Hertfordshire Dementia Care Standards for Residential and Nursing Care

Support Guidance: Practical Care delivery

Purpose of this support guidance:

- To help commissioned residential and nursing services understand and apply Standards 1, 3, 9 and 10 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 support partnership working between residential services, nursing services and wider health and social-care partners, without replacing role-specific professional guidance or agreed local arrangements.
- 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 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 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 Act 1998 and Equality Act 2010.

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.


Hertfordshire

Standard 1- Person Centred Care

Summary Statement

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

Indicators

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

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

Applying the Standard in Practice

Providers should show how knowledge of the person is translated into current, personalised care. A completed care plan is not enough: evidence should connect the person's history, strengths, wishes and communication needs with daily support, observed outcomes and review.

Knowing the person and planning ahead

- Gather life history, preferences, culture, relationships, strengths and medical information from the person and those who know them well.
- Record current abilities alongside support needs and plan for likely future changes.
- Update care plans promptly when needs, wishes, communication or circumstances change.

Responding to distress and supporting independence

Use Positive Behaviour Support and personalised, least-restrictive approaches to understand distress. Promote participation in daily life, adapt tasks and communication, and use therapeutic interventions because they are meaningful to the individual.

Reviewing outcomes and sharing learning

Records should show the intended outcome, what was tried, how the person responded and what will continue, change or stop. Share effective approaches across shifts so good care does not depend on one staff member.

What leaders should test

- Can staff describe what matters to the person and how this shapes daily care?
- Do care plans show strengths, communication needs, current outcomes and anticipated change?
- Are distress responses personalised, proactive and least restrictive?
- Is independence supported through everyday routines and positive risk-taking?
- Can the service show what changed for the person following an intervention?

References

The indicator mappings identify relevant supporting context, not a claim that each source directly establishes every local requirement. Read the applicable provisions or recommendations alongside the indicator and the person's circumstances.

Reference	Relevant indicator(s)
Care Act 2014	All indicators
Mental Capacity Act 2005 and associated Code of Practice	Indicators 2, 4, 5, 6 and 7
Human Rights Act 1998	Indicators 1, 4, 5 and 6
Equality Act 2010	Indicators 1, 5, 6 and 10
NICE Guideline NG97: Dementia: assessment, management and support for people living with dementia and their carers	All indicators
Skills for Care Dementia Training Standards Framework	All indicators
Hertfordshire Dementia Strategy 2023–2028	All indicators

Hertfordshire Residential and Nursing Dementia Care Standards	All indicators
NICE QS184: Quality statement 6 — Managing distress (assessment of causes of distress; supporting context for personalised responses, not a standalone PBS framework)	Indicators 3, 7, 8 and 9
Alzheimer's Society 'This is Me'	Indicators 1, 4, 5 and 10

Resources

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

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

Indicator	Strongest library matches
1. Life history, interests, cultural background and medical history	Alzheimer's Society: "This is Me" document click here Dementia UK: Life story template click here Culturally Appropriate Resources: Developing culturally competent adult and social care services click here These life-story and personalisation tools supplement, rather than replace, the person's medical history, clinical records and relevant professional advice. Use the care documentation and professional insight sources in the Evidence section to show how medical history informs daily support.
2. Anticipatory care planning	Skills for Care: Dementia resources click here Alzheimer's Society: Advance decisions and advance statements click here Dementia UK: Advance care planning for dementia click here Gold Standards Framework: Advance care planning click here Resuscitation Council UK: ReSPECT form click here (*must be implemented with clinical input*) HCPA: The MCA resource pack click here Marie Curie: End-of-life dementia care click here

3. Positive Behaviour Support	Alzheimer's Society: Understanding and managing behavioural changes click here NHS: Coping with behavioural changes click here Use the person's Positive Behaviour Support plan, ABC records and outcome reviews alongside these general behaviour-change resources. They support understanding distress but are not a standalone PBS planning framework. NICE QS184: Quality statement 6 — Managing distress (structured assessment of possible clinical and environmental causes). Read the NICE quality statement
4. Regular review and adaptation of care	Alzheimer's Association: Daily care guides click here NICE: Assessment, Management and support for people living with dementia and their carers click here NICE: Quality standards for dementia care click here Dementia UK: Frailty and dementia click here British Geriatrics Society: PINCH ME tool click here RESTORE2 and RESTORE2 Mini tools for recognising deterioration and prompting reviews click here
5. Independence and activities of daily living	Dementia UK: Meaningful activities click here Alzheimer's Society: Supporting with daily tasks click here HCPA: "An enabling care approach" resource booklet click here NHS: Activities for people living with dementia click here Playlists for life click here "Music for My Mind" playlists click here Age Space Hertfordshire: Dementia friendly communities click here
6. Human value and identity	Alzheimer's Society: Dementia "We" statements click here Alzheimer's Society: Free community help cards click here

	Dementia UK: Supporting people with dementia in faith communities click here Dementia UK: LGBTQ+ support click here LGBT Health: Dementia toolkit click here
7. Responding to distress	Dementia UK: Coping with distress click here Dementia UK: Restlessness and agitation click here Dementia UK: Sundowning click here NICE Quality Standard QS184: Dementia and managing distress click here Lewy Body Dementia Association: Understanding behavioural changes in dementia click here
8. Therapeutic interventions	Alzheimer's Research UK: Management of symptoms click here Alzheimer's Research UK: Complementary therapies click here Alzheimer's Society: Anti-psychotic and other drug approaches in dementia care click here Alzheimer's Society: Therapy and approaches for memory loss support click here
9. Clear person-centred goals and intended outcomes, with impact tracked and evaluated through robust record-keeping	SCIE: Evaluating personalised care click here (*This is a general evaluation guide. Use alongside the suggested care plan outcome tracker*)
10. Communication and sensory needs	Alzheimer's Society: Communication guide click here Dementia UK: Communication tips click here Alzheimer's Society: Sight and hearing Loss click here CQC: Meeting the "Accessible Information Standard" click here

Relevant learning videos for standard 1	My Home Life England: Thriving in residential care watch here Life History Work: Good practice guide watch here Dementia UK: Life story work watch here Teepa Snow: Supporting language changes in early dementia watch video Alzheimer's Research UK: A walk through dementia - at home (*communication awareness*) watch here Alzheimer's Society: 7 stories watch here Alzheimer's Society: Hat's story (*PCA lived experience video*) watch here Dementia UK: Gail's story (*young-onset dementia lived experience video*) watch here Rare Dementia Support: Semantic dementia/PPA watch here

Learning and Development

Learning should be proportionate to each staff member's role, responsibilities and level of involvement in assessment, care planning and review. Providers should also use supervision, team reflection, observation and practice-based learning to support the application of formal training.

HCPA learning mapped to Standard 1

Standard 1 indicator	Relevant HCPA learning and development
1. Care plans reflect the person's life history, interests, cultural background and medical history	Tier 1: Foundations of Dementia Care covers life history work, personalisation and person-centred care. Tier 2: Extended Knowledge includes planning and delivering person-centred care. Tier 3: Dementia Champion covers personalised, outcomes-focused care planning. Topic-specific sessions include 'This is Me' and Creating Quality Assessments and Care Plans Enhanced by Life Stories.
2. Care plans are anticipatory and address current and future care needs	Tier 1: Foundations of Dementia Care introduces advance care planning. Tier 2: Extended Knowledge covers dementia progression, early diagnosis and advance care planning. Tier 3: Dementia Champion

	considers changing needs, evidence-based interventions and multidisciplinary working.
3. Care plans include Positive Behaviour Support strategies	Tier 1: Foundations of Dementia Care introduces Positive Behaviour Support and behaviour support interventions. Tier 2: Extended Knowledge covers behaviours of distress and Positive Behaviour Support planning. Tier 3: Dementia Champion includes Positive Behaviour Support, active support and proactive strategies. Tier 4: Managers covers Positive Behaviour Support approaches and ABC charts.
4. Care plans are regularly reviewed and adapted as dementia progresses	Tier 2: Extended Knowledge develops understanding of dementia progression and changing needs. Tier 3: Dementia Champion covers the use and evaluation of evidence-based interventions, measuring impact, SMART goals and action planning.
5. Care plans promote independence and incorporate activities of daily living	Tier 2: Extended Knowledge covers prevention, enablement and risk-positive care. Tier 3: Dementia Champion includes active support, risk-positive approaches, daily living needs and meaningful engagement. Tier 4: Managers includes positive risk-taking and approaches to supporting wellbeing.
6. Care upholds the human value of individuals regardless of age or cognitive ability	Tier 1: Foundations of Dementia Care establishes the principles of person-centred practice. Tier 3: Dementia Champion covers dignity, autonomy and an inclusive, non-stigmatising culture. Tier 4: Managers links person-centred practice with Connected Lives and positive organisational culture.
7. Care plans include strategies for responding to distressing symptoms and behaviours that express distress	Tier 1: Foundations of Dementia Care covers the relationship between communication, interaction and behaviour alongside Positive Behaviour Support. Tier 2: Extended Knowledge considers the causes of behaviours of distress. Tier 3: Dementia Champion covers Positive Behaviour Support and pharmacological and non-pharmacological interventions. Tier 4: Managers includes behaviours of concern, de-escalation and recognising escalation.
8. Care plans refer to therapeutic interventions aimed at reducing distress	Tier 3: Dementia Champion covers non-pharmacological approaches and evidence-based interventions. Dementia Music Champion develops skills in using personalised and therapeutic music techniques. Music in Herts Dementia Homecare covers

	the practical use of music to support communication, wellbeing and positive behaviour. Topic-specific learning includes Therapeutic Observations for Dementia: Best Practice for 1:1s.
9. Clear person-centred goals and intended outcomes, with impact tracked and evaluated through robust record-keeping	Tier 3: Dementia Champion covers evaluating standards, measuring impact, SMART goals and action planning. Dementia Music Champion includes session planning, practical observation and evidencing the impact of music. Tier 4: Managers supports oversight of practice, therapeutic observation and positive dementia care culture.
10. Communication plans reflect adjustments for sensory needs	Tier 1: Foundations of Dementia Care covers effective communication and the relationship between communication and behaviour. Tier 2: Extended Knowledge includes communication needs, sensory loss and dementia-friendly environments. Tier 3: Dementia Champion covers enabling positive interactions. Dementia Music Champion and Music in Herts Dementia Homecare demonstrate how music can support communication and connection.

Suggested learning pathway

Staff group	Suggested HCPA learning
All staff supporting people living with dementia	Pre-learning: Introduction to Prevalence and Types of Dementia, followed by Tier 1: Foundations of Dementia Care
Staff involved in assessment, care planning, key working or care reviews	Tier 2: Extended Knowledge, supported by relevant topic-specific sessions
Staff supporting people with complex needs or frequent expressions of distress	Tier 2: Extended Knowledge and appropriate Positive Behaviour Support, therapeutic observation or topic-specific learning
Dementia Champions and practice leads	Tier 3: Dementia Champion, with Dementia Music Champion learning where relevant to the service
Registered managers, deputies and senior leaders	Tier 4: Managers: Creating a Positive Culture of Dementia Care
Staff requiring targeted development	Topic-specific learning, including 'This is Me', Therapeutic Observations, Creating Quality Assessments and Care

	Plans Enhanced by Life Stories, Early Onset Dementia and Supporting Rare Dementias

Completion of a course alone does not demonstrate competence. Providers should consider how learning has been applied through observation, supervision, care plan review, reflective discussion and feedback from people living with dementia and those important to them.

Assessing competence in practice

Use a care-plan review and direct observation to check whether staff can connect the person's life and medical history, strengths and wishes to current support; explain anticipatory planning, Positive Behaviour Support and distress responses; enable daily living and uphold identity; and apply therapeutic and sensory adjustments. Ask staff to identify a personal goal, explain the intended outcome and show how records support review. Record the indicator checked, observed practice, feedback, development action and reassessment. Use the person's response and relevant feedback alongside records, rather than course completion alone.

Evidence

Evidence should be meaningful, proportionate and drawn from a balanced range of sources. Providers are not expected to create duplicate records where suitable evidence already exists.

Examples of evidence

Type of evidence	Possible examples for Standard 1
Voice and lived experience	Feedback from the person; observations of responses and choices; family or carer feedback; complaints and compliments; resident meetings; advocacy feedback
Care documentation	Pre-admission assessment; life history; one-page profile; communication plan; care plan; risk assessment; Positive Behaviour Support plan; ABC charts; review records
Observation of practice	Staff using preferred communication approaches; offering meaningful choices; enabling independence; adapting support in response to the person; respectful interactions
Outcomes and impact	Evidence showing changes in distress, engagement, independence, communication, safety or quality of life following an intervention

Professional insight	Occupational therapy recommendations; nursing or medical advice; speech and language therapy guidance; dietetic input; pharmacy reviews; multidisciplinary meeting records
Family and carer involvement	Records of discussions, review meetings, information provided by families and agreed communication arrangements
Workforce evidence	Training records; competency assessments; supervision discussions; reflective accounts; team meeting records; champion activity; observation of staff practice
Quality assurance	Care plan audits; observational audits; thematic reviews; action plans; case studies; learning from incidents; evidence of improvements being sustained

Can the service show the full evidence cycle?

1. Understand	2. Plan	3. Deliver	4. Review	5. Improve
What matters to the person?	What outcome is the person seeking?	What personalised support or intervention was provided?	What changed and what was the person's response?	What will be continued, changed or stopped?

Suggested care plan outcome tracker

Personal goal or desired outcome	Planned support or intervention	How impact will be measured	Review findings	Action following review
Example: To feel calmer during personal care	Use the person's preferred music, explain each step and involve a familiar staff member	Record signs of comfort or distress and whether personal care is completed at the person's preferred pace	The person appeared more comfortable on most occasions and participated in parts of the routine	Continue the approach and identify additional preferred music with the person and family

Evidence may include photographs, audio or short video recordings where this is appropriate, lawful, securely stored and supported by valid consent or another appropriate legal basis. These should supplement, rather than replace, clear care records.

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. Additional practice scenarios are illustrative, not reports of verified service outcomes.

Indicator 1: Life history, interests, cultural background and medical history

What good practice may look like:

- Life history information begins before or during admission and develops over time.
- Information is gathered from the person wherever possible.
- Family members, friends, advocates and professionals contribute where appropriate.
- The care plan records strengths, interests, routines, relationships, culture, faith, occupation, significant life experiences and relevant medical history, and explains how these shape daily support.
- Information is translated into clear guidance for everyday care.
- New information is shared through handovers and added to relevant care documentation.

Practice example: connecting through a former occupation

Staff learnt through ongoing conversations that a person had previously worked as a firefighter. This information was added to the person's life story and shared with the wider staff team. The service used the information to create meaningful conversations and arranged contact with the local fire service. The person showed sustained interest and engagement.

Possible evidence: updated life story and care plan; daily records describing the person's response; feedback from the person and family; activity or engagement records; review of how the information changed the support provided. Relevant medical history and professional advice are considered alongside life history when adapting support.

Indicator 2: Anticipatory care planning

- Care plans consider current needs and likely future changes.
- The person's preferences and wishes are explored before a crisis occurs.
- Changes associated with dementia progression are discussed sensitively.
- Contingency and escalation arrangements are clear.
- Relevant family members and professionals are involved appropriately.
- Plans are reviewed following deterioration, illness, hospital admission or a significant change.

Illustrative practice example: The person discusses preferred routines and future support with staff and those they want involved. Staff record likely changes, agreed contingency arrangements and who to contact. Following a change in needs, the plan is reviewed with the person and the relevant professionals.

Possible evidence: advance care planning discussions; future wishes and preferences; contingency or escalation plans; multidisciplinary review records; evidence of changes made following deterioration; family and advocate involvement.

Indicator 3: Positive Behaviour Support strategies

- Staff recognise behaviour as a possible form of communication.
- Negative labels are avoided when describing the person.
- Physical health, pain, communication, environment, relationships, routine and unmet needs are considered.
- Triggers, early warning signs and protective factors are recorded.
- Proactive and preventative approaches are prioritised.
- Reactive strategies are personalised, least restrictive and clearly documented.
- The impact of each strategy is reviewed.

Illustrative practice example: Staff use ABC records and knowledge of the person to identify that a busy routine precedes distress. They agree a proactive Positive Behaviour Support plan with quieter timing, familiar support and early reassurance. The team reviews observations and changes the plan where distress continues.

Possible evidence: Positive Behaviour Support plan; ABC charts used to identify patterns; pain and physical health assessments; communication and sensory assessments; records of non-pharmacological interventions; staff reflection and multidisciplinary input; reviews showing whether distress reduced or changed.

Indicator 4: Reviewing and adapting care

- Reviews are based on meaningful changes and outcomes rather than repeating previous information.
- The person is involved using communication methods appropriate to them.
- Different staff contribute observations to build a complete picture.
- Family and professional information is considered where appropriate.
- Approaches that are not working are changed or stopped.
- Care documentation clearly records what has changed and why.

Illustrative practice example: Staff notice that a familiar daily task now needs more support. They involve the person using their preferred communication method, review

observations with relevant others and update the care plan with smaller steps. A later review checks whether the revised support remains effective.

Quick review prompts: What matters to the person now? What has changed since the previous review? What is working well? What is not working? What has the person communicated verbally or non-verbally? What have family members, staff and professionals observed? What needs to change in the care plan? How will the impact be evaluated?

Indicator 5: Independence and activities of daily living

- Care plans record what the person can do, not only the support they need.
- Staff offer opportunities for the person to participate in everyday routines.
- Tasks are adapted or broken into manageable steps.
- Positive risk-taking is used to balance autonomy and safety.
- Staff allow sufficient time and avoid taking over unnecessarily.
- Independence is promoted even where the person requires substantial support.

Illustrative practice example: A person wishes to continue setting the table. Staff offer manageable steps and time to participate rather than completing the task for them. Observations record which steps the person chooses and completes, and the care plan is adjusted to preserve their involvement.

Possible evidence: strengths-based care plans; positive risk assessments; observation of staff practice; records showing participation in daily routines; occupational therapy recommendations; reviews showing maintenance or development of abilities.

Indicator 6: Human value, identity and choice

- The person remains central to decisions about their daily life.
- Everyday preferences are respected, provided they do not create a disproportionate risk.
- Staff do not make assumptions based on age, diagnosis or cognitive ability.
- Individual routines are supported rather than requiring everyone to follow the service's routine.
- Cultural identity, faith, relationships and personal expression are recognised.
- Family preferences do not automatically override the person's wishes.

Illustrative practice example: A person prefers a different morning routine from the usual service timetable. Staff explore and record the preference, adapt support and check the person's response. Handover guidance helps the team respect the same choice consistently.

Possible evidence: personalised daily routines; records of choices and preferences; mental capacity assessments where required; best-interest decision records; advocacy involvement; observations of respectful and enabling staff practice.

Indicator 7: Managing distressing symptoms and behaviours that express distress

Staff use the person's recorded signs of distress and agreed responses to adapt support, consider possible unmet needs and seek relevant professional input. Records connect the symptoms observed, the response provided and the person's comfort following support.

Illustrative practice example: During personal care, a person becomes tense and turns away. Staff pause, reduce demands and use the communication approach in the care plan. They record the person's response, consider pain and physical health needs, and seek professional advice where concerns remain. The review identifies which approaches supported comfort and updates guidance across shifts.

Possible evidence: records of symptoms and distress; care plan strategies; pain and physical health assessments; escalation records; observations of comfort; review of the response and any changes to support.

Indicator 8: Therapeutic interventions

- Interventions are selected because they are meaningful to the individual.
- Life history, culture, preferences and sensory needs inform the approach.
- Interventions may include activities of daily living, music, movement, reminiscence, creative activity, familiar routines, sensory approaches or environmental adjustments.
- The purpose of the intervention is clear.
- The person's response is observed and recorded.
- The intervention is reviewed and adapted rather than continued automatically.

Illustrative practice example: Staff select a short personalised music session to support a person who appears unsettled. They record the intended outcome, offer the session without pressure and observe comfort or distress. The review identifies whether to continue, adapt or stop the approach.

Possible evidence: personalised intervention plan; music or activity profile; session or daily records; observations of verbal and non-verbal responses; family feedback; outcome and impact reviews.

Indicator 9: Person-centred goals, intended outcomes and impact evaluation

Providers should identify the intended outcome before evaluating an intervention. Recording that an activity took place does not, on its own, demonstrate its impact.

Identified need	Personal outcome	Intervention	Evidence reviewed	Impact and next action
The person becomes distressed during busy periods in the lounge	To feel comfortable and remain connected with others	Offer access to a quieter seating area with familiar music during the busiest period	Daily notes; observations; the person's verbal and non-verbal responses; family feedback	Fewer signs of distress were observed. Continue the approach and review whether the timing remains appropriate.

Good recording should show: the starting position or identified need; the person's desired outcome; what was tried and why; how often or when the approach was used; how the person responded; whether there were any unintended effects; what was learnt; and what will happen next.

Indicator 10: Communication and sensory needs

- The person's preferred name, language and communication style are recorded.
- Hearing, sight and other sensory needs are assessed.
- Staff understand the person's verbal and non-verbal communication.
- Information is provided at an appropriate pace and in an accessible format.
- Background noise, lighting, positioning and distractions are considered.
- Communication approaches are updated when needs change.
- Relevant equipment is available, working and used appropriately.

Illustrative practice example: Staff notice that a person follows conversation more easily in a quieter area. The communication plan records reduced background noise, suitable positioning and checks of relevant sensory equipment. Observation across shifts confirms whether staff apply the adjustments and whether communication is easier.

Possible evidence: communication passport or profile; sensory needs assessment; hearing and vision review information; care plan guidance for staff; observation of interactions; family and professional feedback; evidence that staff consistently apply agreed adjustments.

What Good Looks Like at a Glance

- Care plans describe the person, not only their diagnosis and care tasks.
- Life history information meaningfully influences daily support.
- Strengths, abilities, relationships, culture and preferences are represented.
- Care plans contain personalised outcomes rather than general statements.
- Current and future needs are considered.
- The person's involvement is visible throughout assessment, planning and review.
- Communication and sensory adjustments are recorded and applied.
- Positive Behaviour Support and non-pharmacological approaches are used to understand and reduce distress.
- Independence and positive risk-taking are promoted.
- Interventions are reviewed to establish whether they improve the person's experience or outcomes.
- Evidence comes from multiple sources and is not limited to care plan documentation.
- Good practice is shared across the staff team and does not depend on one member of staff knowing the person well.
- Recording is proportionate, meaningful and focused on the person's experience.

Standard 3 - Carer and Family Involvement

Summary Statement

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

Indicators

To meet this standard, providers must demonstrate that:

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

Applying the Standard in Practice

Providers should show how the person's wishes, rights and relationships shape carer and family involvement. Recording a next of kin or sending updates is not enough: evidence should connect consent and lawful authority, agreed involvement, communication, support offered and the impact on the person.

Identifying important relationships and agreed involvement

- Ask the person who is important to them and how each person should be involved.
- Record preferred contacts, communication arrangements and the knowledge carers can contribute.
- Review arrangements when relationships, wishes, capacity or circumstances change.

Balancing involvement, privacy and autonomy

Check consent, capacity and any legal authority before sharing information or involving others in decisions. Welcome family insight while keeping the person central, using clear escalation and best-interest processes where views differ.

Communication, education and emotional support

Agree how and when updates will be provided, communicate consistently in plain language and explain changing needs and expectations across stages of dementia. Involve carers in decision-making where appropriate, in line with the person's wishes and relevant information-sharing arrangements. Help carers access education and training, distinguish training offered from training received and follow up their experience. Recognise carer distress, acknowledge carers' valued contribution, discuss self-care and access to emotional support, and know when to listen, refer or escalate concerns.

What leaders should test

- Can staff explain who the person wants involved and what may be shared?
- Are consent, capacity, LPA and best-interest considerations current and clear?
- Do families receive consistent information and know whom to contact?
- Are difficult family dynamics recorded and managed respectfully?
- Can the service show how involvement improved understanding, confidence or outcomes?
- Can the service distinguish training offered from training received by carers and show follow-up on understanding and confidence?
- Are emotional support, self-esteem and self-care discussed with carers, with follow-up on support accessed and its usefulness?

References

The indicator mappings identify relevant supporting context, not a claim that each source directly establishes every local requirement. Read the applicable provisions or recommendations alongside the indicator and the person's circumstances.

Reference	Relevant indicator(s)
Care Act 2014 and Care and Support Statutory Guidance	All indicators
Mental Capacity Act 2005 and associated Code of Practice	Indicators 2, 3, 4 and 7
NICE Guideline NG97: Dementia: assessment, management and support for people living with dementia and their carers	All indicators
Human Rights Act 1998	Indicators 2, 3 and 4
Equality Act 2010	Indicators 2, 3, 5, 6, 7 and 8
Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 9 Person-centred care and Regulation 10 Dignity and respect	Indicators 1, 2, 3, 4 and 7
Hertfordshire Dementia Strategy 2023–2028	All indicators
Hertfordshire Residential and Nursing Dementia Care Standards	All indicators

Resources

The resources below are suggested prompts and tools. Providers can use their own systems where these show that carers, families and significant others are identified, involved appropriately and supported in a way that respects the person's wishes, rights and privacy.

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

Indicator	Strongest library matches
1. Carers are identified and valued	SCIE: Care planning, involvement and person-centred care click here Skills for Care: Working with families click here Innovations in Dementia: The importance of belonging click here

2. Rights, privacy and autonomy are balanced	Alzheimer's Society: Dementia and the Mental Capacity Act 2005 click here Alzheimer's Society: Support if you are struggling with decisions relating to care click here
3. Family dynamics are understood and respected	Alzheimer's Society: Staying connected to the people who matter to you after a dementia diagnosis click here Dementia UK: How dementia can affect relationships and roles click here NHS: Dementia and relationships click here Alzheimer's Research UK: Dementia in the family and the impact on carers click here
4. Carers are kept informed and involved in decision-making where appropriate	Alzheimer's Society: Accessing and sharing information click here NHS England Digital: A guide to confidentiality in health and social care click here Office of Public Guardian: Lasting power of attorney (LPAs) click here NHS: Managing legal affairs for someone with dementia click here
5. Carers access support, education and guidance	Alzheimer's Society click here Dementia UK and Admiral Nurses Helpline click here Alzheimer's Research UK click here Dementia Carers Count: Family support service click here Memory Support Hertfordshire click here Carers in Herts click here Age UK: Caring for someone with dementia information guide click here Rare Dementia Support: Small group meetings click here (*a free RDS membership is required to join; check the appropriate group and current arrangements*).
6. Carers receive training to understand and respond to	iSupport Training for Adult and Young Dementia Carers (FREE) click here

behaviours associated with dementia	
7. Communication is clear and consistent	Skills for Care: Working with families, friends and carers — A framework for adult social care employers. Use its section on maintaining appropriate communication with families to agree updates, discuss expectations and review communication arrangements. Read the framework and guidance The communication resources below offer complementary guidance on communicating with the person living with dementia; they do not replace service-to-family communication arrangements. Alzheimer's Society: Communication guide click here Dementia UK: Communication tips click here Alzheimer's Society: Fact sheet (*other languages and BSL guides available*). click here
8. Emotional support, self-esteem and self-care are promoted	Carers UK: Guides and tools click here Alzheimer's Society: "Looking after yourself" guide for carers click here Alzheimer's Research Association: Self-care when supporting someone living with Alzheimer's disease click here
Relevant learning videos for standard 3	Dementia Carers Count: What's it like to care for someone with dementia? watch here Care UK: "One step at a time" watch here Dementia UK: Advice videos watch here Dementia Community: Personal care – support for family carers webinar recording watch here

Learning and Development

Learning should be proportionate to staff roles and responsibilities. All staff should understand that families, carers and friends can be important partners in care, while also recognising that the person living with dementia remains central to decisions about their

own life. Staff involved in assessment, care planning, reviews, complaints, safeguarding, mental capacity or family communication may need additional knowledge and confidence.

HCPA learning mapped to Standard 3

Standard 3 indicator	Relevant HCPA learning and development
1. Carers are identified and valued	Tier 1: Foundations of Dementia Care covers the role of families, carers, support networks and community services. Tier 2: Extended Knowledge reinforces person-centred planning and advance care planning. Tier 3: Dementia Champion supports partnership working and personalised care planning.
2. Rights, privacy and autonomy are balanced	Tier 2: Extended Knowledge includes capacity and the Mental Capacity Act 2005. Tier 3: Dementia Champion supports dignity, autonomy, risk-positive practice and multidisciplinary collaboration. Tier 4: Managers supports legal literacy, governance and positive culture.
3. Family dynamics are understood and respected	Tier 1 supports relationship-based, person-centred care. Tier 2 and Tier 3 help staff understand communication, planning and changing needs. Tier 4 supports leaders to create clear expectations, manage complexity and support staff with difficult conversations.
4. Carers are kept informed and involved in decision-making where appropriate	Tier 1 covers collaboration with families and support networks. Tier 2 covers advance care planning and communication. Tier 3 supports outcomes-focused reviews, multidisciplinary working and involving families and carers in care planning.
5. Carers access support, education and guidance	Tier 1 and Tier 2 support staff to understand the role of families, carers and community services. Topic-specific sessions such as The 3Ds, Early Onset Dementia, Rare Dementias and Therapeutic Observations can help staff identify when carers may need additional information or signposting.
6. Carers receive training to understand and respond to behaviours associated with dementia	Tier 1 introduces Positive Behaviour Support and communication. Tier 2 covers behaviours of distress and dementia progression. Tier 3: Dementia Champion covers PBS, active support and non-pharmacological approaches. Tier 4: Managers covers behaviours of concern, de-escalation and supporting teams. Staff apply this learning when helping carers access appropriate training, supporting their participation and following up

	what they have learnt; staff training alone does not evidence training received by carers.
7. Communication is clear and consistent	Tier 1 covers effective communication and collaboration. Tier 2 builds knowledge of communication needs and dementia progression. Tier 3 supports positive interactions and partnership working. Tier 4 supports consistent expectations, governance and culture.
8. Emotional support and interventions address carer distress and promote self-esteem and self-care	Tier 2 includes dementia progression, advance care planning and emotional impact. Tier 3 supports family and carer involvement, complex case reflection and person-centred planning. Tier 4 supports leaders to ensure staff respond compassionately to carer distress and know when to signpost or escalate. Use supervision and reflection to check how staff recognise carers' contributions, discuss self-care and follow up emotional support, without assuming distress has resolved.

Suggested learning pathway

Staff group	Suggested HCPA learning
All staff	Pre-learning and Tier 1: Foundations of Dementia Care, with service induction covering confidentiality, respectful communication and who the person identifies as important.
Care staff, key workers and activity or wellbeing staff	Tier 1 and Tier 2, supported by supervision and practical discussion about involving families, friends and carers in daily life, reviews and meaningful engagement.
Senior carers, nurses and staff leading care reviews	Tier 2: Extended Knowledge, with topic-specific learning on capacity, advance care planning, communication, distress and behaviours associated with dementia.
Dementia champions and practice leads	Tier 3: Dementia Champion, with responsibility for modelling partnership working, supporting staff with complex family dynamics and helping evidence impact.
Registered managers, deputies and senior leaders	Tier 4: Managers: Creating a Positive Culture of Dementia Care, with focus on governance, legal literacy, staff confidence, escalation routes and a culture of transparent family communication.

Course completion alone does not demonstrate competence. Providers should evidence how learning is applied through observation, supervision, reflective discussion, care plan

review, communication records, family feedback and examples of staff confidently supporting carers while protecting the person's rights.

Assessing competence in practice

Use a review record, observation and reflective discussion to check whether staff identify and value carers early; explain agreed privacy and involvement boundaries; respect family dynamics; involve carers appropriately in decisions; assist access to support and training; communicate changing needs consistently; and respond to distress while promoting self-esteem and self-care. Check training received by carers separately from training completed by staff. Record the indicator checked, observed practice, feedback, development action and reassessment, using the person's and carers' experience alongside documentation.

Evidence

Evidence should show that the service knows who is important to the person, understands the person's wishes about involvement, communicates consistently and supports carers without allowing family preferences to override the person's rights, choices or best interests.

Type of evidence	Possible examples for Standard 3
Care documentation	Admission assessment; carer and family involvement record; relationship map; LPA and consent records; care review notes; communication logs; care plan updates following family or carer input
Observation of practice	Staff welcoming families; involving carers in a way that supports the person; respectful boundary-setting; staff explaining why the person's choice must be followed; calm and compassionate responses to carer distress
Family, carer and resident voice	Feedback forms; compliments and complaints; resident views about who they want involved; relatives' meeting notes; peer-support forum feedback; evidence that concerns have been listened to and acted on
Workforce evidence	Training records; supervision notes; role-play or reflective discussion about difficult conversations; competency observations; staff confidence to explain dementia progression, consent, confidentiality and family boundaries; records of staff competence in helping carers access training, with separate evidence of carers' participation and feedback
Professional input	Social worker, GP, mental health, OT, advocacy, safeguarding or legal input where family dynamics, consent, capacity or best-interest decisions are complex

Quality assurance and governance	Audits of care reviews and communication records; complaints themes; evidence of learning from concerns; governance meeting minutes; action plans following family feedback
Outcomes and impact	Improved family confidence; reduced repeated concerns; clearer decision-making; better attendance at reviews; family involvement improving nutrition, wellbeing, activity or emotional comfort; timely referral for carer support; carer feedback on emotional support, self-esteem and self-care, with follow-up on support and training accessed

Simple evidence cycle for carer and family involvement

1. Identify	2. Agree	3. Involve	4. Support	5. Review impact
Who is important to the person and what role do they have?	What does the person want shared, and who should be involved?	How are carers, families or significant others included appropriately?	What information, education, training or emotional support was offered and accessed, and what follow-up is needed?	Did involvement improve understanding, confidence, outcomes or relationships?

Suggested carer and family involvement outcome tracker

Carer or family input identified	Person's wishes, consent or best-interest consideration	Action taken	Support, training or information offered and accessed by carer	Impact and next step
Example: family shares that the person previously enjoyed gardening and became calmer outdoors	The person shows positive responses to garden visits and family involvement is agreed as appropriate	Care plan updated to include regular supported time outdoors and family invited to contribute photographs or ideas	Family given information about the activity plan and how they can support visits	The person appears more settled after outdoor visits. Continue and review with the person and family.

Illustrative example: a carer asks for help understanding and responding to distress	Agree involvement and information sharing in line with the person's wishes and relevant decision-making arrangements	Help the carer access suitable training and agree follow-up	Record the offer, help with access, participation reported and feedback, rather than treating signposting as training received	Review the carer's understanding and confidence; agree further support where needed
Illustrative example: a carer describes distress and guilt about self-care	Keep the person's wishes and privacy central while recognising the carer's own support needs	Listen compassionately, recognise the carer's contribution and agree support options	Offer emotional support and self-care information, with agreed referral or signposting and follow-up	Ask whether support was accessed and helpful for emotional wellbeing or self-esteem; record the next step without assuming improvement

Good Practice Examples

The examples below show how services may involve carers, families and significant others in a way that supports the person living with dementia, respects rights and privacy, and recognises the emotional impact of dementia on those close to the person. The practice scenarios are illustrative, not reports of verified service outcomes.

Indicator 1: Carers are identified and valued

- Staff identify who the person considers important, rather than assuming this is limited to next of kin.
- The person's wishes about involvement are explored and recorded wherever possible.
- Carers, family members, friends or advocates are welcomed as partners where this supports the person.
- The service records what role each person has and how they prefer to be contacted.
- Carer knowledge is valued as part of assessment, care planning and review.

Illustrative practice example: On admission, staff ask the person who matters to them and record the contribution and preferred contact arrangements of each carer. At review, staff show how a carer's knowledge has informed daily support.

Possible evidence: admission records; relationship map; preferred contact arrangements; care review notes; evidence that information shared by carers has influenced daily support.

Indicator 2: Balancing rights, privacy and autonomy

Good practice is shown when staff welcome family insight while being clear that the person living with dementia remains central to decisions about their own life. Staff should check consent, understand any legal authority such as Lasting Power of Attorney, and use best-interest processes where required.

Illustrative practice example: A person wishes to keep part of their care information private. Staff record what may be shared and explain the agreed boundaries to relatives. A review checks that communication follows the person's wishes and any relevant lawful decision-making arrangements.

Possible evidence: consent records; LPA checks; mental capacity assessments; best-interest records; communication logs; records of family meetings; evidence of professional or advocacy input where decisions are complex.

Indicator 3: Understanding and respecting family dynamics

Where family members have different views, the service records the discussion, seeks to understand the reasons for concern and uses clear escalation routes. Involvement is tailored to the person's wishes and to how each family member or carer wishes to engage, rather than assuming everyone has the same relationship or role.

Illustrative practice example: Relatives prefer different ways of being involved. Staff discuss arrangements with the person and agree distinct roles and contact preferences. A review checks whether the arrangements reflect the person's wishes and whether disagreements need further support.

Possible evidence: relationship map; preferred involvement records; family meeting notes; communication logs; escalation records; professional or advocacy input where needed.

Indicator 4: Keeping carers informed and involved in decision-making

- Families know who to contact and how concerns or questions will be responded to.
- The service agrees the frequency and method of updates, taking account of the person's wishes and confidentiality.
- Care reviews provide meaningful information about what has changed, what is working and what needs to happen next.

- Staff communicate consistently so families do not receive conflicting messages.
- Information is shared in plain language and avoids jargon wherever possible.

Illustrative practice example: With the person's agreed involvement arrangements in place, a carer contributes observations to a care review. Staff record how these observations informed the options discussed, the decision reached and the resulting care-plan change, and explain the outcome to those appropriately involved.

Possible evidence: named contact record; care review invitations and minutes; communication logs; family portal updates where used; complaints and compliments records; examples of changes made following family feedback.

Indicator 5: Access to support services, education and guidance

Carers may need information and guidance as dementia progresses. Good practice includes offering clear signposting, explaining changes in presentation and helping carers access suitable education and support. Staff follow up whether the support was accessible and useful, rather than recording only that information was provided.

Illustrative practice example: A carer asks for help understanding available support. Staff discuss suitable services, assist with access where needed and agree to check back. The follow-up records whether the carer accessed support and whether another option is required.

Possible evidence: records of signposting to local or national carer support; family information sessions; relatives' meetings; records of discussions about dementia progression, communication and distress; feedback from carers; evidence that staff have responded compassionately to carer distress.

Indicator 6: Training for carers on dementia-related behaviours

Help carers access training to understand and respond to behaviours associated with dementia. Distinguish the training offered from training received and discuss how learning can support communication and responses to distress.

Illustrative practice example: A carer asks how to respond when their relative becomes distressed. Staff help the carer access relevant training, such as the iSupport resource listed above, and agree a follow-up conversation. The record distinguishes the offer, participation reported by the carer and their feedback about applying the learning.

Possible evidence: training information; support with access; participation or completion information where available and appropriate; carer feedback; follow-up discussions about understanding and confidence.

Indicator 7: Clear and consistent communication across stages of dementia

Agree the frequency and method of updates and explain changes in needs and expectations in plain language. Review communication arrangements as dementia progresses so families receive consistent information and know whom to contact.

Illustrative practice example: A family receives different messages about the person's changing support needs. A named contact brings the information together, explains the current plan and agrees future updates. Staff record the discussion and check with the family that the explanation was understood.

Possible evidence: agreed update arrangements; communication logs; accessible information; review notes; family feedback; changes made following conflicting messages.

Indicator 8: Emotional support, self-esteem and self-care

Recognise anticipatory grief, anxiety and carer strain. Offer compassionate listening, reassurance and access to emotional support or interventions, with attention to the carer's self-esteem and self-care. Staff should know when to listen, when to signpost and when to escalate concerns.

Illustrative practice example: A carer describes feeling guilty about taking time for themselves. Staff acknowledge their feelings, recognise their valued contribution and discuss support and self-care options. An agreed follow-up asks whether the carer accessed support and found it helpful, without assuming that signposting resolved their distress.

Possible evidence: support discussions; agreed referrals or signposting; self-care information; carer feedback about confidence and emotional wellbeing; follow-up and escalation records where needed.

What Good Looks Like at a Glance

- The service knows who is important to the person and records their preferred involvement.
- Carers and families are welcomed as partners where this supports the person.
- The person's wishes, privacy, autonomy and rights remain central.
- Consent, capacity, LPA and best-interest considerations are clearly documented where relevant.
- Family dynamics are understood and managed respectfully.
- Communication expectations are agreed and applied consistently.
- Carers receive clear information, education and signposting when needed.
- Staff respond compassionately to carer distress and know when to escalate concerns.

- Family insight is translated into personalised care, support and review.
- Evidence shows how carer involvement improves understanding, confidence, wellbeing or outcomes.

Standard 9 - Supportive Environment

Summary Statement

Care is delivered in environments that feel homely, promote positive risk-taking and are designed to reduce confusion and distress. Environments should support emotional comfort, independence and safety for people living with dementia.

Indicators

To meet this standard, providers must demonstrate that:

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

Applying the Standard in Practice

Providers should show how the physical, social and sensory environment is reviewed and adapted around the individual. An environmental audit alone is not enough: evidence should connect what the person experiences, the barrier or risk identified, the change made and its effect on comfort, orientation, independence and safety.

Creating a familiar, enabling environment

- Personalise rooms and shared spaces using meaningful objects, routines and cues agreed with the person.
- Support safe movement and positive risk-taking rather than applying blanket restrictions.
- Review signage, lighting, flooring, contrast and access to important destinations.

Using the social and sensory environment

Adapt staff approach, tone, pace, routines, noise, smell, lighting and stimulation before distress escalates. Consider all senses and record individual preferences, triggers and effective adjustments.

Outdoor access and assistive technology

Enable everyday access to safe outdoor spaces where possible. Use assistive technology only for a clear, person-centred purpose, with appropriate consent or best-interest processes, maintenance and review of benefit, restriction and unintended effects.

What leaders should test

- Can staff explain how the environment affects each person's comfort and behaviour?
- Are restrictions necessary, proportionate and regularly reviewed?
- Do environmental changes respond to individual sensory and orientation needs?
- Is assistive technology supporting independence without unnecessary restriction?
- Can the service show that changes improved the person's experience?

References

The indicator mappings identify relevant supporting context, not a claim that each source directly establishes every local requirement. Read the applicable provisions or recommendations alongside the indicator and the person's circumstances.

Reference	Relevant indicator(s)
Care Act 2014 and Care and Support Statutory Guidance	All indicators
Mental Capacity Act 2005 and associated Code of Practice	Indicators 1, 4, 6, 7 and 8
Human Rights Act 1998	Indicators 1, 2, 4, 6 and 9
Equality Act 2010	Indicators 4, 5, 6, 8 and 9
Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 9 Person-centred care, Regulation 10 Dignity and respect, Regulation 12 Safe care and treatment, and Regulation 15 Premises and equipment	All indicators
NICE Guideline NG97: Dementia: assessment, management and support for people living with dementia and their carers	All indicators

Hertfordshire Dementia Strategy 2023–2028	All indicators
Hertfordshire Residential and Nursing Dementia Care Standards	All indicators
Dementia UK: Making the home safe for a person with dementia; Alzheimer's Society: Keeping safe and independent at home — practical environmental guidance, adapted to the person and setting	Indicators 1, 3, 4, 5, 6 and 8
NICE QS184: Quality statement 6 — Managing distress — structured assessment of clinical and environmental causes; supporting context, not a standalone PBS framework	Indicators 1, 2, 5, 6, 7 and 9

Resources

Providers can use their own systems where they show that the environment is personalised, safe, enabling, respectful and responsive to the needs of people living with dementia.

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

Indicator	Strongest library matches
1. Homely, risk-positive environment promoting comfort and security	NHS: Dementia friendly environments click here Alzheimer's Society: Dementia-friendly environment checklist click here Dementia UK: Making the home safe for a person with dementia click here Skills for Health: Creating a safe and supportive environment for individuals with Alzheimer's and dementia click here GOV.UK: "Nothing ventured, nothing gained" - risk guidance for people with dementia click here Department of Health Victoria AU: Bedrooms and privacy (*international resource, intended to be guidance only*) click here Dementia Australia: Designing dementia-friendly care environments click here
2. Social environment used as a first-line intervention to reduce distress	Alzheimer's Society: Managing behaviour changes click here Dementia UK: Acts of kindness for someone with dementia click here

	Dementia UK: Finding community through dementia support groups and cafés click here
3. Familiar objects and layout incorporated to minimise confusion	Alzheimer's Society: Daily routines using everyday objects and material citizenship in dementia care click here **Book:** Material citizenship in dementia care, everyday objects to transform quality of life (Dr Kellyn Lee) purchase here
4. Clear signage, appropriate lighting and flooring, and safe unrestricted movement where appropriate	Dementia UK: Making the home safe for a person with dementia — practical environmental checks and adaptations. Use alongside individual assessment when considering layout, lighting, flooring and clear movement routes. Read the environmental guidance Alzheimer's Society: Keeping safe and independent at home — includes lighting, furniture and flooring. Read the practical booklet Alzheimer's Society: Dementia friendly signage click here Dementia Care Products: Planning clear signage in a care home click here Find Memory Care: Dementia lighting standards click here Alzheimer's Society: Light therapy and dementia click here
5. Environmental design considers all senses, including sound and smell	Rare Dementia Support: The senses click here Age Scotland: Dementia and sensory challenges (*nationally relevant*) click here
6. Access to outdoor spaces that are safe and therapeutic	NHS Forest: Sensory gardens click here University of Worcester: Making your garden dementia-friendly (booklet with checklist) click here
7. Evidence-based assistive technology supports independence and safety	Alzheimer's Society: How technology can help click here Age Scotland: Creating an enabling home (*nationally relevant*) click here
8. Contrasting colours aid	KYN: How lighting and colour influence wellbeing in care environments

recognition and orientation	click here Dementia Care Products: Using colour and contrast in dementia-friendly design click here
9. Language, tone and words used in care settings are appropriate and supportive	Alzheimer's Society: Positive language guide click here KYN: Inclusive language guide "Talking about dementia" click here
Relevant learning videos for standard 9	PCA Awareness: Do you see what I see? watch here SCIE: Dementia and sensory loss click here SCIE: The dementia environment in a care home watch here Wendy Mitchell: How I made my home dementia friendly watch here

Learning and Development

Learning should help staff understand that the environment is not only the physical building. It also includes the social, emotional and sensory experience created by staff, routines, noise, lighting, movement, language and opportunities for independence. Staff should understand how the environment can either reduce or increase confusion, distress and restriction.

HCPA learning mapped to Standard 9

Standard 9 indicator	Relevant HCPA learning and development
1. The environment is homely and risk-positive, promoting emotional comfort and security	Tier 1: Foundations of Dementia Care covers person-centred care, personalisation, life history and Positive Behaviour Support. Tier 2: Extended Knowledge includes prevention, enablement, risk-positive care, sensory loss and dementia-friendly environments. Tier 4: Managers supports leaders to create a positive dementia care culture and balance safety with autonomy.
2. The social environment is used as a first-line intervention to reduce distress	Tier 1 covers the relationship between communication, interaction and behaviour. Tier 2 explores behaviours of distress and dementia progression. Tier 3: Dementia Champion includes Positive Behaviour Support, active support, non-pharmacological approaches and practical ways to reduce distress. Tier 4 covers de-escalation,

	recognising escalation and supporting consistent staff approaches.
3. Familiar objects and layout are incorporated to minimise confusion	Tier 1 covers life history work and personalisation tools. Tier 2 supports understanding of memory, orientation, dementia progression and environmental adaptation. Topic-specific sessions such as 'This is Me' and Creating Quality Assessments and Care Plans Enhanced by Life Stories support staff to translate personal history into the person's living environment.
4. Clear signage, appropriate lighting and flooring are in place, with safe unrestricted movement where appropriate	Tier 2 includes sensory loss, dementia-friendly environments, prevention and enablement. Tier 3 supports staff to identify barriers to independence and review care approaches. Tier 4 supports managers to consider organisational risk, restriction, governance and quality assurance of the environment.
5. Environmental design considers all senses, including sound and smell	Tier 2 includes sensory loss and dementia-friendly environments. Tier 3 supports non-pharmacological intervention planning and evaluation. Dementia Music Champion and Music in Herts Dementia Homecare support understanding of how sound, music and auditory stimulation can influence communication, engagement and wellbeing.
6. Individuals have access to outdoor spaces that are safe and therapeutic	Tier 2 covers prevention, enablement and risk-positive approaches. Tier 3 includes active support, meaningful engagement and evidence-based interventions. Tier 4 supports managers to promote a culture where access, autonomy and proportionate risk are considered alongside safety.
7. Evidence-based assistive technology is used to support independence and safety	Tier 2 supports staff to consider changing needs, risk, communication and sensory loss. Tier 3 supports personalised interventions, multidisciplinary working and measuring impact. Tier 4 supports governance, legal literacy, oversight and ensuring technology does not become unnecessarily restrictive.
8. Contrasting colours are used to aid recognition and orientation	Tier 2 includes sensory loss and dementia-friendly environments. Tier 3 supports practical application of personalised environmental adjustments. Staff should understand how visual contrast can support independence, recognition, eating and drinking, orientation and safe movement.

9. Language, tone and words used in care settings are appropriate and supportive	Tier 1 covers respectful communication and the relationship between interaction and behaviour. Tier 3: Dementia Champion includes inclusive, non-stigmatising culture and enabling positive interactions. Tier 4 supports managers to embed expectations through supervision, role modelling, observation and governance.

Suggested learning pathway

Staff group	Suggested HCPA learning
All staff supporting people living with dementia	Pre-learning: Introduction to Prevalence and Types of Dementia, followed by Tier 1: Foundations of Dementia Care. Service induction should include respectful communication, orientation cues, personalisation, safe movement, sensory needs and how the environment can affect distress.
Care staff, night staff, hospitality, housekeeping, maintenance and activity staff	Tier 1, supported by practical walkarounds, environmental observation, reflection on noise, lighting, signage, smell, clutter, routines and staff approach.
Senior carers, nurses, team leaders and key workers	Tier 2: Extended Knowledge, with emphasis on dementia-friendly environments, sensory loss, positive risk-taking, changing needs, communication and behaviours of distress.
Dementia champions and practice leads	Tier 3: Dementia Champion, with responsibility for modelling good environmental practice, supporting staff reflection, identifying barriers to independence and helping evidence the impact of environmental changes.
Staff supporting therapeutic or sensory approaches	Dementia Music Champion or Music in Herts Dementia Homecare where relevant, plus topic-specific learning on therapeutic observations, sensory engagement and personalised interventions.
Registered managers, deputies, clinical leads and senior leaders	Tier 4: Managers: Creating a Positive Culture of Dementia Care, with focus on environmental governance, restriction, risk-positive practice, staff culture, observation of practice and continuous improvement.
Staff requiring targeted development	Topic-specific learning, coaching, supervision, environmental walkarounds, reflective practice or competency observation linked to the identified gap.

Course completion alone does not demonstrate competence. Providers should evidence how learning is applied through observation, environmental walkarounds, supervision, care plan review, incident learning, resident and family feedback, and examples of staff changing practice in response to environmental needs.

Assessing competence in practice

Use an environmental walkaround and observation to check whether staff can identify and address barriers to homeliness, positive risk-taking, familiar layout, signage, lighting, flooring, movement, sensory comfort, outdoor access and visual contrast. Ask staff to demonstrate respectful language and a personalised social response to distress. For assistive technology, check that they can explain the evidence informing selection, agreed use, maintenance and review of benefit or restriction. Record the indicator checked, observed practice, feedback, development action and reassessment, using the person's experience to test the impact of adjustments.

Evidence

Evidence should demonstrate that the environment is actively reviewed and adapted to support people living with dementia. This should include the physical environment, the social environment, the sensory environment and the way staff use language, routines and interactions to promote comfort, independence and safety.

Type of evidence	Possible examples for Standard 9
Observation of the environment	Dementia-friendly environmental walkaround; observations of lighting, noise, signage, flooring, clutter, contrast, access to toilets, safe walking routes and use of outdoor space
Observation of practice	Staff using calm tone and supportive language; staff adapting the environment before distress escalates; staff enabling movement and independence; staff reducing noise or distraction; staff using personalised social approaches
Care documentation	Care plans showing environmental preferences, sensory needs, communication needs, walking patterns, personal objects, orientation cues, safe access arrangements and individual risk-benefit decisions
Resident, family and carer voice	Feedback about comfort, orientation, safety, homeliness, access to outdoor space, personalisation of rooms and whether the environment feels calm, familiar and respectful
Assistive technology evidence	Assessment of need; consent, capacity or best-interest considerations; equipment maintenance records; staff guidance; review of whether technology supports independence and safety

	without unnecessary restriction; evidence or guidance informing selection and suitability for the person, with the source recorded
Quality assurance and governance	Environmental audits; action plans; maintenance records; incident trend reviews; falls analysis; restriction reviews; infection prevention and safety walkarounds; improvement plans
Workforce evidence	Training records; supervision notes; reflective practice; staff environmental observations; evidence that staff understand how noise, lighting, smell, contrast, tone and restriction affect people living with dementia
Outcomes and impact	Evidence that environmental changes have improved comfort, orientation, engagement, independence, movement, nutritional intake, sleep, safety or reduced distress

Simple evidence cycle for supportive environments

1. Notice	2. Understand	3. Adapt	4. Review	5. Sustain
What is the person experiencing in this environment?	What might be contributing to confusion, distress, restriction or reduced independence?	What change can be made to the physical, social or sensory environment?	Did the change improve the person's comfort, safety, independence or engagement?	How will the learning be embedded and shared with the team?

Suggested supportive environment outcome tracker

Environmental need or issue identified	Planned change or intervention	How impact will be measured	Review findings	Action following review
Example: the person becomes unsettled in the dining room when it is busy and noisy	Offer a quieter table, reduce unnecessary background noise and use familiar staff support during meals	Record signs of comfort or distress, food and drink intake, time spent at the table and the person's response	The person appeared calmer, remained at the table for longer and accepted more of the meal	Continue the approach, share with all staff and review whether the layout or mealtime routine needs wider adjustment

Evidence may include photographs of environmental changes where appropriate, lawful, securely stored and supported by valid consent or another appropriate legal basis. Photographs should supplement, rather than replace, clear records showing why the change was made and whether it improved the person's experience.

Good Practice Examples

The examples below illustrate how services may create supportive environments that promote comfort, independence and safety while avoiding unnecessary restriction or approaches that may undermine dignity or truthfulness. The practice scenarios are illustrative, not reports of verified service outcomes.

Indicator 1: Homely and risk-positive environment

Good practice may include:

- Bedrooms and communal spaces feel comfortable, familiar and personalised rather than institutional.
- Personal items, photographs and meaningful objects are used with the person's agreement.
- Risk is considered in relation to quality of life, not only avoidance of harm.
- Positive risk assessments show how independence and movement are supported safely.
- Staff consider whether rules, routines or restrictions are necessary and proportionate.
- The environment supports ordinary living, routine, choice and connection.

Illustrative practice example: A person brings familiar objects into their room and chooses where they are placed. Staff review any risks with the person and agree adjustments that preserve ordinary use. Feedback and observations inform whether the room feels comfortable and supports independence.

Possible evidence: personalised room plans; environmental walkaround records; positive risk assessments; resident and family feedback; observation of movement, comfort and independence; reviews showing how restrictions have been reduced where possible.

Indicator 2: Social environment as a first-line intervention

The social environment can reduce distress when staff approach people calmly, respectfully and consistently. Good practice includes noticing early indicators of distress, adapting tone and pace, offering reassurance, reducing demands, changing the setting, involving familiar staff and using personalised interaction before distress escalates.

Illustrative practice example: Staff notice that hurried conversation during a busy routine precedes distress. They slow their approach, reduce demands and offer familiar reassurance in a quieter setting. Records compare the person's responses and the team agrees which approach to continue.

Possible evidence: observations of staff approach; Positive Behaviour Support plans; ABC charts; de-escalation plans; reflective discussion; staff supervision; reviews showing whether distress reduced following changes to staff approach or routine.

Indicator 3: Familiar objects and layout

People living with dementia may be supported by familiar layouts, consistent placement of important items and personal cues that relate to their own life. Good practice avoids unnecessary environmental change and considers whether each change is helpful, confusing or distressing for the person.

Illustrative practice example: A person repeatedly searches for an important personal object after it is moved. Staff restore its familiar position and record the preference. Observations at review check whether the person can locate it more easily.

Possible evidence: life history records; personalised bedroom or object lists; orientation cues; care plans showing familiar routines; family input; evidence that staff avoid moving important items without reason; reviews after room moves or layout changes.

Indicator 4: Signage, lighting, flooring and safe movement

- Clear, simple and recognisable signage at appropriate height.
- Good lighting that reduces shadows and glare.
- Flooring that avoids confusing patterns or surfaces that may appear wet, uneven or like holes.
- Toilets, bedrooms and communal spaces that are easy to recognise.
- Safe walking routes that support movement rather than unnecessarily preventing it.
- Consideration of trip hazards, clutter and access to meaningful destinations.

Illustrative practice example: Staff notice difficulty finding the toilet along a cluttered route. They review signage, lighting, flooring and access, make appropriate adjustments and observe how the person uses the route. Further changes are based on the person's response.

Possible evidence: environmental audit; maintenance records; falls or incident review; signage review; lighting checks; walking route risk assessment; observations of whether people can find key areas independently.

Indicator 5: Sensory environment

A supportive environment considers sound, smell, light, touch, temperature, movement and visual stimulation. Noise from televisions, alarms, call bells, trolleys or staff conversations may increase distress. Pleasant and familiar smells can support orientation and appetite, while unpleasant or strong smells may cause discomfort.

Illustrative practice example: A person appears uncomfortable during a noisy mealtime. Staff review background sound, lighting and smells, agree individual adjustments and record the response. The next review checks whether the changes remain helpful.

Possible evidence: sensory environment audit; mealtime observations; noise or distraction review; care plans showing sensory preferences; changes made to lighting, sound or smell; evidence that staff adapt the environment when a person becomes distressed.

Indicator 6: Outdoor spaces

Access to outdoor space should be actively supported where possible, rather than treated only as an organised activity. Gardens, courtyards and walking routes can support movement, sensory connection, occupation, appetite, sleep and wellbeing. Risk assessments should consider how access can be enabled safely.

Illustrative practice example: A person wishes to spend time in the garden outside organised sessions. Staff agree how access can be supported safely and share the arrangements across shifts. Records show when the person chooses to go outdoors and inform review of access barriers.

Possible evidence: outdoor access risk assessment; records of garden use; activity plans; resident feedback; observation of wellbeing before and after outdoor time; maintenance checks; review of restrictions on access.

Indicator 7: Assistive technology

Assistive technology should be used to support the person's independence, safety and confidence. It should not replace staff interaction or become unnecessarily restrictive. Decisions should consider consent, capacity, privacy, proportionality, maintenance and whether the technology is achieving its intended outcome. Record the research, recognised guidance or professional advice informing the selection and review this alongside the person's experience.

Illustrative practice example: The team considers a device for an identified independence or safety need. They record supporting guidance or professional advice, the person's involvement and agreed use. Review considers benefit, false alarms, privacy and any restriction before deciding whether to continue.

Possible evidence: assessment of need; consent or best-interest records; technology care plan; staff guidance; maintenance logs; review of false alarms or unintended consequences; evidence of impact on independence, safety or reassurance. Record the evidence or guidance informing technology selection and the reasons it is suitable for the individual.

Indicator 8: Contrasting colours

Colour contrast can help people recognise key objects and spaces. Good practice may include contrasting toilet seats, crockery, table settings, handrails, door frames, switches and bedroom doors. The purpose should be practical recognition and orientation, not decorative change alone.

Illustrative practice example: A person has difficulty recognising items at mealtimes. Staff review visual contrast and trial a suitable change to the table setting. Observations of recognition, participation and the person's preferences guide whether the adjustment is retained.

Possible evidence: contrast audit; photographs where appropriate; mealtime observations; evidence of improved orientation or independence; care plan notes showing how contrast supports the person.

Indicator 9: Language, tone and words used in the care setting

A supportive environment includes how people are spoken to and spoken about. Good practice avoids negative labels, infantilising language, shouting across rooms, task-focused instructions and dismissive comments. Staff should use calm, respectful and enabling language that supports dignity and reduces distress.

Illustrative practice example: Feedback identifies task-focused language during daily support. Staff reflect on the interaction and practise a calmer, respectful approach using the person's preferences. Further observation checks whether the change is used consistently and how the person responds.

Possible evidence: observation of practice; supervision notes; staff reflection; communication standards; examples of language changes following feedback; resident, family or advocate feedback; complaints and compliments themes.

Good practice note: avoiding outdated or deceptive environmental cues

Some approaches previously described as dementia-friendly, such as fake bus stops or generic themed shop fronts, are now increasingly questioned where they rely on deception or do not reflect the person's real life. Good practice should focus on truthful, respectful, personalised and active use of space.

This means asking:

- Does this support the person's dignity and rights?
- Is it truthful and respectful?
- Is it meaningful to this individual?
- Does it promote doing, participating or contributing?
- Does it reduce distress without misleading the person?
- Has the impact been reviewed?

Possible evidence: review of themed or simulated areas; resident and family feedback; staff reflection; equality and dignity considerations; changes made to create more personalised, truthful and purposeful spaces.

What Good Looks Like at a Glance

- The environment feels homely, calm and familiar rather than institutional.
- People can recognise important spaces and move safely where appropriate.
- Personal objects, routines and memories are used meaningfully and respectfully.
- Staff understand that the social environment is part of dementia care.
- Staff adapt tone, pace, activity, noise, lighting and setting to reduce distress.
- Sensory needs are identified and reflected in care planning.
- Outdoor access is supported as part of everyday wellbeing.
- Assistive technology is used proportionately to support independence and safety.
- Colour contrast supports recognition, eating and drinking, orientation and movement.
- Language across the service is respectful, adult, compassionate and non-stigmatising.
- Environmental changes are reviewed to show whether they improve the person's experience.
- Restrictions are considered carefully and reduced where safe and appropriate.
- Good practice is based on the individual, not generic assumptions about dementia.
- The service avoids environmental approaches that depend on deception or undermine dignity.
- Evidence includes observation, lived experience, care records, environmental review and impact.

Standard 10 - Meaningful Engagement, Activity and Occupation

Summary Statement

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

Indicators

To meet this standard, providers must demonstrate that:

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

Applying the Standard in Practice

Providers should show how knowledge of the person leads to meaningful engagement throughout everyday care. An activity timetable or attendance record is not enough: evidence should connect interests, strengths, culture and sensory needs with the opportunity offered, the person's response and what was learnt.

Personalising everyday engagement

- Use life history, relationships, culture, faith, occupation, interests and abilities to shape opportunities.
- Offer one-to-one, group, indoor, outdoor, planned and spontaneous engagement.
- Embed meaningful moments in personal care, meals, movement, household routines and conversation.

Adapting across changing needs

Adjust timing, pace, environment, communication and the steps involved so the person can participate. Continue offering gentle, personalised connection to people who are withdrawn or living with advanced dementia, without pressuring them.

Creative, sensory and community connection

Use music, movement, reminiscence, sensory approaches and community links where meaningful to the person. Involve family and friends according to the person's wishes, including support for long-distance relationships.

What leaders should test

- Can staff explain what each person enjoys, recognises or responds to?
- Is engagement everyone's responsibility rather than limited to activity staff?
- Are people who do not join groups or who are withdrawn still offered meaningful connection?
- Do records describe response and impact rather than attendance alone?
- Is meaningful engagement available across the day, including weekends and periods without activity staff, while respecting choice and rest?
- Can the service show what should continue, change or stop following review?

References

The indicator mappings identify relevant supporting context, not a claim that each source directly establishes every local requirement. Read the applicable provisions or recommendations alongside the indicator and the person's circumstances.

Reference	Relevant indicator(s)

Care Act 2014 and Care and Support Statutory Guidance	All indicators
Mental Capacity Act 2005 and associated Code of Practice	Indicators 2, 7 and 8
Human Rights Act 1998	Indicators 1, 2, 5, 7 and 8
Equality Act 2010	Indicators 2, 3, 5, 6, 7, 8 and 9
Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 9 Person-centred care, Regulation 10 Dignity and respect, Regulation 12 Safe care and treatment, and Regulation 17 Good governance	All indicators
NICE Guideline NG97: Dementia: assessment, management and support for people living with dementia and their carers	All indicators
Skills for Care Dementia Training Standards Framework	All indicators
Hertfordshire Dementia Strategy 2023–2028	All indicators
Hertfordshire Residential and Nursing Dementia Care Standards	All indicators
NICE QS184: Quality statement 6 — Managing distress — structured assessment of causes of distress; supporting context for personalised engagement, not a standalone PBS framework	Indicators 2, 3, 6, 8 and 9
Power of Music – Music in Herts Dementia Care and HCPA Dementia Music Champion learning	Indicators 3, 4, 6, 8 and 9
NICE QS50: Mental wellbeing of older people in care homes — Quality statement 1: Participation in meaningful activity	Indicators 1, 2, 7, 10 and 11
NICE QS184: Dementia — Quality statement 5: Activities to promote wellbeing	Indicators 1, 2, 5, 6 and 8

Resources

The resources below are suggested prompts and practical tools. Providers can use their own systems where they show that activities and engagement are personalised, meaningful, inclusive, risk-positive and adapted to the person's changing needs.

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

Indicator	Strongest library matches

1. Range of one-to-one and group activities indoors and outdoors	Alzheimer's Society Activities Handbook: Supporting someone with dementia to stay active and involved click here HCPA: Managers best practice guide to engagement and activity click here
2. Activities personalised to interests, abilities, culture and life history	Alzheimer's Society: Activity ideas for people with dementia click here NAPA: Dementia and engagement toolkit 2026 click here NAPA: Free activity resources click here Music for Dementia: "Start a choir" resource page click here Purple Angel: Free bespoke MP3 players click here
3. Sensory engagement embedded in activity planning	University of Worcester/TAnDem: Creative and sensory activities booklet 1 click here University of Worcester/TAnDem: Creative and sensory activities booklet 2 click here Dementia UK: Doll therapy for people living with dementia click here Take Note: Making music easy for dementia care click here
4. Activities connect to the past and support being in the moment	Pearl Dementia Support Network: Reminiscence tool click here NAPA: Reminiscence toolkit click here NAPA: Using reminiscence cards in care settings click here Dementia UK: Guidance for gardening with dementia click here
5. Opportunities connect people with wider community resources	Music24 Community music charity click here The Red Shed: Gardening opportunities and experiences for people living with dementia click here Herts Musical Memories: Singing groups click here Willow Dementia Group (HILS) click here

6. Activities support physical, emotional and mental wellbeing	Imagination Dance: Movement for memory click here Hertfordshire Health Walks click here NIHR: Improving access to physical activities for people living with dementia click here
7. Family and friend involvement is encouraged, including long-distance relationships	Dementia UK: How to communicate with someone with dementia remotely click here Alzheimer's Society: Companionship for people living with dementia click here NAPA: Meaningful visits guide for friends and family click here Alzheimer's Society: Each day as it comes - staying connected click here Dementia UK: Caring for someone with dementia from a distance click here
8. Activities are adapted across all stages of dementia	Alzheimer's Society: Later stage activities click here Find Memory Care: Late-stage dementia and enhancing connection and comfort click here Occupational Therapy OT: 35 ideas by stage of dementia click here
9. Creative therapy approaches, including music therapy techniques	HCPA: Music in Hertfordshire programme resources click here **Book:** The Creative Dementia Practice Handbook: Arts for Health and Wellbeing (edited by Maria Pasiecznik Parsons and Richard Coaten) purchase here **Book**: Living well with dementia through music - a resource book for activities providers and care staff (Catherine Richards) purchase here
10. All staff contribute to meaningful engagement and occupation	HCPA: Managers best practice guide to engagement and activity — use alongside induction, role expectations and everyday engagement prompts. click here NICE QS50: Participation in meaningful activity — spontaneous and planned opportunities supported by trained staff.

	NICE quality statement on meaningful activity
11. Meaningful engagement is available throughout the day, independently of activity-coordinator presence or a scheduled programme	HCPA: Managers best practice guide to engagement and activity — use with the guide's everyday engagement prompts and records across different times of day. click here NICE QS50: Participation in meaningful activity — opportunities during the day, including spontaneous and planned activity. NICE quality statement on meaningful activity
Relevant learning videos for standard 10	Pearl Support Network: Memory box demonstration video watch here Music in Hertfordshire: Dementia sessions video library watch here Teepa Snow: Filling the day with meaning watch here

Learning and Development

Learning should help staff understand that meaningful activity is not limited to a planned activity calendar. Engagement should be part of everyday care, relationships, routines, environment and communication. All staff have a role in noticing what matters to the person and creating opportunities for connection, occupation, movement, creativity and contribution.

HCPA learning mapped to Standard 10

Standard 10 indicator	Relevant HCPA learning and development
1. A range of one-to-one and group activities are offered indoors and outdoors	Tier 1: Foundations of Dementia Care introduces person-centred support, life history and meaningful engagement. Tier 2: Extended Knowledge covers prevention, enablement, dementia-friendly environments and risk-positive care. Tier 3: Dementia Champion supports active support, evidence-based interventions and practical application. Tier 4: Managers supports leaders to ensure meaningful engagement is embedded across roles, routines and service culture.
2. Activities are personalised to interests, abilities, culture and life history	Tier 1 covers life history work and personalisation tools. Tier 2 develops understanding of changing needs and planning person-centred support. Tier 3 supports personalised, outcomes-focused care planning. Topic-specific sessions such as 'This is Me' and Creating Quality Assessments and Care

	Plans Enhanced by Life Stories support staff to translate personal history into meaningful activity.
3. Sensory engagement is embedded in activity planning	Tier 2 includes sensory loss and dementia-friendly environments. Tier 3 supports non-pharmacological approaches and evidence-based interventions. Dementia Music Champion and Music in Herts Dementia Homecare support staff to use sound, rhythm, music and personalised preferences to promote communication, wellbeing and connection.
4. Activities foster connection to the past and support being in the moment	Tier 1 and topic-specific life story learning support staff to use memory, identity and personal history respectfully. Dementia Music Champion supports use of personalised music, reminiscence and emotional connection. Tier 3 supports staff to observe and respond to verbal and non-verbal signs of engagement.
5. Opportunities extend beyond immediate services and connect individuals with wider community resources	Tier 1 includes the role of families, carers, support networks and community services. Tier 3 supports multidisciplinary working, collaboration and community connection. Tier 4 supports managers to build partnership working and ensure engagement is not limited to internal activities.
6. Activities support physical, emotional and mental wellbeing	Tier 2 includes prevention, enablement and risk-positive care. Tier 3 covers health promotion, wellbeing, active support and evidence-based interventions. Dementia Music Champion highlights the benefits of music for communication, emotional expression, cognitive stimulation, self-esteem and social connection.
7. Family and friend involvement is encouraged, including long-distance relationships	Tier 1 and Tier 2 support understanding of family, carers and support networks. Standard 3 learning on carer and family involvement should be linked to this indicator. Tier 3 supports personalised care planning and involving families in meaningful engagement where this reflects the person's wishes.
8. Activities are adapted across all stages of dementia	Tier 2 supports understanding of dementia progression and changing needs. Tier 3 supports adapting interventions, active support and measuring impact. Topic-specific learning on Early

	Onset Dementia, Rare Dementias and Therapeutic Observations can support staff to adapt engagement for people with varied and complex needs.
9. Creative therapy approaches, including music therapy techniques, are used to enhance person-centred care and wellbeing	Dementia Music Champion and Music in Herts Dementia Homecare directly support this indicator. Learning includes personalised music approaches, integrating music into life stories and care planning, developing music session plans, using instruments, singing, movement and call-and-response, and evidencing the impact of music in dementia care. For creative approaches beyond music, use the guide's existing topic-specific learning, coaching, observation and reflective practice route to address identified skill gaps; the music courses listed here do not by themselves cover every creative approach.
10. All staff recognise and contribute to meaningful engagement and occupation as part of their role	Apply the existing all-staff pathway: pre-learning and Tier 1: Foundations of Dementia Care, supported by induction and practical discussion of meaningful moments across care, night, hospitality, housekeeping, maintenance and activity roles. Use Tier 3 practice leadership and Tier 4 management learning, as described in the pathway, to reinforce role modelling, shared responsibility and assurance.
11. Meaningful engagement is available throughout the day and is not dependent on an activity co-ordinator or scheduled programme	Use the existing Tier 1 everyday-engagement approach and service-based coaching to embed spontaneous and planned opportunities in routines across the day. Apply the Tier 3 and Tier 4 responsibilities already described in the learning pathway to review handovers, weekends, evenings and periods without activity staff. Observe practice and review records to identify gaps rather than relying on a timetable.

Suggested learning pathway

Staff group	Suggested HCPA learning
All staff supporting people living with dementia	Pre-learning: Introduction to Prevalence and Types of Dementia, followed by Tier 1: Foundations of Dementia Care. Service induction should include the expectation that

	meaningful engagement is everyone's responsibility, not only the activity lead's role.
Care staff, night staff, hospitality, housekeeping, maintenance and activity staff	Tier 1, supported by practical ideas for meaningful moments during everyday care, meals, movement, conversations, personal care, household routines and outdoor access.
Activity leads, wellbeing staff, care staff and key workers	Tier 2: Extended Knowledge, with emphasis on life history, communication, sensory loss, prevention, enablement, dementia-friendly environments and risk-positive engagement.
Dementia champions and practice leads	Tier 3: Dementia Champion, with responsibility for modelling meaningful engagement, supporting staff to adapt activities, using evidence-based interventions and helping evidence impact.
Staff leading music or creative engagement	Dementia Music Champion or Music in Herts Dementia Homecare where relevant, with focus on personalised music profiles, music session planning, therapeutic techniques, observation and evidencing impact.
Registered managers, deputies and senior leaders	Tier 4: Managers: Creating a Positive Culture of Dementia Care, with focus on embedding engagement across job roles, supporting activity and wellbeing leads, enabling positive risk-taking and ensuring meaningful activities are part of governance and quality assurance.
Staff requiring targeted development	Topic-specific learning, coaching, reflective practice, observation, mentoring or competency review linked to the identified gap, such as engaging people who are withdrawn, adapting activities for advanced dementia or involving families safely and appropriately.

Course completion alone does not demonstrate competence. Providers should evidence how learning is applied through observation, care plan review, activity and engagement records, resident and family feedback, reflective practice and examples of staff adapting engagement to improve the person's experience.

Assessing competence in practice

Use observation, care-plan review and reflection to check whether staff can offer a suitable range of opportunities; personalise them to life history, culture and ability; adapt sensory, reminiscence, community, wellbeing, relationship and creative approaches; and include people at all stages of dementia. Check contributions across staff roles for indicator 10 and

review engagement at different times, including periods without activity staff, for indicator 11. Ask staff to explain the person's choice, response and next step. Record the indicator checked, observed practice, feedback, development action and reassessment. Do not use attendance alone as evidence of benefit.

Evidence

Evidence should demonstrate that meaningful activity and engagement are personalised, inclusive and embedded in everyday care. It should show how activities are planned, adapted, delivered and reviewed, and how they improve the person's experience, wellbeing, connection, independence or comfort.

Type of evidence	Possible examples for Standard 10
Care documentation	Life history records; activity preferences; care plans showing strengths, abilities, interests, culture, faith, sensory needs and preferred routines; risk-benefit assessments for engagement and community access
Observation of practice	Staff creating meaningful moments during daily care; staff adapting pace, communication, environment or activity; staff supporting movement, conversation, music, sensory engagement, occupation or outdoor access
Activity and engagement records	One-to-one and group activity records; outdoor engagement records; activity planner; records of engagement outside scheduled activities; evidence of personalised participation rather than attendance only; records across mornings, evenings, weekends and periods without activity staff, showing offers, choices, responses and gaps (indicator 11)
Resident, family and carer voice	Feedback about what the person enjoys; family input into life history, music, culture, occupation or interests; resident views and observed responses; compliments, concerns or suggestions about engagement
Creative and sensory evidence	Personalised music profiles; sensory engagement plans; music session plans; creative activity records; observations of verbal and non-verbal responses; evidence of how creative approaches are adapted; personalised creative activity plans and reviews beyond music, where relevant
Community connection evidence	Records of visitors, community groups, faith links, cultural activities, intergenerational links, local outings or virtual connections; evidence that community links reflect the person's preferences

Workforce evidence	Training records; supervision; reflective practice; staff confidence to offer meaningful moments; role descriptions or routines showing that engagement is not limited to the activity lead; observations showing contributions from different staff roles (indicator 10)
Quality assurance and governance	Activity audits; engagement observations; analysis of who is and is not engaging; action plans; resident and family feedback themes; review of whether activities are meaningful, inclusive and risk-positive
Outcomes and impact	Evidence that engagement has improved mood, comfort, connection, communication, movement, appetite, sleep, identity, independence, reduced distress or increased participation

Simple evidence cycle for meaningful activities and engagement

1. Know the person	2. Plan	3. Engage	4. Observe impact	5. Adapt and sustain
What matters to the person, and what helps them feel connected?	What activity, routine, relationship, place or sensory experience may be meaningful?	How was the person supported to take part or connect in the moment?	What did the person communicate verbally or non-verbally?	What should continue, change or stop, and who needs to know?

Suggested meaningful engagement outcome tracker

Interest, need or opportunity identified	Planned engagement approach	How impact will be measured	Review findings	Action following review
Example: the person previously enjoyed music and becomes more alert when familiar songs are played	Develop a personalised playlist and offer short music sessions during quieter parts of the day	Record attention, facial expression, movement, verbal response, signs of comfort or distress and whether the person chooses to continue	The person showed increased eye contact, tapped along to the rhythm and appeared more engaged during and after the session	Continue the playlist, involve family in adding songs, and share the approach with staff through the care plan and handover

Evidence may include photographs, audio or short video recordings where this is appropriate, lawful, securely stored and supported by valid consent or another appropriate legal basis. These should supplement, rather than replace, records showing why the activity was meaningful and whether it improved the person's experience.

Good Practice Examples

The examples below illustrate how services may support meaningful activities and engagement as part of everyday dementia care. They are not intended to prescribe a fixed activity programme. Good practice should focus on the person's identity, preferences, abilities, culture, relationships, sensory needs and current stage of dementia. The practice scenarios are illustrative, not reports of verified service outcomes.

Indicator 1: Range of one-to-one and group activities indoors and outdoors

Good practice may include:

- Offering both planned and spontaneous engagement.
- Providing one-to-one opportunities for people who do not enjoy or benefit from groups.
- Supporting outdoor activity, movement and access to fresh air where safe and appropriate.
- Ensuring night staff, domestic staff, catering staff and care staff understand their role in meaningful engagement.
- Reviewing whether people who remain in their rooms, are withdrawn or have advanced dementia are receiving meaningful interaction.
- Recording the person's response and adapting the offer.

Illustrative practice example: A person does not enjoy group sessions but chooses a short one-to-one conversation and supported time outdoors. Staff offer both alongside group options, record the person's response and review whether the range remains suitable.

Possible evidence: activity records; one-to-one engagement notes; outdoor access records; staff observations; review of who takes part and who does not; care plan updates following engagement.

Indicator 2: Personalised activities

Meaningful engagement should reflect the person, not only what is available on the activity timetable. Good practice includes using life history, culture, faith, hobbies, occupation, relationships, routines and abilities to shape what is offered. Personalisation may involve adapting a familiar activity, offering a smaller part of a task, or creating meaningful everyday roles.

Illustrative practice example: Staff learn that a person valued household routines. They offer a familiar task in manageable steps at the person's preferred time. The care plan records what the person chooses and the review checks whether the opportunity remains meaningful.

Possible evidence: life history profile; care plan; activity preference record; resident and family feedback; evidence that personal information has changed the activity offer; review of the person's response.

Indicator 3: Sensory engagement

Sensory engagement can support comfort, connection and communication, particularly where verbal communication is reduced. Good practice includes considering touch, sound, smell, taste, movement, light and visual stimulation. Staff should understand the person's sensory preferences and avoid assuming that sensory activity is always calming or enjoyable.

Illustrative practice example: Staff use the person's sensory preferences to offer a gentle, familiar sensory activity. They observe verbal and non-verbal responses, stop or adapt if discomfort appears and record what to offer next time.

Possible evidence: sensory profile; sensory activity records; observation of verbal and non-verbal responses; care plan updates; evidence of adjustments where a sensory experience causes discomfort or distress.

Indicator 4: Connection to the past and being in the moment

Activities can connect people with memories, identity and past roles, but they should also support present comfort, enjoyment and connection. Good practice avoids pressuring the person to remember or answer questions correctly. Staff should focus on emotional connection, recognition, rhythm, familiarity, sensory prompts and shared moments.

Illustrative practice example: A familiar object prompts a shared conversation without questions testing the person's memory. Staff follow the person's interest in the moment and record whether the interaction supports comfort or connection.

Possible evidence: reminiscence resources; memory boxes; personalised music or object lists; observation notes; family input; review of whether the activity supported comfort, connection or wellbeing.

Indicator 5: Wider community connection

Meaningful engagement should not be limited to the care home environment. Good practice may include links with local schools, faith communities, cultural groups, volunteers, community organisations, intergenerational projects, outdoor spaces, libraries, musicians,

artists or digital connections. Community links should reflect the person's preferences and should be supported safely.

Illustrative practice example: Staff explore a community link that reflects the person's interests, discuss how participation can be supported safely and involve those the person wishes. Feedback and observations guide whether to continue or adapt the connection.

Possible evidence: community partnership records; visitor records; event plans; risk-benefit assessments; resident and family feedback; evidence that community links are personalised rather than generic.

Indicator 6: Physical, emotional and mental wellbeing

Activities should support wellbeing in a broad sense. This may include movement, occupation, rest, stimulation, creativity, humour, reassurance, social contact, calm sensory experience, familiar routines, spiritual connection or a sense of contribution. Staff should consider whether activities reduce distress, support sleep, appetite, mobility, confidence or connection.

Illustrative practice example: A person chooses short opportunities for movement and social contact. Staff record the intended wellbeing outcome, observe participation and comfort and review whether timing or support needs adjustment. These records are not treated as proof of slower dementia progression.

Possible evidence: wellbeing observations; care plan outcomes; activity and engagement records; falls or mobility considerations; nutritional or sleep observations where relevant; evidence of changes made following review.

Indicator 7: Family and friend involvement

Families and friends can support meaningful engagement by sharing life history, photographs, music, cultural traditions, favourite routines or important relationships. Where families live at a distance, services should help maintain connection through telephone calls, video calls, letters, photographs, recorded messages or shared playlists where appropriate.

Illustrative practice example: A person's friend lives at a distance. Staff agree a suitable way and time to stay in contact, support the call or shared message and observe the person's response. The arrangement is reviewed with the person rather than continued automatically.

Possible evidence: family involvement records; communication logs; agreed contact arrangements; digital contact support plans; family feedback; evidence that family input has shaped activity or engagement.

Indicator 8: Adapting activities across all stages of dementia

Activities should be adapted as dementia progresses. Good practice includes simplifying steps, reducing distractions, changing timing, adapting the environment, shortening sessions, using sensory prompts, offering reassurance and focusing on participation rather than completion. People who appear withdrawn should still be offered gentle, personalised opportunities for connection.

Illustrative practice example: A previously enjoyed activity becomes difficult to sustain. Staff shorten the session, simplify steps and offer sensory prompts without pressure. Records show the person's responses and inform the next adaptation.

Possible evidence: adapted activity plans; observation records; care plan reviews; evidence of engagement for people with advanced dementia; staff reflection; changes made where an activity no longer supports the person.

Indicator 9: Creative therapy approaches, including music therapy techniques

Creative approaches can support communication, identity, emotional expression and connection. Music may be particularly effective when it is personal to the individual and linked to their life story, culture and preferences. Good practice includes personalised playlists, singing, rhythm, movement, instruments, passive or active listening, reminiscence and structured music sessions where staff have appropriate skills. Other personalised creative approaches may include creative activity, movement and reminiscence, chosen around the person's preferences and abilities. Select the approach within staff skills and seek relevant professional input where needed.

Illustrative practice example: Staff offer a personalised creative session using music, movement or another familiar creative activity within their skills. They record the person's choice and responses and review which elements support connection, comfort or expression.

Possible evidence: personalised music profile; music session plan; Dementia Music Champion action plan; observation of verbal and non-verbal response; evidence of impact on mood, communication or distress; review of playlists or creative approaches over time. Include plans and reviews for non-music creative approaches where these are used.

Indicator 10: Meaningful engagement and occupation are everyone's responsibility

Meaningful engagement should not rely only on the activity coordinator or scheduled group sessions. All staff can support engagement through conversation, personal care, mealtimes, household routines, outdoor access, music, movement, humour, reassurance and noticing what matters to the person.

This means asking:

- What does this person enjoy, recognise or respond to?
- What roles, routines or relationships give them a sense of identity?
- How can engagement be built into ordinary daily care?
- How can the activity be adapted so the person can take part safely?
- What does the person communicate through words, body language, facial expression or behaviour?
- What impact did the engagement have, and what should happen next?

Illustrative practice example: Care, hospitality and housekeeping staff identify meaningful moments in routines, using the person's recorded interests and preferences. They share useful approaches at handover and record the person's response. Observation checks that engagement is supported across roles rather than left solely to the activity team.

Possible evidence: care observations; staff reflection; role descriptions; handover notes; engagement records across different times of day; evidence that staff beyond the activity team contribute to meaningful engagement.

Indicator 11: Meaningful engagement throughout the day

Plan for meaningful engagement across the person's day, including mornings, evenings, weekends and periods when activity staff are absent. Combine spontaneous opportunities with planned support, respect the person's choices and need for rest, and ensure suitable resources and guidance are available across shifts.

Illustrative practice example: A review identifies that a person has few opportunities for engagement when the activity coordinator is absent. The team uses the person's preferences to agree meaningful moments within meals, conversation and household routines. Staff share the approach across shifts and review records and observations at different times to identify remaining gaps.

Possible evidence: engagement records across times and shifts; handover guidance; accessible personalised resources; observations when activity staff are absent; resident and family feedback; action and review records addressing gaps.

What Good Looks Like at a Glance

- Activity and engagement are personalised, not limited to a generic timetable.
- People have access to one-to-one, group, indoor, outdoor, spontaneous and planned engagement. Opportunities are available throughout the day and do not depend on activity-coordinator presence or a scheduled programme.
- Life history, culture, faith, interests, relationships and abilities shape the activity offer.

- All staff recognise and contribute to meaningful engagement and occupation within their everyday role, not only designated activity or wellbeing staff.
- Engagement is adapted for people at all stages of dementia.
- People who are withdrawn or less able to initiate engagement are still supported to connect.
- Sensory engagement is planned, observed and reviewed.
- Music and creative approaches are used where meaningful to the person.
- Family and friend involvement supports relationships and personalisation where appropriate.
- Community links reflect individual preferences and promote connection.
- Positive risk-taking enables participation rather than unnecessarily restricting opportunity.
- Staff record more than attendance; they record response, meaning and impact.
- Activities support comfort, identity, independence, movement, social connection and wellbeing.
- The service reviews who is and is not benefiting from the activity and engagement offer.
- Evidence shows how engagement improves the person's experience or outcomes.

Appendix 1: Glossary of Terms

Term	Draft definition
Activities of daily living	Everyday tasks and routines that support a person's independence, comfort and quality of life, such as personal care, eating, drinking, moving around, dressing and participating in household or social routines.
Advance care planning	A process that supports a person to think about and record their wishes, preferences and priorities for future care, particularly if their needs change or they are unable to make or communicate decisions later.
Advocacy	Support that helps a person understand information, express their views, uphold their rights and be involved in decisions about their care and support.
Anticipatory care planning	Planning that considers current needs alongside likely future changes, so support can be prepared in advance rather than only responding during a crisis.
Assistive technology	Equipment, devices or digital tools used to support independence, safety, communication, orientation or reassurance. Examples may include sensor technology, reminder devices, call systems or communication aids.
Best-interest decision	A decision made on behalf of a person who lacks capacity to make a specific decision at that time. It must follow the Mental Capacity Act 2005 and consider the person's wishes, feelings, beliefs, values and least restrictive options.
Capacity	A person's ability to make a specific decision at the time it needs to be made. Capacity is decision-specific and time-specific.
Carer	A person who provides unpaid support to someone who needs help due to illness, disability, dementia, mental health needs, addiction or age-related needs. This may include family members, friends or significant others.
Cognitive stimulation	Activities and interactions that support thinking, memory, attention, communication and engagement. These should be meaningful and adapted to the person's interests and abilities.
Communication passport	A short, practical profile that helps staff understand how a person communicates, including preferred name, language, sensory

	needs, non-verbal communication, communication aids and helpful approaches.
Consent	A person's agreement to care, treatment, support or information sharing, given freely and with enough information to make an informed choice.
De-escalation	Approaches used to reduce distress, tension or risk by adapting communication, environment, tone, pace, demands or support before distress increases.
Dementia-friendly environment	An environment designed and used in a way that supports orientation, independence, safety, comfort and recognition for people living with dementia. This may include lighting, signage, contrast, layout, noise reduction and familiar cues.
Distress	A state of discomfort or upset that may be shown through words, facial expression, body language, behaviour, withdrawal or changes in presentation. The document uses distress as communication that should be understood and responded to.
Equality, diversity and inclusion	An approach that recognises and respects people's individual identities, rights, cultures, faiths, relationships, backgrounds, needs and preferences, and seeks to remove barriers to fair care and support.
Evidence-based intervention	An approach or intervention informed by research, recognised guidance, professional knowledge, lived experience and review of what works for the individual person.
Good governance	Systems and processes that help services monitor quality, manage risks, learn from feedback and incidents, evidence compliance and continuously improve care.
Human rights	Basic rights and freedoms that protect dignity, privacy, autonomy, family life, safety and fair treatment. These rights apply to people living with dementia and should remain central to care decisions.
Lasting Power of Attorney	A legal arrangement that allows a person to appoint someone to make certain decisions on their behalf if they lose capacity in the future. Staff should understand what type of authority is held and what decisions it covers.
Least restrictive option	The approach that meets the person's needs while limiting their rights, freedom or choices as little as possible.
Life history	Information about a person's past and present life, including relationships, culture, work, interests, routines, important events, preferences and what matters to them.

Meaningful activity	Activity or engagement that has personal value to the individual. It may be planned or spontaneous and can include conversation, movement, music, routine, occupation, outdoor access, sensory engagement or connection with others.
Mental Capacity Act 2005	The law that sets out how to support people to make decisions and how to make decisions in their best interests if they lack capacity for a specific decision.
Non-pharmacological approaches	Supportive interventions that do not rely on medication, such as communication changes, environmental adjustments, sensory engagement, personalised activity, music, reassurance, routines or Positive Behaviour Support.
Outcome	The difference made by care or support for the person, such as improved comfort, safety, independence, wellbeing, communication, connection or reduced distress.
Person-centred care	Care and support that starts with the person's identity, wishes, strengths, rights, relationships, history, culture, needs and preferences rather than their diagnosis or tasks alone.
Positive Behaviour Support	A person-centred approach used to understand distress or behaviour as communication and to develop proactive, least restrictive strategies that improve quality of life.
Positive risk-taking	Supporting people to make choices and take part in meaningful activities while managing risks proportionately, rather than avoiding all risk at the expense of independence or quality of life.
Proportionate evidence	Evidence that is meaningful and sufficient to show how care is delivered and reviewed, without creating unnecessary duplication or excessive recording.
Restriction	Any practice, decision or environmental control that limits a person's movement, choice, privacy, access or independence. Restrictions should be necessary, proportionate, lawful and regularly reviewed.
Risk-benefit assessment	An assessment that considers both potential risks and the benefits of an activity, choice or intervention, including independence, identity, wellbeing and quality of life.
Sensory engagement	Activities, environments or interactions that involve the senses, such as sound, smell, touch, taste, movement, lighting or visual stimulation, and are adapted to the person's preferences and responses.

Social environment	The atmosphere and interactions created by staff, residents, visitors, routines, communication, relationships and culture within the service.
Therapeutic intervention	A planned, personalised approach intended to improve comfort, wellbeing, communication, connection or reduce distress. This may include music, reminiscence, sensory approaches, movement, environment changes or structured observation.
Wellbeing	A person's overall sense of comfort, dignity, connection, identity, safety, purpose, emotional health, physical health and quality of life.

Appendix 2- Challenges and Barriers

Standard	Challenges and barriers identified	Mitigations or improvement actions
Standard 1 – Person Centred Care	Providers identified that it can be difficult to know what evidence is expected, particularly where care plans are lengthy but do not clearly show the person's goals, outcomes or the impact of interventions.	Develop a simple model care profile or worked example showing what proportionate evidence looks like. Encourage services to record personal outcomes before evaluating interventions, using the cycle of understand, plan, deliver, review and improve.
Standard 1 – Person Centred Care	Life history information may be incomplete or delayed, especially where families are unavailable, hospital information is out of date, or a person's needs change gradually.	Strengthen pre-admission and life history prompts, involve family, friends and professionals where appropriate, and use daily notes, handovers and care reviews to capture small but meaningful changes.
Standard 1 – Person Centred Care	Staff may be delivering good person-centred care but not consistently recording how preferences, strengths, daily choices, changing dependency and emotional responses are understood and acted on.	Reinforce that evidence can include staff explanation, observation, resident response, family feedback and impact statements, not only formal care plan entries.
Standard 3 – Carer and Family Involvement	Providers described family dynamics as one of the most difficult areas to manage and evidence. Barriers include families having different views, unclear or changing LPA arrangements, relatives assuming decision-making authority where the person still has capacity, and family expectations differing from the person's wishes.	Use admission and review processes to agree main contacts, preferred communication routes, consent and information-sharing arrangements. Record relationship maps, LPA checks, family dynamics, boundaries and any best-interest considerations clearly.
Standard 3 – Carer and	Some families are at the beginning of their understanding	Offer regular communication through care reviews, phone calls,

Family Involvement	of dementia when the person is already further along their journey, which can lead to distress, disagreement or repeated concerns.	newsletters, family portals or relatives' forums, and document what has been shared. Support staff to have confident, compassionate conversations about dementia progression, capacity, rights and boundaries.
Standard 3 – Carer and Family Involvement	Carers may need support in their own right, but may not always engage with signposting or information offered.	Strengthen signposting to Memory Support Hertfordshire, Carers in Hertfordshire, Alzheimer's Society and other support routes, and consider peer support between relatives where appropriate.
Standard 9 – Supportive Environment	Providers identified that environments vary significantly, with some homes purpose-built and others in older or listed buildings where layout, ensuite provision, lighting, flooring or redesign options may be limited.	Promote proportionate environmental review rather than expecting all buildings to look the same. Encourage homes to evidence how they play to the strengths of their environment and mitigate limitations through personalised rooms, memory boxes, meaningful objects, clear signage, contrast, safe walking routes, sensory approaches and outdoor access.
Standard 9 – Supportive Environment	Financial cost was raised as a barrier for larger environmental changes, assistive technology, interactive tables and customisable equipment.	Encourage services to identify low-cost, high-impact adjustments first and share practical examples through peer learning visits between homes.
Standard 9 – Supportive Environment	There was uncertainty about what "appropriate" lighting, flooring and signage would be assessed against.	Develop clear guidance or prompts on lighting, flooring, signage and contrast expectations, with examples of reasonable adjustments.
Standard 9 – Supportive Environment	Additional barriers included inconsistent recording of environmental adaptations, sensory needs such as smell and sound being less routinely considered, language barriers, internet or digital system issues,	Support staff to record why environmental changes were made and whether they improved comfort, orientation, safety or independence. Consider a short resource for visiting professionals on respectful language and

	and inappropriate language from external professionals.	escalation routes where professional language or practice does not align with the standards.
Standard 10 – Meaningful Engagement, Activity and Occupation	Providers highlighted that meaningful engagement can be misunderstood as scheduled activities rather than everyday occupation, connection and wellbeing.	Reframe meaningful activity as meaningful engagement and wellbeing, with all staff responsible for creating everyday moments of connection. Embed engagement into care, mealtimes, conversations, household routines, outdoor access and personal care.
Standard 10 – Meaningful Engagement, Activity and Occupation	A key barrier is reliance on activity coordinators, with gaps at weekends or when activity staff are not available.	Embed responsibility for meaningful engagement across all staff roles and make everyday interactions part of the service's activity and wellbeing offer.
Standard 10 – Meaningful Engagement, Activity and Occupation	Staff may provide meaningful moments but not record them consistently, especially where recording systems encourage tick-box attendance rather than person-centred impact.	Use care plans and daily records to capture what was meaningful, how the person responded and what should be continued, changed or stopped.
Standard 10 – Meaningful Engagement, Activity and Occupation	Other barriers include limited life history information, people's preferences changing as dementia progresses, some people not wishing to engage in groups or one-to-one activity, limited community resources for younger people with dementia, relatives unintentionally disrupting meaningful activities, and difficulty evidencing engagement where the person's response is subtle or non-verbal.	Encourage homes to review who is not engaging and why, including whether this reflects preference, dementia progression, anxiety, communication needs or lack of suitable options. Strengthen links with community services, schools, volunteers, faith groups, music programmes and local dementia-friendly opportunities, including more in-reach into care homes. Support family communication so relatives understand the value of activities and can contribute without unintentionally disrupting meaningful routines.