Royal College of Nursing

NURSING PRACTICE ACADEMY

Commitment to the Care of People living with Dementia

SPACE principles

NURSING PRACTICE ACADEMY

Acknowledgements

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Introduction

This updated document is designed to be used in a wide range of health and social care settings and has included the most recent evidence and best practice.

The NHS Long Term Plan

The NHS 10-year health plan, *Fit for the Future*, published on 3 July 2025, sets out three main shifts in care, from hospital to community, from analogue to digital, and from treatment to prevention. A modern service framework for frailty and dementia will set standards for care and identify the best types of support that health professionals should provide for people with dementia and their carers, whether in hospital, at home or in care homes. This publication provides principles that nurses and other health and social care staff can use to fulfil that commitment.

Principles

This document sets out the five principles that form a shared commitment to improving care for people with dementia and their families. They are based on evidence gathered from over 1,200 people living with dementia, carers and 700 practitioners. Each principle is considered essential to ensure the appropriate delivery of care.

This guide is for nurses and other staff working in health and social care settings, as well as senior managers and directors. The aim is to support the implementation of the SPACE principles and embed good quality practice in the care of people with dementia and their families.

SPACE

Staff who are skilled and have time to care.

Partnership working with carers.

Assessment, early identification of dementia and post diagnostic support.

Care and support plans which are person-centered, holistic and individual.

Environments that are dementia friendly.

These resources can be used along with other initiatives that support innovation and improvement. Staff and patient/resident teams should use them to support the development of practice in a systematic way that demonstrates real benefits for patients, carers and staff.

This requires dedicated leadership, development of shared action plans and evaluating outcomes, particularly patient and carer experience.

A checklist to support leadership in this area can be found in **Appendix 1**.

Appendix 2 shows a spidergram (visual tool) to assess status and areas for further development.

Dementia – what is dementia?

The term dementia is used to describe a range of conditions which affect the brain and result in an impairment of the person's function. The person may experience memory loss, problems with communication, impaired reasoning, and difficulties with daily living skills.

This can result in changes in behaviour, which can disrupt their ability to live independently and may affect social relationships. There are more than 100 different types of dementia. The most common cause is Alzheimer's disease, where there tends to be a progressive and gradual decline over time. Another common type is vascular dementia, where small blood vessels in the brain become damaged and the circulation is affected. Other types include dementia with Lewy bodies, fronto-temporal lobe dementias, Posterior Cortical Atrophy and alcohol related dementia.

Each type of dementia has different features and people may experience elements of more than one type of dementia, in which case a mixed dementia may be diagnosed. Although dementia is more prevalent with increasing age, it is not a normal feature of ageing.

Dementia can also affect younger people and it is estimated that more than 70,000 people in the UK under the age of 65 have young onset dementia according to **Young onset dementia: facts and figures** (Dementia UK).

Dementia is a progressive and terminal condition, which will in most cases lead to increasing cognitive difficulties and dependence on others. How long the person will live depends upon the type of dementia, their age and their general health, but many will live with the condition for several years and can have a good quality of life.

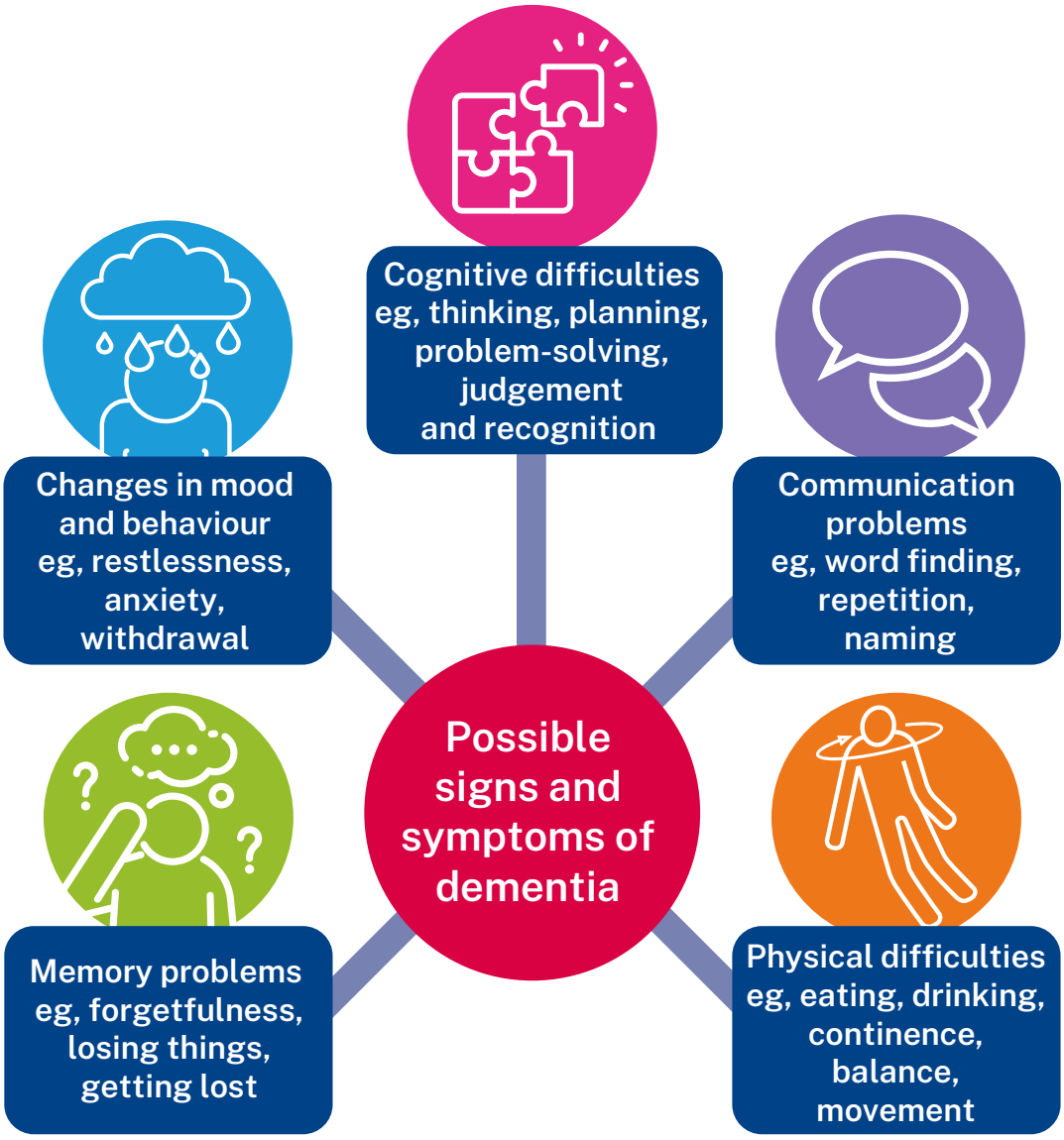
The recognition of dementia as a 'disability' provides individuals with legal rights and gives protection under disability legislation. This ensures those with dementia have their human rights recognised and have equal access to opportunities and services through reasonable adjustments. This is an important concept in the delivery of dementia care.

A humanistic approach to dementia care has produced the PANEL acronym: Participation, Accountability, Non-discrimination and equality, Empowerment and Legality of rights. This promotes the right to tailored and adequate support services, regardless of age and stage of dementia.

Symptoms of dementia

Common symptoms of dementia include memory problems, changes in cognitive ability, difficulties with communication, changes in mood and behaviour and physical difficulties.

Figure 1: Symptoms of dementia



For more information see: **What are the signs and symptoms of dementia?** (Dementia UK)

While there are common symptoms of dementia not all of them may be present and each person will be affected in a different way. This depends on the type of dementia, the stage of the illness, the individual's personality and importantly, the way others interact with them. Some people have limited awareness of their difficulties and as the condition progresses, insight tends to decline along with other cognitive abilities.

People living with dementia may also experience depression and older people who are acutely ill commonly experience delirium.

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Delirium and dementia

Delirium is a disturbance of consciousness and a change in cognitive functioning that develops over a short period of time, and which can fluctuate during the course of the day.

People affected may become more “confused”, disoriented, agitated, restless or drowsy and withdrawn and unable to think or remember clearly. They may experience visual or auditory hallucinations and develop abnormal thoughts or sudden mood swings.

Delirium is a medical emergency requiring urgent treatment and it is attributed to physical factors (dehydration, constipation, changes in environment, pain, sensory impairments, etc.) and medical factors (surgery, acute infection, medications etc).

People with dementia have an increased risk of developing delirium due to progressive frailty, gradual worsening of memory and cognition, and/or increased difficulty in articulating their needs and symptoms.

Delirium may be prevented in up to one third of older patients through effective interdisciplinary prevention, diagnosis, treatment of the underlying cause and supportive nursing care.

Research indicates that many older people who have delirium will either also have an underlying dementia or have an increased chance of developing dementia.

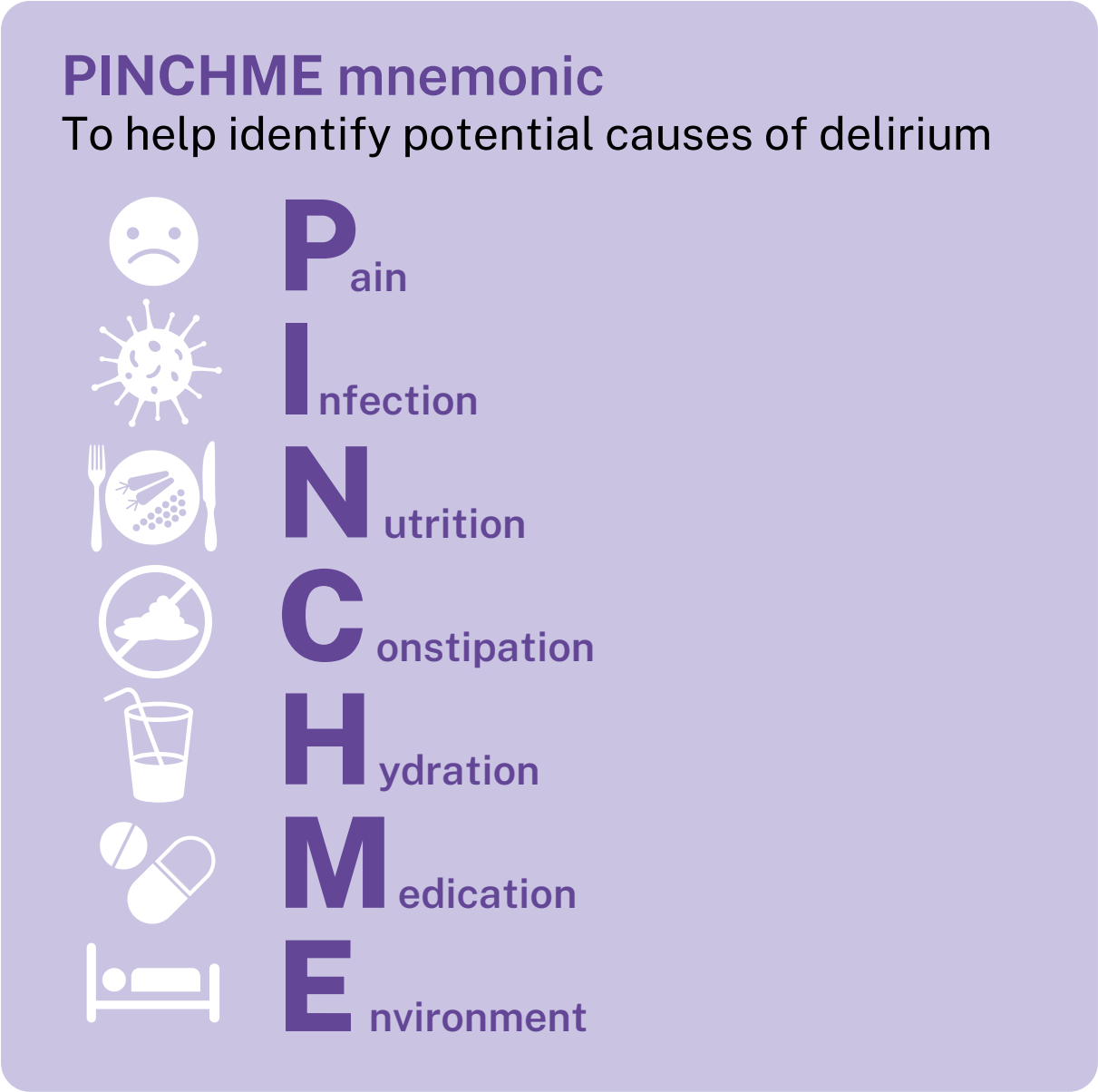
There are three types of delirium.

1. Hyperactive delirium where the person presents with agitation, hyper-alertness, aggression, and irritability.
2. Hypoactive delirium where the person presents with drowsiness, sleepiness and inattention which is the hardest to detect as it is often thought that the person is just too tired and catching up with some sleep/rest or depression.
3. Mixed delirium where the person presents with both types (hyperactive and hypoactive) either on the same day or on alternate days.

It is important to highlight that delirium is an acute onset of temporary confusion which is often fully resolved once all the reversible causes are treated. Dementia, on the other hand, is a gradual decline in memory and cognition (depending on the type of dementia) which sometimes takes years for a person to either recognise or admit to experiencing symptoms and seek support and diagnosis.

Diagnosis of delirium involves the use of a screening or assessment tool, these can be different depending on the setting.

Figure 2: Recognising the causes of delirium involves the use of the PINCHME acronym.



Essential to the delivery of high quality and compassionate nursing care for patients with delirium is education about delirium for all staff, patients and families as it is often missed from the assessment and management process. Education about delirium is important to achieve holistic and personalised care.

For more information about delirium please visit: **Delirium and dementia: symptoms, causes and treatment** (Dementia UK).

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Depression and dementia

Depression is a condition characterised by low mood that usually develops over weeks or months but can result in significant problems with concentration, sleep patterns and impaired functioning. Identification of depression is very important as treatment can be offered which can reduce or remove these symptoms.

Symptoms of depression can mimic symptoms of dementia such as poor concentration, agitation or restlessness, disturbed sleep, and changes in functioning but depression can be treated with psychological therapies and/or medication.

It is estimated that at least 24% of people with dementia are experiencing symptoms of depression that is not being treated or managed effectively. **NICE Guideline NG222** and **Clinical Guidance CG91** provides more information about depression in older adults including people living with dementia.

Older adults who have depression may experience it differently from younger adults. They may present with agitation and health-related anxiety. Older adults are more likely to be living with other long-term conditions which may cause pain, and this can accelerate symptoms of depression.

Depression can affect memory and cognition which is often confused with symptoms of dementia, so it is important to consider assessing for depression.

There are a number of factors which can exacerbate symptoms of depression

- **Physical health problems**
  Older adults often live with multiple long-term conditions which can lead to depression.
- **Excess alcohol use**
  Alcohol excess will affect the chemistry in the brain increasing the risk of depression and dementia.
- **Loneliness**
  Older people could be experiencing loneliness due to bereavement, long-standing health problems or living alone. Older adults may be at higher risk of developing depression due to chronic loneliness.
- **Moving into care homes**
  Some older adults who move into care homes may experience feelings of loss and struggle with the new environment or routines. People with dementia may struggle to process their emotions resulting from this change – this can result in low mood and/or depression.

Distinguishing between delirium, depression and dementia is an important aspect of assessment and all people who present as ‘confused’ should be assessed carefully. Staff should have awareness training for all three conditions and be able to make appropriate referrals.

The person living with a dementia

It is vital to understand that while some general statements can be made about dementia, each person with dementia will be affected differently. Also, while a diagnosis of dementia fundamentally changes the way in which a person functions, it is only one aspect of their life. Rather than seeing 'someone with a dementia' it is essential to seek to understand the individual. Knowing and respecting each person remains central to the relationship and includes:

- valuing people with dementia and those who care for them and recognising their rights
- not using stigmatising terms when referring to people living with dementia, and ensuring that family and friends are aware of this too
- using inclusive and sensitive language, appreciating generational differences and adapting communication style appropriately
- treating people as individuals; appreciating that all people have a unique history and personality
- looking at the world from the perspective of the person and listening to their voice
- recognising that all human life is grounded in relationships and that people need to live in a social environment, which supports their wellbeing
- understanding changes related to behaviour and mood
- affording opportunities for new and life affirming experiences
- responding to distressed behaviour in a calm and compassionate way.

The role of family carers

Family carers often have a crucial role in the care of people with dementia. When a person with dementia develops a physical health problem and/or their behaviour changes the carer is often the first to be aware of this.

As capacity declines, family carers can provide vital information about the person's needs and preferences so that the right care and treatment is provided. Carers should be kept involved and informed throughout assessment and treatment of the person they care for.

Family carers also have their own needs, which should be assessed and taken into account. It is known that carers of people with dementia can experience greater strain and distress than carers of people with other conditions. In addition, many carers of people with dementia are older people themselves, with physical needs and health conditions of their own.

Carers, informal carers or families sometimes feel more comfortable when they are called by their marital or familial capacity, for example husband or wife, daughter or son; practitioners may say "are you Mrs. Jones' husband?" which is factual and may be comforting for the carer.

Family carers may experience anticipatory grief as their loved one changes due to the progression of dementia. It is important to make time to explore and validate these feelings before encouraging the carer to accept the person with dementia as they are on the day and support them to understand their presentation may change daily.

Family carers should be offered an assessment in their own right and be supported in their caring role through psychoeducation, skills training, access to support services and psychological support such as Admiral Nurse support.

Admiral Nurses are registered nurses with experience in dementia care, more information is available at: **dementiauk.org**

SPACE principles

Principle 1: Staff who are trained and confident to support people with dementia

Staff need to be informed, educated, skilled, and have the right equipment and enough time to care in the most appropriate setting.

Proposed strategy to achieve principle 1

- Good quality training and education in dementia for all staff that is easy to access, practical and focuses on attitudes/approach and communication and is based on recognised guidelines.

This involves listening to the way people with dementia want to be cared for and hearing the views of family carers. A flexible approach to training delivery, for example, considering alternative means of delivery, virtual, hybrid, outside of classroom setting, simulation training, bitesize sessions on specific topics.

It is recommended that:

- all staff have training in dementia awareness and are informed about the needs of those affected by dementia
- staff who have regular responsibilities for providing care have an enhanced knowledge and are skilled in dementia care
- focus on values, attitudes and approach of staff, which supports good communication and a relationship-centred approach.
- use experiential learning in addition to theoretical concepts.

In addition

- Each service should have an identified clinical lead for dementia, with an expert level of skills and knowledge.
- Careful consideration must be given to staffing to ensure that skill mix, ratio and numbers of staff are adequate to support the complex needs and numbers of people with dementia being cared for.

Principle 2: Partnership working

Effective care requires a relationship-centred approach, which acknowledges the needs of families and carers as well as the person with dementia. It is important to learn from carers about the person with dementia and how they function best in everyday life. It is also important to recognise that carers may themselves feel in need of support.

Family carers can experience stress in relation to finances, changes in role, practical demands, emotional and physical needs. For example, they may have physical health problems, emotional difficulties due to changes in their relationship and be experiencing feelings of loss. However, carers who are supported and can derive something positive out of caregiving have better wellbeing.

It is essential for staff to work in partnership with people with dementia and their family carers so that needs are understood and recognised.

Proposed strategy to achieve principle 2

- Recognition and assessment of both the person and family carers' needs following diagnosis.
- Involvement in assessment, care planning and decision-making, including family carers/supporters where appropriate.
- Flexible visiting and flexible approaches so that family carers/supporters can be involved directly in care where desired – see John's campaign.
- In the event that an individual does not have access to **family/carers**, advocacy should be arranged. This can be achieved by following local guidelines and policies.
- Engagement with and signposting to local community resources. Signposting people to appropriate community support such as local peer support groups, charities and events.
- Relationship-centred care identifies the person with dementia, family or friends, and practitioners. Quality of care is dependent on the relationships between each of these agencies.

Principle 3: Assessment, early identification of dementia and post diagnostic support

Assessment is fundamental to achieve the services and support that a person with dementia will need. Reasons for assessment should be explained to the individual and their families. Some may not be comfortable to undergo screening or fear the implications of stigma within their community. Prior to any assessment it is important to create a good therapeutic environment for communication and ensure the person can see and hear to the best of their ability with aids as necessary.

Systematic identification of people with cognitive impairment is also likely to improve the detection of delirium and depression and give opportunities to support them better. As dementia progresses or if the individual has complex health needs, further assessment should be tailored to the person's individual needs.

The Comprehensive Geriatric Assessment (CGA) for older people provides a holistic approach to assessment which helps to identify a person's medical, social and functional needs and the development of an integrated and coordinated care plan to address these needs

See: **Comprehensive Geriatric Assessment (CGA) Hub** (British Geriatrics Society)

Strategy to achieve principle 3

Use of validated and agreed screening and assessment tools such as GPCog, MoCA, ACEIII, RUDAS for dementia and CAM or 4AT for delirium.

It can be difficult when a person does not have a diagnosis of dementia but seems to have symptoms. As the diagnosis of dementia is complex, most screening tools are used to identify the presence of cognitive impairment. The term cognitive impairment is an overarching term for someone who may be experiencing problems with memory, perception, judgment and reasoning. It is recommended that there are agreed processes for screening and assessment so that people with a cognitive impairment receive the right treatment and care, depending on whether they have dementia, delirium and/or depression.

Assessment of dementia should include:

- a full medical history of the person, including any previous physical or mental health problems
- a physical examination, to rule out any treatable causes including delirium and depression
- an initial test or screen of the person's cognitive abilities
- gathering collateral history from a relative or friend who knows the person well
- skilled knowledgeable practitioners, who have received appropriate dementia training to support assessment and to build confidence in supporting people with dementia and their carers.

Clear delirium protocols, dementia/depression pathways and referral to post diagnostic support.

As dementia and delirium share commonalities, having an agreed pathway in place for people with dementia and delirium can help ensure that people receive the right treatment and care.

- Clinical review of medication to address any polypharmacy and ensuring any use of antipsychotic medication is only as a last resort and on a short-term basis. Antipsychotic medication should be used alongside non-pharmacological approaches to manage distress.
- Some people with dementia may exhibit behaviours which can be described as distressed, agitated and uncharacteristic. This may be due to neuropsychiatric symptoms of dementia (formally known as behavioural and psychological symptoms of dementia BPSD), and requires an individual and sensitive response.
- It is important to understand that distressed behaviours are not always due to dementia. Factors such as boredom, pain, discomfort disorientation or misinterpreting information may cause distress.
- There are two main responses to neuropsychiatric symptoms of dementia – pharmacological (medication) and non-pharmacological (use of other strategies and activities).

Principle 4: Care and support plans which are person-led and individual

All people with a diagnosis of dementia should be offered a care and support plan by a nominated professional who will co-ordinate their care. If people initially refuse a care plan, the offer should be re-made routinely at subsequent appointments. Ensuring that care is based on the individual, their biography, preferences and an understanding of their abilities is particularly important for people with dementia in achieving person-led care. This requires an understanding of the way dementia affects that person and how care can be adapted to compensate for and meet individual needs.

Care plans should be developed collaboratively and be communicated clearly with families and those providing care. Care plans will be person-led, responsive to individual needs and encompass all activities of daily living including nutrition, oral health, comfort, continence, wellbeing, rehabilitation, activity, meaningful occupation, sleep, advance care wishes, safeguarding needs and end-of-life care.

Care plans should be held by the person. There should also be a copy within their medical records. There should be strategies in place for communication of care and support plans particularly during transitions across health and social care settings.

There are some resources available to support person-led care planning, some of which are here:

6 GEMS® You Need to Know For A Positive Approach to Dementia Care (Positive Approach to Care). This resource offers positive ways to approach and support people with dementia.

carefitforvips.co.uk

dementiahub.sg/wp-content/uploads/2022/10/full-list-of-vips-indicators.pdf

Strategy to achieve principle 4

- Routine gathering of personal life story information eg, This is Me or brief personal profiles.
- Involvement of family, friends and/or carers in care planning and review.
- Use of mental capacity act (MCA) assessments and identification of those with legal authorities i.e. lasting power of attorney, court of protection.
- Plans must include advance care planning, nutritional tools, pain assessments and safety assessment tools.
- Provision of appropriate activity to encourage social engagement, peer support, maintenance of function and wellness including recognition of spiritual and sexual health needs.
- Access to dementia specialists/leads.
- Access to and availability of palliative care specialists.

Principle 5: Environments that support people with dementia

Environments can become more difficult to navigate for people living with dementia due to changes in cognition and perception, sensory impairments, coordination and physical frailty.

Unfamiliar environments can be particularly difficult for people living with dementia. The physical environment and design play key roles for the wellbeing of people living with dementia.

The following resources provide guidance on making the environment safer:

Making the home safe for a person with dementia (Dementia UK) **dementiauk.org/information-and-support/living-with-dementia/making-the-home-safe-and-comfortable-for-a-person-with-dementia**

dementia.org.au/professionals/designing-dementia-friendly-care-environments

Dementia resources and information (University of Worcester) **worcester.ac.uk/about/academic-schools/school-of-health-and-wellbeing/health-and-wellbeing-research/association-for-dementia-studies/dementia-resources-and-information**

alzheimers.org.uk/get-support/publications-factsheets

Strategy to achieve principle 5

- **Minimal moves to avoid unnecessary distress**
  Moving between environments can cause unnecessary distress to people living with dementia and such moves should only be undertaken when it is in the best interests of the person.
- **Dementia-inclusive design features such as signage, lighting, minimising noise**
  This also considers accessibility to spaces indoors and outdoors that are re-enabling for people living with dementia, stimulating and adapted to their needs, for example raised flower beds with edible plants in them.

  kirklees.gov.uk/beta/health-and-well-being/pdf/kirklees-dementia-design-guide.pdf
- **Personalised space**
  Regardless of facility, individuals should have access to items they recognise as their own, this can include personal possessions.
- **Resources to support activity and stimulation**
  Settings should ensure people have access to rehabilitative opportunities and opportunities to maintain functional independence – this might include cooking, gardening, pet care, etc.
- Involvement of trained volunteers to support social and pastoral care.
- Sensitive use of technology to support independence.

There is an increasing opportunity for the sensitive use of technology to support independence, this might include alarms, prompts, tracking and visual surveillance. This should be undertaken with the permission of the person and/or family/legal representatives. Ideally people with dementia should participate in the development of new technologies to foster a dementia-inclusive culture.

Summary

These guidelines are not exhaustive, but when embedded into practice the SPACE principles will support the assessment, planning, and delivery of good quality care for people living with dementia.

Appendix 1: Checklist

Commitment to the care of people with dementia

We believe that more can be done to improve the care of people with dementia.

These principles have been identified as essential in ensuring the appropriate delivery of care.

Staff need to be informed, skilled and have enough time to care.

This will be supported by:

- good quality training and education in dementia that is easy to access, practical and focuses on attitudes/approach and communication. Training should be made available to all staff based on an analysis of training needs, and incorporate perspectives of people with dementia and carers
- availability of identified clinical leads for dementia eg dementia specialists/nurses, mental health liaison, dementia champions
- careful consideration of staffing levels which ensures that skill mix, ratio and numbers of staff are adequate to support the complex needs and numbers of people with dementia being cared for.

Join us in putting these principles into practice.

Please use the following checklist to help identify achievements and areas for further development.

Family, carers and friends are seen as partners in care.

This will be supported by:

- recognition and assessment of carers' needs
- involvement of families/friends in assessment, care planning and decision making
- flexible visiting and flexible approaches to routines so that family carers/supporters can be involved directly in care where desired.

A dementia assessment will be offered to all those at risk, to support early identification and appropriate care.

This will be supported by:

- use of agreed screening and assessment tools by skilled, knowledgeable practitioners
- clear delirium protocols and dementia pathways
- clinical review of medication to support the appropriate use of antipsychotic medication.

Care plans will be person-centred, responsive to individual needs and support nutrition, dignity, comfort, continence, rehabilitation, activity and palliative care.

This will be supported by:

- routine gathering of personal life story information
- involvement of family and friends in care planning
- use of mental capacity assessments, advance care planning, nutritional tools, pain assessments and safety tools
- provision of appropriate activity to encourage social engagement, maintenance of function and recovery
- access to and availability of palliative care specialists.

Environments will be dementia friendly and support independence and wellbeing.

This will be supported by:

- minimal moves to avoid unnecessary distress
- appropriate lighting and floor coverings plus aids to support orientation and visual stimulation
- personalised bed area
- adequate space and resources to support activity and stimulation
- availability of staff to support rehabilitation, eg, occupational therapy, physiotherapy, activity coordinators
- inclusion of trained volunteers to support activity and pastoral care.

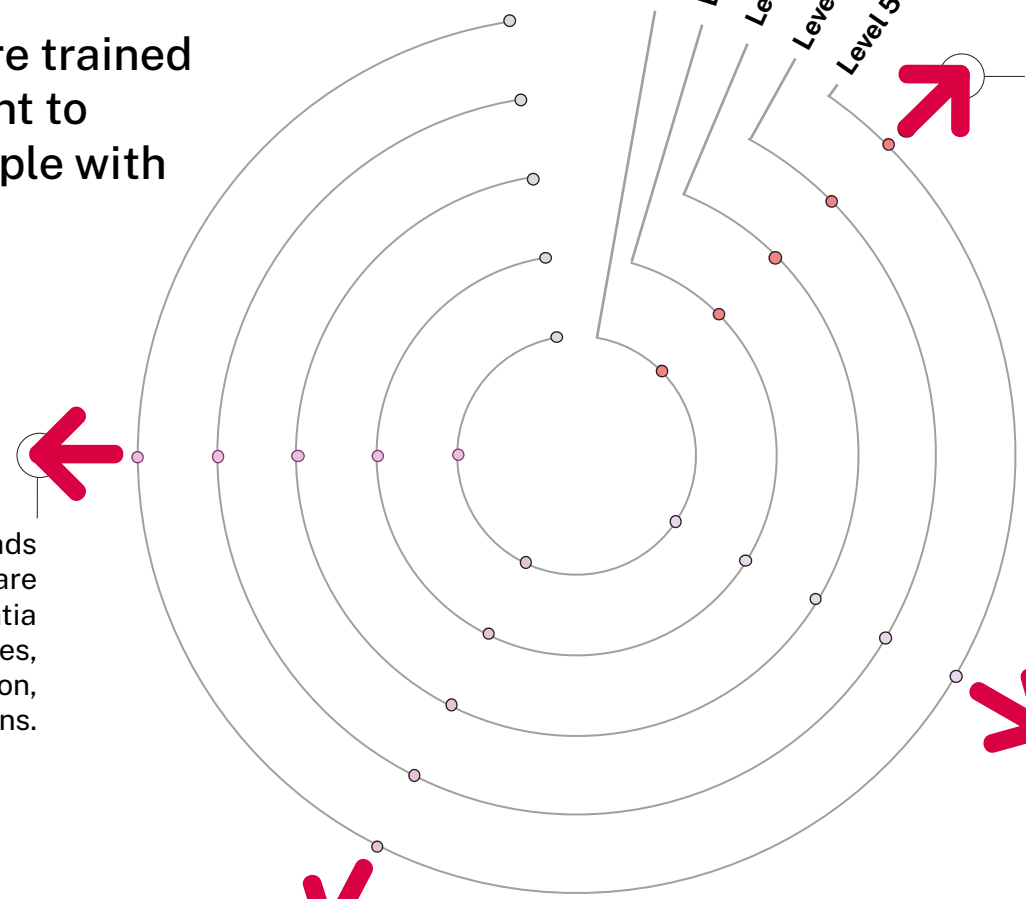
Appendix 2: Transforming dementia care spidergram

Please print these pages for use by your organisation.

Please write in the name of your organisation:

Date completed:

S Staff who are trained and confident to support people with dementia



Careful consideration of staffing levels to ensure appropriate skill mix, ratio and numbers.

Level 1: I do not see these things happening.
Level 2: there is an awareness of this but little action.
Level 3: this happens some of the time but not always.
Level 4: this happens most of the time but not always.
Level 5: I see these things happening all the time.

Good quality training and education in dementia that is easy to access, practical and focuses on attitudes/approach and communication.

Identified clinical leads for dementia are available eg, dementia specialists/nurses, mental health liaison, dementia champions.

Training is available to all staff based on an analysis of training needs.

Training includes the perspectives of people with dementia and carers.

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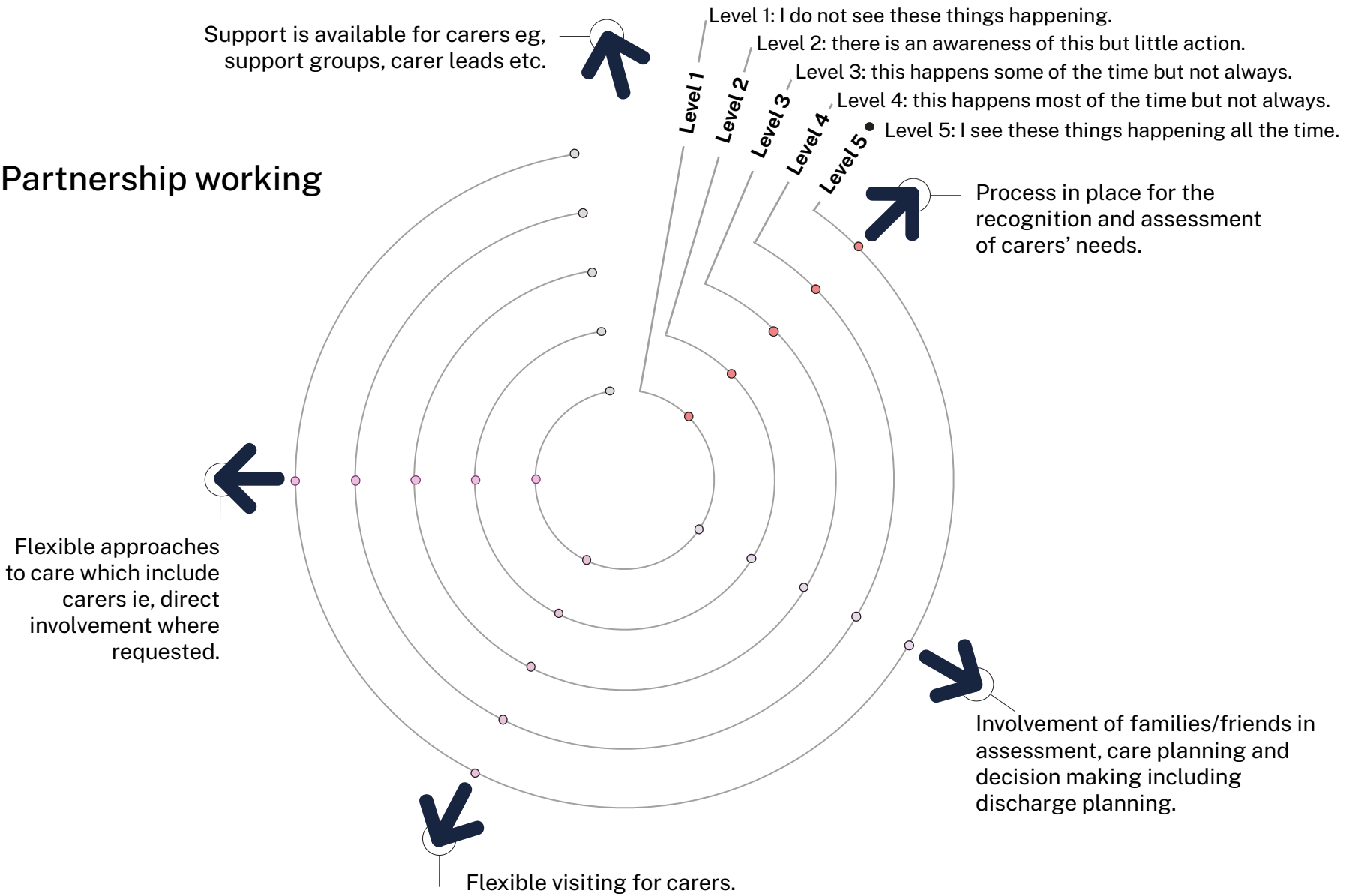
P Partnership working



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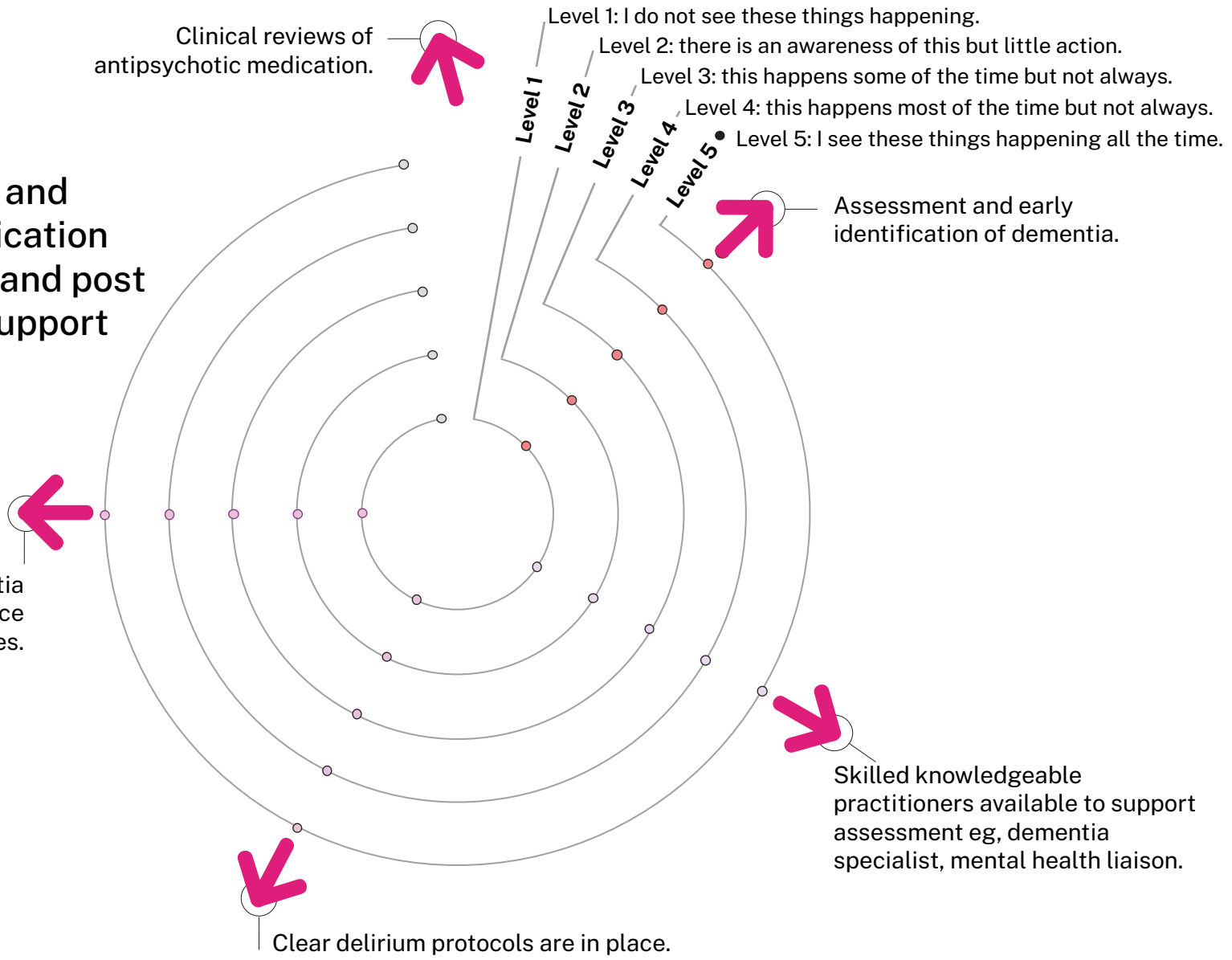
A Assessment and early identification of dementia and post diagnostic support



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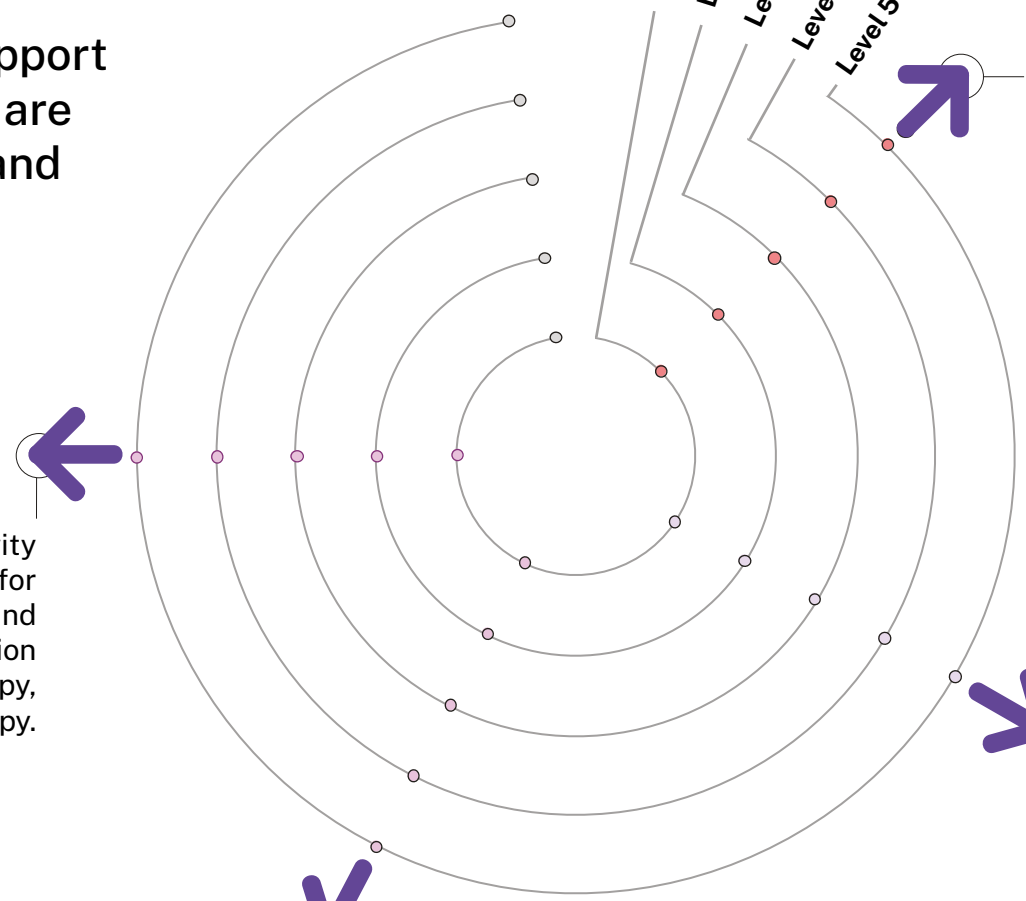
C Care and support plans which are person-led and individual



Use of dementia appropriate tools eg, assessment of nutrition, pain, function, risk, etc.

Level 1: I do not see these things happening.
Level 2: there is an awareness of this but little action.
Level 3: this happens some of the time but not always.
Level 4: this happens most of the time but not always.
Level 5: I see these things happening all the time.

Routine gathering of personal life story information using an agreed template.

Support and activity is available for rehabilitation and maintenance of function eg, physiotherapy, occupational therapy.

Person with dementia and/or carers involved in care planning.

Use of mental capacity assessments and advance care planning to inform care.

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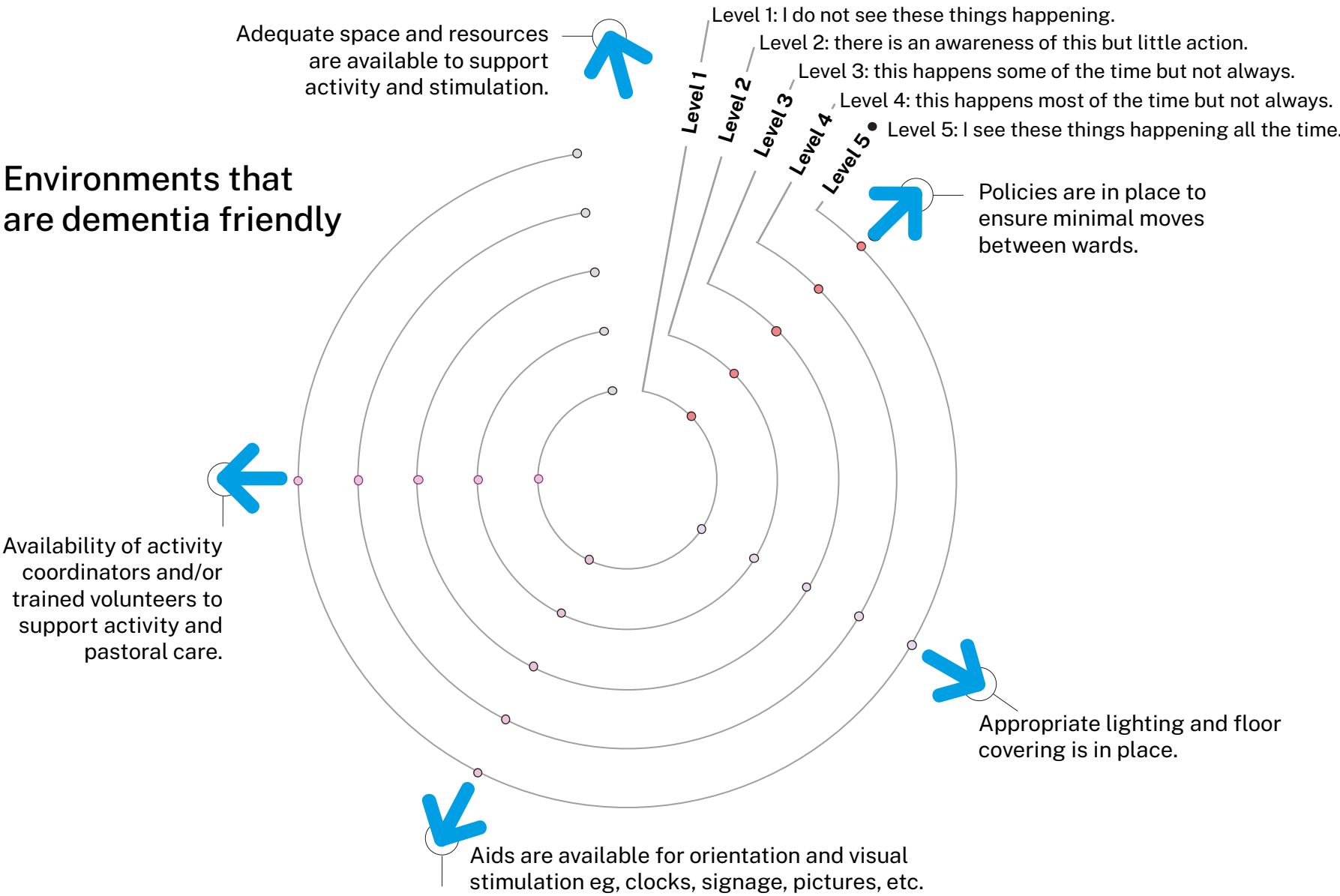
E Environments that are dementia friendly



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S Skilled staff who are informed and have enough time to care

Good quality training and education in dementia that is easy to access, practical and focuses on attitudes/approach and communication.

Training is available to all staff based on an analysis of training needs.

Training includes the perspectives of people with dementia and carers.

Identified clinical leads for dementia are available eg, dementia specialists/nurses, mental health liaison, dementia champions.

Careful consideration of staffing levels to ensure appropriate skill mix, ratio and numbers.

What we are doing well	What we are doing not so well	What can we do about it

P Partnership working with carers

Process in place for the recognition and assessment of carers' needs.

Involvement of families/friends in assessment, care planning and decision making, including discharge planning. Flexible visiting for carers.

Flexible approaches to care which include and involve carers ie, direct involvement where requested.

Support is available for carers e.g. support groups, carer leads, etc.

What we are doing well	What we are doing not so well	What can we do about it

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A Assessment and early identification of dementia

Use of agreed screening and assessment tools.

Skilled knowledgeable practitioners available to support assessment eg, dementia specialist, mental health liaison.

Clear delirium protocols are in place.

Clear dementia pathway is in place across services.

Clinical reviews of antipsychotic medication.

What we are doing well	What we are doing not so well	What can we do about it

C Care plans which are person-centred and individualised

Routine gathering of personal life story information using an agreed template.

Person with dementia and/or carers involved in care planning.

Use of mental capacity assessments and advance care planning to inform care.

Use of dementia appropriate tools eg, assessment of nutrition, pain, function, risk, etc.

Support and activity is available for rehabilitation and maintenance of function eg, physiotherapy, occupational therapy.

What we are doing well	What we are doing not so well	What can we do about it

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E Environments that are dementia friendly

Policies are in place to ensure minimal moves between wards.

Appropriate lighting and floor covering is in place.

Aids are available for orientation and visual stimulation eg, clocks, signage, pictures, etc.

Adequate space and resources are available to support activity and stimulation.

Availability of activity co-ordinators and/or trained volunteers to support activity and pastoral care.

What we are doing well	What we are doing not so well	What can we do about it

Further reading and information

Admiral Nurses (Dementia UK) **dementiauk.org**

Alzheimer's Society **alzheimers.org.uk**

Alzheimer's Scotland **alzscot.org**

Alzheimer's Northern Ireland **alzheimers.org.uk/about-us/who-we-are/alzheimers-society-northern-ireland**

Alzheimer's Wales **alzheimers.org.uk/about-us/wales**

Carers Trust **carers.org**

Johns Campaign **johnscampaign.org.uk**

NICE Dementia Topic **nice.org.uk/guidance/conditions-and-diseases/mental-health-behavioural-and-neurodevelopmental-conditions/dementia**

NHS About Dementia **nhs.uk/conditions/dementia/about**

SCIE Dementia **scie.org.uk/dementia**

nice.org.uk/guidance/cg103

cks.nice.org.uk/topics/delirium/diagnosis/assessment

the4at.com

va.gov/covidtraining/docs/The_Confusion_Assessment_Method.pdf

RCN quality assurance

Publication

This is an RCN practice guidance. Practice guidance are evidence-based consensus documents, used to guide decisions about appropriate care of an individual, family or population in a specific context.

Description

This guidance sets out the five principles that form a shared commitment to improving care for people with dementia and their families. The document is designed to be used in a wide range of health and social care settings and has included the most recent evidence and best practice. It is aimed at staff and managers working in a range of health and social care settings.

Publication date: March 2026 Review date: March 2028

The Nine Quality Standards

This publication has met the nine quality standards of the quality framework for RCN professional publications. For more information, or to request further details on how the nine quality standards have been met in relation to this particular professional publication, please contact **publications.feedback@rcn.org.uk**

Evaluation

The authors would value any feedback you have about this publication. Please contact **publications.feedback@rcn.org.uk** clearly stating which publication you are commenting on.

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