasures, relationships, activity, food, drink or treatment. Staff should observe comfort and adapt meaningful engagement.
12. Learning after death	Managers and practice leads should learn structured after-death review, duty of candour where applicable, staff debrief, identification of themes and translating learning into service improvement.

Suggested learning pathway

Staff group	Suggested learning and application
All staff	Tier 1 and induction on compassionate communication, dignity, comfort, recognising and reporting change, cultural humility and maintaining ordinary life.
Key workers, senior carers and staff leading reviews	Tier 2 plus advance-care conversations, accessible communication, plan review, lawful family involvement, documentation and transfer arrangements.
Nurses and clinical leads	Recognition of dying, clinical assessment, symptom management, anticipatory medicines, nutrition and hydration decisions, escalation and multidisciplinary coordination.
Dementia and end-of-life champions	Tier 3 and End of Life Care Champion learning, with responsibility for modelling conversations, coaching comfort care, supporting reflection and evidencing that wishes are used in practice.
Registered managers and deputies	Tier 4, legal and ethical oversight, local pathway assurance, staff support, competency, audit, after-death review, governance and improvement.
Staff requiring targeted development	Simulation, role-play, coaching, shadowing, reflective supervision and reassessment linked to gaps such as difficult conversations, capacity, symptom recognition or family conflict.

Evidence

Evidence for advance planning and end-of-life care should combine the person's expressed wishes and experience, advance plans and legal documentation, direct observation of comfort care, clinical input, family or carer feedback, workforce competence, review activity and outcomes.

Examples of evidence

Type of evidence	Possible examples for Standard 13
Voice and lived experience	The person's expressed wishes and verbal or non-verbal comfort; accessible feedback from family, carers, advocates and people important to them; complaints and compliments about involvement and care.
Care documentation	Voluntary conversation records, communication and spiritual/cultural profiles, advance plans and legal document

Type of evidence	Possible examples for Standard 13
	checks, capacity/best-interests records, review history, transfer summaries, symptom and anticipatory-medicine records.
Observation of practice	Observed or simulated sensitive conversations, access to current plans, lawful information sharing and individualised comfort support that preserves privacy, relationships and ordinary pleasures.
Professional input	Primary-care, nursing, hospice, community palliative-care, pharmacy, therapy, dietetic, mental health or multidisciplinary advice, including symptom plans, individual medicines instructions and follow-up.
Workforce evidence	Conversation and legal-reasoning scenarios, plan and transfer-record reviews, observed comfort care, relevant medicines competence, supervision and reflective learning.
Quality assurance and governance	Audits of plan currency and accessibility, transfer information, changing wishes, symptom response and family communication; after-death reviews, complaints, debriefs and checked improvement actions.
Outcomes and impact	Whether wishes were understood and followed, comfort and symptoms reviewed, relationships and quality of life maintained as wanted, and learning after significant events or death translated into improvement.

Can the service show the full evidence cycle?

1. Understand wishes	2. Plan and document	3. Deliver and communicate	4. Review wishes and comfort	5. Learn and improve
What matters and what is usual?	What needs to happen, why and by whom?	What personalised support or intervention was provided?	What changed and what was the person's response?	What should continue, change or stop?

Suggested outcome tracker

Wish, need or concern	Current plan or baseline	Action	Outcome or impact	Next review
Record the person-centred issue	Describe the starting position and	Record the agreed personalised	Record what changed for the person, including	State what will continue, change or stop

Wish, need or concern	Current plan or baseline	Action	Outcome or impact	Next review
or desired outcome.	relevant wishes.	response and responsibility.	benefit or burden.	and when it will be reviewed.

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: Timely voluntary conversations

What good practice may look like:

- The person is offered sensitive conversations before crisis about what matters, future care, treatment and place of care, and may decline or revisit them.
- Support is personalised to the person's wishes, communication, strengths, risks and current needs.
- Staff record the action taken, review the person's response and adapt the approach where needed.

Illustrative practice example: At a calm time before crisis, a key worker offers a conversation about what matters, future treatment and place of care. The person chooses whether to take part; staff record the wishes expressed or the decision to decline and agree whether to revisit the conversation.

Possible evidence: conversation record, the person's feedback and planned review.

Indicator 2: Accessible communication and involvement

What good practice may look like:

- Staff use the person's preferred communication approach and ask whom they want involved and what information may be shared.
- Support is personalised to the person's wishes, communication, strengths, risks and current needs.
- Staff record the action taken, review the person's response and adapt the approach where needed.

Illustrative practice example: Before a review, staff check the person's communication profile and ask whom they want involved and what may be shared. The meeting uses that approach and records the person's choices about involvement and information.

Possible evidence: communication profile, consent and meeting record.

Indicator 3: Legal clarity

What good practice may look like:

- The plan clearly distinguishes preferences, an advance decision, LPA authority and emergency clinical recommendations, with documents verified.
- Support is personalised to the person's wishes, communication, strengths, risks and current needs.
- Staff record the action taken, review the person's response and adapt the approach where needed.

Illustrative practice example: When preparing an advance plan, staff separate the person's preferences from any advance decision, health and welfare LPA authority and emergency clinical recommendations. They verify relevant documents and record where the current versions can be found.

Possible evidence: advance plan, document checks and professional confirmation.

Indicator 4: Capacity and best interests

What good practice may look like:

- Capacity is assessed for the specific decision and any best-interests process gives proper weight to past and present wishes, beliefs and values.
- Support is personalised to the person's wishes, communication, strengths, risks and current needs.
- Staff record the action taken, review the person's response and adapt the approach where needed.

Illustrative practice example: A specific future-care decision cannot be resolved through ordinary supported discussion. Where required, capacity is assessed for that decision and any best-interests process records consultation and the person's past and present wishes, beliefs and values.

Possible evidence: capacity assessment, consultation and best-interests decision.

Indicator 5: Review and changing wishes

What good practice may look like:

- The plan is reviewed after a health change and the person's changed wish about hospital treatment is recorded and communicated promptly.
- Support is personalised to the person's wishes, communication, strengths, risks and current needs.

- Staff record the action taken, review the person's response and adapt the approach where needed.

Illustrative practice example: After a health change, staff offer a plan review. A changed wish about hospital treatment is recorded, the current plan updated and relevant staff and professionals informed, with superseded versions clearly withdrawn.

Possible evidence: review history, updated plan and communication record.

Indicator 6: Access and information sharing

What good practice may look like:

- Current plans are available to staff and accompany the person during transfer, with information shared lawfully with relevant services.
- Support is personalised to the person's wishes, communication, strengths, risks and current needs.
- Staff record the action taken, review the person's response and adapt the approach where needed.

Illustrative practice example: Before transfer, staff check that the current advance plan and relevant legal information are accessible and included in the transfer information. They share information lawfully and check that receiving professionals can identify the current wishes and arrangements.

Possible evidence: transfer checklist, plan accessibility audit and professional feedback.

Indicator 7: Recognising the last days of life

What good practice may look like:

- Staff recognise possible signs, seek clinical input and continue monitoring because the person may deteriorate, stabilise or recover.
- Support is personalised to the person's wishes, communication, strengths, risks and current needs.
- Staff record the action taken, review the person's response and adapt the approach where needed.

Illustrative practice example: Staff notice changes that may indicate the last days of life and seek timely clinical input. They continue monitoring and reviewing the plan because the person may deteriorate, stabilise or recover, explaining uncertainty compassionately.

Possible evidence: clinical review, observation record and updated plan.

Indicator 8: Individualised comfort care

What good practice may look like:

- The person receives regular mouth care, repositioning, symptom relief, privacy and meaningful spiritual, cultural and relational support according to their wishes.
- Support is personalised to the person's wishes, communication, strengths, risks and current needs.
- Staff record the action taken, review the person's response and adapt the approach where needed.

Illustrative practice example: The comfort plan records the person's mouth care, positioning, symptom support, privacy and spiritual, cultural and relational wishes. Staff provide support, observe the response and adapt care with relevant professional input and feedback from people important to the person.

Possible evidence: comfort plan, observations and feedback from people important to them.

Indicator 9: Anticipatory medicines

What good practice may look like:

- Anticipatory medicines have individual indications, dose and route instructions; competent staff monitor response and escalate unresolved symptoms.
- Support is personalised to the person's wishes, communication, strengths, risks and current needs.
- Staff record the action taken, review the person's response and adapt the approach where needed.

Illustrative practice example: Before anticipatory medicine is used, competent authorised staff check the individual indication, dose and route instructions. They record administration and the response, monitor comfort and escalate unresolved symptoms through the agreed clinical arrangements.

Possible evidence: prescription, administration record, competency assessment and symptom review.

Indicator 10: Supporting family and carers

What good practice may look like:

- People important to the person receive honest updates, practical guidance and bereavement signposting consistent with consent and legal authority.

- Support is personalised to the person's wishes, communication, strengths, risks and current needs.
- Staff record the action taken, review the person's response and adapt the approach where needed.

Illustrative practice example: Staff agree how people important to the person will receive updates within consent and legal authority. They explain changes honestly, offer practical and emotional guidance, record concerns and signpost to suitable bereavement support.

Possible evidence: communication plan, feedback and signposting record.

Indicator 11: Quality of life until death

What good practice may look like:

- A person continues to enjoy music, conversation, faith practice or a familiar activity for as long as this remains wanted and comfortable.
- Support is personalised to the person's wishes, communication, strengths, risks and current needs.
- Staff record the action taken, review the person's response and adapt the approach where needed.

Illustrative practice example: A person's plan identifies familiar music, conversation, faith practice or another valued activity. Staff continue to offer these while observing whether they remain wanted and comfortable, adjusting duration or approach rather than withdrawing ordinary pleasures automatically.

Possible evidence: observation, activity or spiritual-care record and feedback.

Indicator 12: Learning after death

What good practice may look like:

- The team reviews whether wishes and comfort were achieved, identifies learning and offers staff a supportive debrief.
- Support is personalised to the person's wishes, communication, strengths, risks and current needs.
- Staff record the action taken, review the person's response and adapt the approach where needed.

Illustrative practice example: After a death, the team uses the records and available feedback to review whether wishes and comfort were achieved. They record learning, assign improvement actions and offer a supportive staff debrief, then check progress through governance and supervision.

Possible evidence: after-death review, action log and supervision or debrief record.

Appendix 1: Glossary of Terms

Term	Definition
Advance care planning	A voluntary process that helps a person consider and communicate preferences and priorities for future care.
Advance decision to refuse treatment	A decision made by a person with capacity to refuse specified treatment in specified future circumstances; it is legally binding when valid and applicable.
Anticholinergic burden	The cumulative effect of medicines with anticholinergic properties, which may contribute to confusion, constipation, dry mouth, falls or other adverse effects.
Anticipatory medicines	Medicines prescribed in advance for individually assessed symptoms that may occur, commonly near the end of life.
Clinically assisted nutrition and hydration	Nutrition or fluids provided by a clinical route rather than ordinary eating and drinking.
Covert administration	Giving medicine in food or drink without the person's knowledge. This is only lawful following the required capacity, best-interests and professional processes.
Diagnostic overshadowing	Incorrectly attributing a new symptom or change to dementia or disability instead of considering other causes.
DNACPR	A clinical recommendation not to attempt cardiopulmonary resuscitation if breathing or the heart stops. It does not mean that other appropriate treatment should be withheld.
Dysphagia	Difficulty swallowing food, drink, saliva or medicines.
Lasting power of attorney for health and welfare	A person legally appointed to make specified health and welfare decisions if the donor lacks capacity, within the authority granted.
Medicines reconciliation	The process of creating and checking the most accurate current list of a person's medicines when care changes or transfers.
Positive risk-taking	A balanced approach that supports choice and meaningful activity while identifying and reducing avoidable harm.
PRN medicine	Medicine prescribed to be given when required for a defined indication and within stated limits.

Term	Definition
ReSPECT	A process for recording personalised recommendations for emergency care and treatment when a person may be unable to express choices; local adoption must be confirmed.

Appendix 2- Challenges and Barriers

The following themes were raised in the forum. They are anonymised and grouped; they should not be interpreted as universal provider experience or confirmed system findings.

Standard	Challenges and barriers identified	Mitigations or improvement actions
8 – Comprehensive Health Care	Some participants described delayed access to mental health, memory, GP or specialist input; unclear referral routes; differences between residential and nursing clinical capacity; and risk that urgency is diluted through referral chains.	Record baseline and risk clearly; use structured communication; escalate early; maintain an escalation log; agree interim plans; develop clear local pathways and use MDT or ward-round opportunities where available.
8 – Comprehensive Health Care	Staff may attribute change to dementia or use tools inconsistently.	Teach diagnostic overshadowing and reversible causes; coach all staff to notice change; observe competence and review whether action improved outcomes.
11 – Medication	Variation in access to medication reviews and specialist pharmacy input was discussed. Transitions from home may reveal informal routines, over-the-counter medicines or family expectations that do not match the prescription.	Complete reconciliation; clarify prescriptions promptly; involve the person and family; document routines; request multidisciplinary review and explain benefits and risks accessibly.
11 – Medication	Risk that psychotropic medication is viewed as a quick solution, with insufficient monitoring of sedation, falls, intake or changed distress.	Use personalised non-drug approaches where appropriate; set clear PRN criteria; monitor outcomes and adverse effects; seek timely review and deprescribing consideration.

12 – Nutrition and Hydration	Learning may receive less attention than other subjects; appetite, thirst, initiation and preferences can fluctuate; fixed routines may limit access to preferred food or drink.	Use role-based practical learning; flexible access to preferred drinks, snacks and mealtimes; observe the person; track targeted outcomes rather than creating routine paperwork for everyone.
12 – Nutrition and Hydration	Uncertainty or local variation in dietetic and dysphagia pathways.	Validate and publish current pathways; specify escalation information; record referral and interim management; maintain links with dietetic and speech and language therapy services.
13 – Advance Planning including End of Life	Conversations about dying can be difficult; wishes may change; terminology and hospice support vary across localities.	Start voluntary conversations early and revisit them; train and support staff; validate local ReSPECT and hospice arrangements; use a named coordinator and accessible information.
13 – Advance Planning including End of Life	Risk of conflating DNACPR with reduced treatment or assuming that end-of-life status means withdrawal from meaningful life.	Clarify legal and clinical meaning; maintain individualised treatment and comfort; continue relationships, activity and ordinary pleasures according to the person's wishes.