Progress for Providers

Checking your progress in delivering personalised support for people living with dementia

Care homes

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Forewords

Alistair Burns
National Clinical Director for Dementia*

On March 26 2012 the Prime Minister launched a programme of work which aims to deliver major improvements in dementia care and research by 2015 – the Dementia Challenge. One key area for the Challenge was driving improvements in health and care. Ten leading organisations declared a Care and Support Compact for improving quality in care homes.

I therefore welcome this practical tool sponsored by health and social care leaders in my own region, the North West, to help care homes to self–assess and improve their practice. In particular I am very pleased to see the coming together of the worlds of person–centred dementia care and of personalisation in social care. This combination of progressive, evidence based practice offers a very sound basis for improvement. I will be very interested to hear how the tool is used and the impact that it has as part of ongoing efforts to provide people with dementia with the quality, person–centred and personalised support that they deserve.

*My views are given in a clinical capacity and as a national expert in the field. They do not in themselves impose any mandatory requirements on NHS organisations although commissioners are expected to take them into account.

Barbara Pointon MBE
Former carer, Ambassador for the Alzheimer's Society and Dementia UK, member of the Standing Commission on Carers

I am delighted to commend this excellent self-assessment to both care-home staff and to families. It helps us to gain a mutual understanding of what is meant by truly person-centred support and care, and how we can all take steps to achieve it.

What is remarkable is that a truly person-centred approach is not only good for the person with dementia, but the attitudes it fosters then percolates into every aspect of care home life, enriching the whole staff team and the environment. And families are treated as partners in care, thereby creating a two-way flow of information which encourages that important triangle of trust between an individual resident, family member and professional.

The booklet's clear structure helps us to confront the reality of where we are now, recognise where we'd like to be and learn how to get there, whether as an individual or as a team. For family carers who have had to 'give up caring' for someone but who still care deeply about them, it is comforting to know that in this person-centred atmosphere they will continue to be empowered, nurtured and cherished.

Jeremy Hughes
Chief Executive, Alzheimer's Society

I am very glad to welcome this latest title in the well-regarded *Progress for Providers* series. Person-centred care has never been more important in care and nursing homes for people with dementia. This self-assessment approach builds on person-centred care and extends it to encompass personalisation, where the person has as much choice and control in their life as possible.

It compliments established assessment and evaluation processes like *Dementia Care Mapping*[1] and offers a very practical way to demonstrate progress against the *National Dementia Declaration*[2] and the Think Local Act Personal Making it Real[3] personalisation markers.

I am pleased that the approach is easy to use and shows clearly what to aspire to next, with links to helpful resources. It should be very helpful to providers who want to know what personalisation means in practice in their service, and for families who want to make informed choices when looking for care for their loved one.

[1] *Dementia Care Mapping* was developed by Professor Tom Kitwood at the University of Bradford, Bradford Dementia Group, 1992. See www.brad.ac.uk/health/dementia/dcm
[2] *National Dementia Declaration for England.* Dementia Action Alliance, 2010
[3] Making it Real: Marking progress towards personalised, community based support. Think Local Act Personal, 2011

Who this tool is for and how it was developed

This publication is primarily for managers of care homes supporting people with any type of dementia, at any stage. It may also interest families of people with dementia who may be looking for a care home and wish to know how to assess the homes they are visiting.

This publication is a self–assessment tool for managers to use with their staff to check how they are doing in delivering personalised support for people with dementia. 'Personalised support' is a key aim of national policy and means tailoring support to the individual, and enabling them to have as much choice and control over their service and life as possible, rather than supporting everyone in the same way.

The tool was developed by providers, commissioners and academics who have experience in personalisation and people with dementia, working in partnership with the Alzheimer's Society. The group looked at and built on the pioneering work of:

- Tom Kitwood, University of Bradford Dementia Group.
- Dawn Brooker and David Sheard on person–centred care.
- Mike Nolan on relationship–centred care.
- Ruth Bartlett and Deborah O'Connor's work on dementia and social citizenship.

The group consulted with a wide group of providers, commissioners, practitioners and families during the drafting process. The Alzheimer's Society is extending this consultation and working with people with dementia and their families.

How to use the tool

The self–assessment tool asks you to look at the practices, policies, knowledge and skills of you and your staff team and at the experience of the person with dementia and their family. It takes about 40 minutes to complete the self–assessment.

Each topic enables you to score yourself on a scale of 1 to 5:

If you tick boxes 1 or 2 you are **starting to look at** and act on the topic.

Tick 3 or 4 if you are **delivering person-centred care** in that area.

Tick 5 if you are **delivering truly personalised services** and using person–centred practices in that area (including individualised funding).

Once you have scored yourself on these criteria, you can record your next steps on the summary sheets on pages 32–35 which then provides an overview of how you are doing.

You can use this assessment tool:

- By yourself, for individual self–reflection.

- With your manager, to agree goals.
- With your team to agree team and individual goals.
- With other managers, for example as a practice group, or as part of an organisational development programme.

We mention specific person–centred thinking tools and approaches in *Progress for Providers* and these are highlighted in **bold type**. These are recommended in the Department of Health Guidance (2010) on using person–centred practices to deliver 'Putting People First.' At the end of the booklet we provide a description of each of these and where you can get further information.

What next? Actions and resources

Once you have assessed your practice you can use this information to develop an action plan. The action plan should describe how you are going to develop and change and move towards statement 5 (excellent practice) for each topic. There is a blank action summary on pages 32–35.

You can check on your progress by doing the assessment on a regular basis and tracking your scores over time. This will give you an overview of where you have improved and where you need to progress further. Even if progress is slow it's important for you and the whole staff team to record and celebrate your achievements.

At the end there is a list of resources that could help inform your actions. We have mapped this document against the Dementia Action Alliance's *National Dementia Declaration for England*, and Think Local Act Personal's *Making it Real*. This *Progress for Providers* also enables staff to deliver the *Common Core Principles for Supporting People with Dementia* by Skills for Care and Skills for Health. The Skills for Care and Dementia UK guide *Dementia: Workers and Carers* together recommends keeping up–to–date with best practice like person–centred approaches. This self–assessment will help you to do this.

You can record your scores electronically, to create a visual summary and to compare your scores over time. We can send you a free format to use on Excel so that you can create pivot tables from your scores. Please email Kerry@helensandersonassociates.co.uk if you are interested in this.

Finally, if you would like help in either completing the self–assessment or moving ahead with actions, we can provide a range of support from workshops and webinars to individual coaching for managers and organisational development programmes. Contact Kerry@helensandersonassociates.co.uk for more information.

We hope that you find this Progress for Providers useful as a way of thinking about the progress you are making, and how to move towards delivering truly personalised support for people living with dementia in care homes.

Helen Sanderson

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Section 1

The person

1 We see and treat the person with dementia as an individual, with dignity and respect

Tick one box ✓

1	We have only very basic information about the person and their needs. Staff struggle to describe the person in a positive way.	
2	We see the person as an individual as much as possible, but we only have information about their care needs. Most of the time people are talked about respectfully.	
3	We see the person as an individual with strengths and qualities. People are consistently described and treated with dignity and respect.	
4	Staff describe people positively. We have recorded information about the qualities and strengths of each person we support. We don't just record this, we try to use it in our day-to-day support and in our conversations with the person. Dignity is seen as everyone's business and every staff member sees themselves as a 'Dignity Champion'.	
5	We know and have a record of each person's gifts and qualities. We use a variety of ways to communicate how we value each person. We use the information about what we value about individuals in their day-to-day support. People are described and treated respectfully and positively, as individuals, by all staff. Staff feel comfortable expressing positive feelings to people.	

2 We understand the person's life history

1	The only information that we have about the person is in the care plan. Any record of their life history is likely to be in the context of negative experiences or behaviour.	
2	We know it is important to know about the person's life history but we don't have time to do this.	
3	We are committed to finding out about each person's life history and have started to work with a few people to write their histories when we have time.	

		Tick one box ✓
4	We have recorded histories for most of the people we support. We have different ways to record and share people's history, according to what the person wants. We are starting to use this information in our conversations with people. We have a plan to complete histories for everyone.	
5	We know and have a record of each individual's personal history. This is recorded in a way that works for the person, (for example on a **history map, life story book**, timeline, scrapbook, memory box or DVD). We use this information in our day-to-day conversations and support. We share ourselves through our own life stories.	

3 We know and act on what matters to the person

1	We focus on keeping people clean, fed and safe. We do not know what matters to each person. Our priority is to look after them.	
2	We know we need to recognise what is important to people, but we don't have the time to do this. We make sure that staff use the individual's preferred name.	
3	We have started to find out about and record what is important to the person, and we are using person-centred thinking tools to help us do this (for example **good days and bad days, relationship circles**, learning about people's routines). This information is starting to change how we support people.	
4	Most people have a record of what matters to them (for example a **one-page profile**). Staff use this information in conversations and how they support people. New staff use this to get to know the person quickly.	
5	We know what is important to each person we support. This is clearly recorded and includes specific detailed information, including relationships, sexuality, routines, interests and ways of participating. Every person has a **one-page profile**. Staff intentionally work to make sure that what is important to the person is happening purposefully in their day-to-day life. Where there are obstacles to achieving this, these are shared with the managers, who help to find ways around this.	

Tick one box ✓

4 We know and act on what the person wants in the future (outcomes)

1	Our job means focusing on the here and now.	
2	We think it would be good to plan for the future but we are not sure if it is our role and we don't have the time to do this.	
3	We are trying to help some people think about their future and what we may need to do to help with this.	
4	We help everyone think about their future; what they may like to try or do. We have a record of this and actions that we are working on. This includes advance decision-making about end of life care and arrangements.	
5	We know what people want in the future; their dreams, hopes and aspirations. We have gathered this information from the person and those who know, love and care about them. There are specific, measureable, achievable and timely actions for us, to help people to achieve their wishes (outcomes). We are clear about our role in this and how to support the person to make changes themselves. We review progress with the person. We have person-centred advance decision making in place for end of life care and arrangements (for example, using *Living well: thinking and planning for the end of your life*[4]).	

5 We know and respond to how the person communicates

1	We support people by following our policies and procedures; we do not specifically record how people communicate.	
2	We realise that we need to understand more about how people communicate and what they are trying to tell us.	
3	We have started to introduce **communication charts** as a first step. Staff are now beginning to understand that all behaviour (including 'challenging behaviour') is communication and are developing their skills in observing, recording and communicating with people.	
4	We use communication charts with the majority of the people we support. Staff understand their own role in effective listening and communication and know how to respond to people.	

[4]*Living well: thinking and planning for the end of your life*. Helen Sanderson, 2010

		Tick one box ✓
5	We know and respond to how the person communicates. This is clearly recorded (for example using **communication charts**) and staff know what a person means when they behave in certain ways and how staff should respond. These are up to date and used consistently by all staff.	

6 The person is supported to make choices and decisions every day

1	The people we support are not involved in decisions about their life.	
2	We realise that people should be involved and included in any decisions about their life. We also recognise that this could help people feel more in control. We do not know how to do this yet. We use best interest meetings.	
3	We have started to develop **decision-making agreements** with people and tried out different approaches to help people to make decisions. We are using best interest meetings and engaging families to assist in the process.	
4	The use of **decision-making agreements** is common and we have many examples of people making decisions about what is important to them. We are struggling to ensure that this includes people with capacity or communication issues. Staff support people to record their decisions. We use advocacy from others where necessary. We support individuals to plan in advance for the end of their life in a sensitive way (for example, using *Living well: thinking and planning for the end of your life*[5]).	
5	Staff know the decisions that are important to the person, how to support the person with these decisions and how the final decision is made. This is recorded (for example in a **decision-making agreement**). We make sure people get representation if they need it. We have supported some people to make decisions that we don't agree with and manage the tension in this. We support people to extend the range and importance of the decisions that they make, to have more control over their life, through advocates if necessary. Everyone is sensitively supported to think about and plan for the end of their life, and these decisions are recorded and shared with the family and GP where appropriate.	

[5]Helen Sanderson Associates, ibid

Tick one box ✓

7 We know exactly how the person wants to be supported and how to support them to be fully part of everyday life

1	We have established policies and procedures for how we support people and we support everyone in the same way.	
2	We know that to support people effectively, we need to find out how they would like to be supported. We are unsure how to do this and record the information. Currently our approach is not flexible enough to allow this to happen. We are task orientated rather than people orientated but we want to change this.	
3	We acknowledge the importance of finding out from people what good support looks like for them individually and we have begun to explore this with them. We have developed a plan to gather this information for everyone, using person-centred thinking tools.	
4	Everyone in the team is clear about what good support looks like for each person they support. We have started to record this (for example, in **one-page profiles**). Staff understand what this means for their practice on a day-to-day basis and are using this information to inform how they support people.	
5	We know and act on how the person wants to be supported. This is clearly recorded, is detailed, is specific to the person and staff use this to deliver individual support. The information includes the support people want in their routines, in relationships and interests, and how to help people to be healthy, safe and participating fully in everyday life. This includes support specific to the person's culture, gender, race, religion, belief and sexuality. We review staff performance on their ability to provide support in the way that someone wants. We use technology and assistive technology to get our support right for the person. People are as active in their own care as possible.	

8 We know what is working and not working for the person, and we are changing what is not working

1	We do not know what is **working or not working** for the people we support.	
2	We want to learn what people think is **working and not working** in their lives. We are not sure how to do this and are fearful that we will not be able to respond and make the changes they want.	

		Tick one box ✓
3	We have started to routinely ask people what is **working and not working** from their perspective about their life and the service they receive (for example, as part of a person–centred review).	
4	Staff are confident in supporting people to tell us what is **working and not working**. This happens for everyone at least once a year. There is an action plan developed from this. We have created a system that will gather this information from people so that we can plan strategically what needs to happen in the service.	
5	We have a process to learn what is **working and not working** for the person, from their perspective. We have actions (with a date and a named person responsible) to change what is not working. The actions are regularly reviewed with all key people, including the person.	

9 We support people to initiate and maintain friendships and relationships

(For family relationships see Section 2, page 19)

1	The only people in the person's life are paid staff. We don't see it as our responsibility to support people's other relationships.	
2	We realise that people might want to meet and make more friends but we are fearful that this could expose people to harm and risk, and we are not prepared to accept responsibility for this. We are not sure how we would begin to find out who is (or could be) important in the person's life.	
3	We have started to work out how we can support people to build and maintain relationships. We are still worried about the risk and how to manage this. We have started to understand what is in the local community and we are developing **relationship circles**. Staff are putting a greater focus on people's interests and friendships.	
4	We have tried a number of approaches to support people with their friendships and relationships. We know who is already important in the person's life (for example, by using a **relationship circle**) and people now have opportunities to meet new people who are not paid to be with them. We are gathering the learning and sharing good practice.	
5	We support people to maintain relationships that are important to them (including sexual relationships). We support people to make new relationships with people in their home and with their wider community. We have a culture that creates positive, mutual, valued relationships between staff and people with dementia.	

Tick one box ✓

10 We support the person to be part of their community and civic life

1	It is not our job to connect people to the community.	
2	We think it would be good if people were out and about in the community more but can't see how we can do this within our current resources.	
3	We are committed to exploring ways of people being part of their communities and civic live, and we have started thinking about how to do this with a few people we support (for example, **using community maps, recording gifts and presence to contribution**).	
4	We support some people to go out and be part of their community, and we use person–centred thinking tools in the way that we approach this.	
5	We support people to be involved in their community and civic life. We use **community maps** that show the places that are important to the person and we actively support people to be part of their community and make a contribution in whatever way works for them.	

11 The environment is pleasant, homely and busy

1	The home looks and feels rather sterile and we don't have the time or resources to make it homely. People rarely engage in purposeful activity. It is not easy for people to find their way around. The chairs are all the same and are placed around the outside of the room. We don't have the resources or skills to develop an environment that supports people's independence.	
2	We understand the need to make things homely and well sign–posted and have tried some simple approaches to this. We are considering how the environment can be enhanced to support people's independence.	
3	Chairs are arranged to enable people to talk to each other easily. There are a few things to occupy people. People can find their way around (use of contrast, colour and appropriate signage). We have made some improvements to support independence.	
4	The home is comfortable and is arranged to suit people (for example where people like to sit) and support their independence. There is a range of things for people to do. There are areas where people can sit and relax, space to do hobbies and activities, and quiet spaces. There is an outdoor space with places to sit.	

		Tick one box ✓
5	The environment is pleasant, homely and busy. People have as much control over their physical environment as possible, (for example the temperature, noise levels, music). There is a wide variety of things for people to do (for example, arts and crafts, hobbies, games). There are spaces inside and outdoors for relaxation and hobbies. Staff understand the importance of how the living environment affects people.	

12 We support individuals to be in the best possible physical health

1	We focus on keeping people clean and comfortable. We do our best to keep track but sometimes people lose their glasses, hearing aids or dentures.	
2	We try to get people moving about when we can. We have a monitoring system that prevents pressure ulcers, falls, infections and so on.	
3	We check on a daily basis that people have the right glasses, hearing aids or dentures and try to ensure that people have regular health checks. We look out for any signs that people may be in pain. We support people to look after their appearance.	
4	We are confident that people have up to date health checks and always have their own glasses, hearing aids and dentures. We keep good records of these. When someone's behaviour changes, we look to see if there is a physical cause and look out for indications that people are in pain. We have an active programme to keep people healthy and fit through exercise programmes and healthy eating. We have a medical review that is part of their person–centred information.	
5	We pride ourselves that people are in the best possible physical health and comfort. We know and have a record of the best ways to support each person to be physically healthy, and how we will know if they are in pain. We support people to be physically active, both inside and outside the home, as part of their daily routine. We actively seek ways to reduce the amount of medication that people are on. We ensure that everyone has regular sight and hearing tests, and have a medical and dental review as part of a person–centred review. We are always looking out for signs that people may be in pain and act immediately.	

Tick one box ✓

13 There is a person-centred culture of respect and warmth

1	Staff talk over people and are focused on getting all the daily tasks done. Sometimes staff 'tell people off' and are patronising. People may be labelled (for example 'the wanderer'). All staff wear uniforms.	
2	Staff try not to talk over people and know the importance of treating people with respect, although there is still some patronising behaviour towards people with dementia. Staff wear uniforms.	
3	No–one wears uniforms and everyone is addressed by their first name (for example no separate staff toilets). Staff know the importance of developing good relationships with people with dementia and take time to talk to people as much as possible. Staff have a name badge with their first name on it.	
4	All staff work to develop good relationships with people and see this as very important in their role.	
5	Staff have a clear, recorded set of values that underpin their work and agreed ways of working in respectful, warm and positive ways. Staff are comfortable in sharing information about themselves to develop warm and trusting relationships with people they support. Staff are clear that their role is not task focused but relationship focused, valuing people with dementia.	

14 People have personal possessions

1	Everything is treated communally and it sometimes means that people end up wearing other people's clothes. People may not have shoes.	
2	Most clothes are labelled and we do our best to make sure people have their own clothes and wear shoes. People have a few personal possessions in their room (for example, photographs).	
3	We encourage people to have as many personal possessions as they want in their bedroom. We ensure that people have their own clothes and shoes and that these are looked after.	
4	Everyone has a range of personal possessions in their room, and we support people to take care of them.	

		Tick one box ✓
5	Everybody has many personal possessions and we know which possessions are important to people. We ensure people have support to look after their possessions (for example photos, plants, jewellery, clothes, ornaments, CDs, DVDs and iPods). We actively support people to buy more possessions if they choose.	

15 Mealtimes are pleasurable, flexible, social occasions

1	We offer one choice of dish each meal time. We have fixed times for meals and have to work hard to make sure that everyone eats then.	
2	We have fixed times for meals, with one dish available but we accommodate dietary preferences and requirements like halal or gluten–free meals. Mealtimes feel rushed but we try and talk to people, as well as feed them.	
3	We are as flexible as we can be around mealtimes and usually offer people the choice of a couple of dishes. We help people to choose the one they want as much as possible. We try to make mealtimes sociable occasions.	
4	We support people to choose from several meal options. We pay attention to the presentation of the food so that it looks appetising. People can take as long as they want over their meals. People are encouraged to help with preparing meals or laying the table.	
5	Mealtimes are pleasurable, sociable occasions. People choose when, where and what they eat (for example, using picture menus) and who they want to eat with. The meals are delicious and attractively presented. People can take as much time as they want over their meals. A range of finger foods and snacks is always available. People are supported to take an active role in meal times, for example preparing meals or laying the tables. People get the support they need to eat and drink in a respectful and unobtrusive way.	

Section 2

Family

1 The home is a welcoming place for families

Tick one box ✓

1	We have visiting hours when families can come. We are strict about these. It is important that staff can get their jobs done without visitors around.	
2	We have visiting hours but we are flexible with these.	
3	Families and friends can visit when they want, within reason. The entrance is welcoming and it is easy to find your way around when you come in.	
4	We welcome family members and friends, work hard to make sure they feel at home and make them drinks when we can.	
5	Family members are welcomed at all times, including meal times. Family members feel at home and can make themselves drinks when they want. Families can meet together privately if they wish, in the person's bedroom and in other places.	

2 Family members have good information

1	We do not see our role as providing information for families. We answer questions that families have, when we have time.	
2	We try and help families as much as we can when they ask questions.	
3	We have leaflets and information at the home and tell families about these when they ask questions. We provide information on notice boards about what is happening in the home.	
4	We proactively make sure that families have good information about what is happening in the home and in their family member's life.	
5	Family members have all the information they need, when they want it, in everyday language. This is through a range of sources, such as newsletters, social media and one-to-one sharing. Family members know what is happening in the home generally, as well as in the life of their family member.	

Tick one box ✓

3 Families contribute their knowledge and expertise

1	We get our information about the people we support from the files.	
2	We know that families have information about the person and we try and get this when we can.	
3	We make sure that we talk to the family and get all the information they have for our records.	
4	We work with the family to learn about the person's past as well as who they are today. We record this information in a person–centred way. We invite the family to reviews.	
5	We acknowledge the expertise of families as those who know and care most about the person. Families contribute to our understanding of the person, for example the person's history, communication preferences, knowing what matters to the person, their aspirations for the future, how they are best supported and their connection to the community. We proactively work with families to enable them to contribute to person–centred reviews (for example, by arranging them at times that suit the family) and actually providing care if they choose.	

4 We support family relationships to continue and develop

1	It is not our role to get involved in relationships between the family and the person.	
2	We try and help families stay in touch but there is not much that we can do.	
3	We do what we can to help families stay connected, for example, by talking to the person about their family.	
4	We spend time working out how the person can stay in contact with their family and what we can do to help, for example, making sure that the person is supported to send birthday and celebration cards.	
5	We support people to remain an active part of their family, continuing with relationships and family celebrations that are important to them. We support families as circumstances and relationships develop and change. We actively work with families to share their perspective through person–centred reviews and learning what is working and not working from different perspectives.	

Section 3

Staff and managers

1 We have knowledge, skills and understanding of person-centred practices

Tick one box ✓

1	None of the staff has any understanding or experience of using specific person–centred thinking tools or practices.	
2	We know that we need to develop our skills, knowledge and understanding of person–centred thinking tools but have not developed any plans to do this and are not sure how to begin.	
3	We have a plan to develop our understanding of person–centred thinking and some of the team have begun to use person–centred thinking tools and approaches. We have started to look at some of the information available on person–centred thinking (for example, the short films on person–centred thinking on YouTube).	
4	I am using person–centred thinking tools and approaches myself, and all the team know and are successfully using several of the tools. I have a **one-page profile** and so do each of the team, and we are using this in our work together.	
5	We all have our own **one-page profile** and we use this to inform our practice. We are all confident and competent in using person–centred thinking tools,using them consistently in all areas of our work to enable people with dementia to have as much choice and control as possible in their lives. Everyone can describe the person–centred thinking tools (why and how you can use them and the benefits to the person with dementia) and talk about their experience of using them, and the outcomes achieved.	

2 Staff are supported individually to develop their skills in using person-centred practices

1	No one in the team has a personal development plan and we are not using any process to reflect on how we work and how to develop our skills.	
2	I recognise that all staff need ongoing support and opportunities for development, to build their skills and knowledge, and a way for their progress to be monitored. I am not sure how to go about this.	
3	I have started to talk to each team member about how they are doing in using person–centred thinking tools and approaches in their work. This is on an ad hoc basis.	

		Tick one box ✓
3	I talk to each team member on a regular planned basis about how they are developing their skills in using person-centred thinking and approaches, and how I can support them in this. I have a record of the progress that team members are making (for example, using the **person-centred thinking rating scale**).	
4	Each staff member has a regularly reviewed individual development plan that includes how they are developing their competence in using person-centred practices with people who have dementia. This includes celebrating successes and solving difficulties. I ensure that staff members reflect on their own practice and are accountable for this. We use a range of ways to ensure each staff member has individual support in using person-centred thinking tools and approaches (for example, peer support, mentoring and person-centred thinking as a standard agenda item for supervision). We have a mechanism for recording and sharing best practice across the organisation.	

3 Our team has a clear purpose

1	We have an organisational mission statement created by the senior manager/management team/owner. This complies with requirements. We have not considered how this should be reflected in the way we work.	
2	We think it would be helpful for the team to think about our purpose as a team but I am not sure how to go about this.	
3	We have begun to talk with staff about what our purpose is and to think about how we can record this.	
4	We are clear about our team's purpose and how this fits with the organisation's mission statement. We have developed this together as a team and with people using the service.	
5	The organisation's mission statement informs the team's purpose. Everyone understands the connection between the mission and their individual purpose and role. The team knows what their team purpose is and what we are trying to achieve together. All team members know their purpose in relation to the people they support, their team and the rest of the organisation. This is recorded (for example in a purpose poster or team purpose statement). The team's purpose informs the work of the team and there is evidence of this in practice.	

Tick one box ✓

4 We have an agreed way of working that reflects our values

1	We don't really think about values, we just get on with the job.	
2	We realise that we need to explore our values and beliefs as a team and how this can inform our practice.	
3	We have started to think together about our team values and how we work together. We know what is working and what needs to change.	
4	We have agreed our values and team principles and developed an action plan that addresses what needs to change, in partnership with people we support.	
5	The team has a shared set of beliefs or values that underpin their work and agreed ways of working that reflect these. These reflect working in a person–centred way to ensure that people have maximum choice and control in their lives, as part of their local community. The team principles and ways of working are clearly documented (for example, ground rules, team charter, person–centred team plan, team procedure file). The team regularly evaluates how they are doing against these agreed ways of working (for example, by using what is working and not working from different perspectives).	

5 Staff know what is important to each other and how to support each other

1	My team members do not know each other very well.	
2	I have started to work on ways that I can help the team know more about each other; what matters to them as people and how they can support each other at work (for example, starting with **one-page profiles** for everyone).	
3	I am learning what is important to my team and how best to support them. We are all aware of how to support each other and what is important to each other and we are working at putting this into practice.	
4	My team and I have all documented how best to support each other and what is important to each of us. We know how we make decisions as a team and the best ways to communicate together.	

		Tick one box ✓
5	As a team we know and act on what 'good support' means to each person. This information is recorded (for example, in a person-centred team plan). We regularly reflect on what is **working and not working** for us as a team, and what we can do about this. We have a culture where we appreciate each other's gifts and strengths and use these in our work wherever we can.	

6 Staff know what is expected of them

1	I think each team member has a general sense of what is expected of them.	
2	All staff have a generic job description and work to organisational policies and procedures.	
3	I know that staff need to be clearer about what their important or core responsibilities are and where they can try out ideas and use their own judgement. We have started to have discussions in the team about this.	
4	Some staff are clear about what is expected of them and where they can make decisions themselves. There are still some grey areas that we need to explore more. We are using person-centred thinking tools (for example, **the doughnut**) in clarifying expectations and decision making.	
5	Staff know what is expected of them – they are clear about their core responsibilities and where they can try new ideas in their day-to-day work. Staff are clear about their role in people's lives and know what they must do in relation to the people they support and team, administrative or finance responsibilities. Staff know how to use person-centred practices to deliver their core responsibilities. Staff know where they can use their own judgement and try new ideas or approaches, and record what they are learning about what works and does not work when they use their own judgement. Roles and responsibilities are clearly recorded (for example, in **a doughnut**) and this is reflected in job descriptions.	

7 Staff feel that their opinions matter

1	I make all decisions; I don't involve my team. I chair team meetings and set the agenda. I set the agenda for supervision and appraisal.	
2	I recognise the need to find a way to listen to my staff team, value their opinions and engage them in decision making. I am trying to improve how I do this.	

		Tick one box ✓
3	My team have some involvement in setting team meeting agendas. I still make most of the decisions.	
4	I regularly meet with my team and discuss issues that they raise (in team meetings and other day-to-day opportunities). They contribute to team meetings agendas and make suggestions for supervision discussions. Some staff make suggestions for new ideas or changes. We are starting to use person-centred thinking tools to listen to each other.	
5	All staff feel that their opinions are listened to. Team members are asked for their opinions and consulted on issues that affect them. Team members feel confident in suggesting new ideas or changes to me. We regularly use person-centred thinking tools in the team to listen to each other's views and experiences (for example, **4 plus 1 questions**).	

8 Staff are thoughtfully matched to people and rotas are personalised to people who are supported

1	I write staff rotas based upon staff availability. The rota meets the requirements of the service. There is a system for staff and people who use the service to make requests.	
2	I have identified the preferences of people who are supported and the staff (for example, using the **matching tool** and **one-page profile**). I write the rotas and take these preferences into consideration where possible.	
3	Sometimes people who are supported are matched to staff with similar interests but service need still takes priority.	
4	My team and I know what individuals' preferences are, how they like to be supported and what is important to them. These preferences are acknowledged in the way that the rota is developed, so that we get a good match between the person and the staff who support them. Rotas are developed around people using the service, based on the support they want and the activities they want to do, and who they want to support them.	

		Tick one box ✓
5	Decisions about who works with whom are based on what the person supported wants. Where the senior staff make this decision, it is based on which staff get on best with different individuals, taking into account what people and individual staff members have in common (for example, a shared love of rock and roll music) as well as personality characteristics (for example, gregarious people and quieter people), necessary skills and experience. People can choose different staff for support with hobbies and interests, and personal care.	

9 Recruitment and selection is person-centred

1	Staff are recruited to the team based on formal job descriptions that have been developed by the organisation.	
2	I know I should involve the people who receive a service in recruitment but I am not sure how to go about this.	
3	I have started to look at 'good practice' examples of ways to involve people in recruiting their support staff. We have started to explore how we can develop job descriptions that reflect what is important to the people we support.	
4	We have worked with people and identified ways for them and their families to be involved in recruitment and selection of their staff. This happens some of the time. We have developed personalised job descriptions and adverts based on what is important to the person and how they want to be supported. We use the **matching tool** in our recruitment processes.	
5	Our recruitment and selection process demonstrates a person– centred approach. We recruit people who can deliver our purpose by selecting people for their values, beliefs and characteristics, not just their experience and knowledge. Where people's funding is individualised, job descriptions are personalised to the people who are supported, using information from the **matching tool**. It is common practice for people to be involved in recruiting their staff, in a way that works for them.	

Tick one box ✓

10 We have a positive, enabling approach to risk

1	I encourage my team to make sure people are safe and do not take risks. We adhere to all required legislation.	
2	I am aware that I need to encourage my team to become less risk averse. I am not sure how to do this.	
3	I am working with the team to help them take a responsive and person-centred approach to risk. We are starting to use this in some situations.	
4	We use a person-centred approach to risk most of the time. We involve the people, family and others in thinking this through. I ensure everything is documented and adheres to the relevant legislation.	
5	We ensure that risks are thought through in a person-centred way that reflects what is important to the person and decisions are clearly recorded. The person and their family are centrally involved in the way that we do this. We support people to take the risks that they want to take.	

11 Training and development is matched to staff

1	All training is based on statutory requirements. I make sure that we meet minimum legal and statutory requirements.	
2	I recognise that I need to find a way for training and development opportunities to reflect the needs of the service we provide to people, and motivate the staff.	
3	I have started to think about how I can introduce learning and development opportunities to staff that will reflect the needs of people who receive a service and also encourage and develop the team member. I have begun to look at **what is working and what is not working** for individuals and also researching what is available.	
4	We have identified all training needs, learning and development opportunities and have a plan in place. Training and development opportunities reflect the needs and wishes of people who receive a service and have been agreed with team members. Person-centred thinking and approaches are central to our approaches to training. We comply with all legal and statutory requirements.	

		Tick one box ✓
5	We provide development and training opportunities to all staff, including volunteers, that focus on increasing choice and control for people we support and delivering an individual, person-centred service. Within a few months of starting with the organisation, new staff have induction training that includes using person-centred thinking and approaches to deliver our purpose. Our training enables staff to be up to date with best practice in delivering choice and control for people with dementia and using person-centred practices to enable people to live the lives they want. We know that the senior staff are key to delivering a person-centred service and we have specific training and support to enable them to use a person-centred approach in all aspects of their role, and to be able to coach their staff in using person-centred thinking skills.	

12 Supervision is person-centred

1	I set the agenda and make the arrangements for staff supervision. I meet the minimum requirement.	
2	I am aware that staff support and supervision practice needs to be reviewed. I am not sure how I can change the current arrangements.	
3	I have started to think about involving people who receive a service in staff supervision. I have talked to people and staff about how we might go about this. Most members of staff have supervision meetings.	
4	All staff (including the manager) are supervised and people who staff support usually contribute through sharing their views with me before the supervision session. Supervision results in actions and the meetings are documented. I have started to use person-centred thinking tools in supervision sessions.	
5	Each staff member and the manager has regular, planned, individual supervision. Supervision includes giving staff individual feedback on what they do well and an opportunity to reflect on their practice. Staff are coached to develop their skills in working in a person-centred way. There is a clear link between training and supervision and what people do when they are at work (for example, when people attend training, managers expect to see a difference in their work, and this is discussed in their individual supervision). The views of people supported and their families are very important in the supervision process and people are asked their views before supervision.	

Tick one box ✓

13 Staff have appraisals and individual development plans

1	Most of my staff have an appraisal. I set the agenda and assign objectives.	
2	I have recognised that people who receive a service and their families should be given the opportunity to feed back on the support they receive from staff. I am not sure how I should go about this. Staff have an appraisal but do not really contribute to the agenda or any development plan.	
3	I have a plan in place to ensure that each member of staff receives an annual appraisal. Where possible, I try to seek the views of people who receive a service and their families.	
4	We have a variety of ways for people who receive a service and their families to contribute their views to staff appraisals. All staff are asked to reflect on what they have tried, what they have learnt, what they are pleased about and whether they have any concerns. We then agree what actions need to be taken from all the information gathered.	
5	Team members get positive feedback about their work and have annual appraisals and individual development plans. Annual appraisals include feedback from people supported and their families, about **what is working and not working** about the support they receive. This results in an individual development plan with clear goals that build on strengths, focus on working in a person–centred way, and further developing skills.	

14 Meetings are positive and productive

1	We have occasional team meetings but not everyone attends or contributes.	
2	There are frequent team meetings. I set the agenda and chair the meeting. There is little structure to the meeting and they are not as well attended as they could be.	
3	I schedule regular team meetings. The meeting tends to be an information–giving forum and does not often include problem solving or celebrating successes.	
4	We have regular structured team meetings which are documented. Actions are agreed, recorded and followed up. They are well attended and most people contribute.	

		Tick one box ✓
5	Our team has regular, productive team meetings that are opportunities to hear everyone's views and contributions. Team meetings include sharing what is going well and problem solving (for example, practicing using person–centred thinking tools to solve problems). Outside of formal meetings, people are encouraged to use peer support (for example practice groups and action learning sets).	

Action plan

On the following page we have included an action plan. You can use your score to plan your next steps. Look at each section and what the next statement suggests you may want to work towards. You can use this to record what you are going to do to achieve this, who will be responsible for this, and when you want this to be achieved.

Summary of actions

Section 1 The person	What we want to work towards (the next statement in the section)
1 We see and treat the person with dementia as an individual	
2 We understand the person's life history	
3 We know and act on what matters to the person	
4 We know and act on what the person wants in the future (outcomes)	
5 We know and respond to how the person communicates	
6 The person is supported to make choices and decisions every day	
7 We know exactly how the person wants to be supported and how to support them to be fully part of everyday life	
8 We know what is working and not working for the person and we are changing what is not working	
9 We support people to initiate and maintain friendships and relationships	
10 We support the person to be part of their community and civic life	
11 The environment is pleasant, homely and busy	
12 We support individuals to be in the best possible physical health	
13 There is a person-centred culture of respect and warmth	
14 People have personal possessions	
15 Mealtimes are pleasurable, flexible, social occasions	

What we are going to do (action)	Who will be responsible for this (name)	When this will be achieved (date)

Section 2 Family	What we want to work towards (the next statement in the section)
1 The home is a welcoming place for families	
2 Family members have good information	
3 Families contribute their knowledge and expertise	
4 We support family relationships to continue and develop	
Section 3 **Staff and managers**	
1 We have knowledge, skills and understanding of person-centred practices	
2 Staff are supported individually to develop their skills in using person-centred practices	
3 Our team has a clear purpose	
4 We have an agreed way of working that reflects our values	
5 Staff know what is important to each other and how to support each other	
6 Staff know what is expected of them	
7 Staff feel that their opinions matter	
8 Staff are thoughtfully matched to people and rotas are personalised to people who are supported	
9 Recruitment and selection is person-centred	
10 We have a positive, enabling approach to risk	
11 Training and development is matched to staff	
12 Supervision is person-centred	
13 Staff have appraisals and individual development plans	
14 Meetings are positive and productive	

What we are going to do (action)	Who will be responsible for this (name)	When this will be achieved (date)

Detailed action plan

Top priority

Why is this your top priority?

First steps

Who

By when

Who else needs to know/help this to happen?

How will I get their help?

What support will I/we need?

From inside the organisation

From outside the organisation

How will I know I have been successful?

What will have changed? What will you see? What will you feel? What will you hear?

Detailed action plan

Next priority

First steps

Who

By when

Who else needs to know/help this to happen?

How will I get their help?

What support will I/we need?

From inside the organisation

From outside the organisation

How will I know I have been successful?

What will have changed? What will you see? What will you feel? What will you hear?

Detailed action plan

Next priority

First steps

Who

By when

Who else needs to know/help this to happen?

How will I get their help?

What support will I/we need?

From inside the organisation

From outside the organisation

How will I know I have been successful?

What will have changed? What will you see? What will you feel? What will you hear?

Detailed action plan

Next priority

First steps

Who

By when

Who else needs to know/help this to happen?

How will I get their help?

What support will I/we need?

From inside the organisation

From outside the organisation

How will I know I have been successful?

What will have changed? What will you see? What will you feel? What will you hear?

Domain	Publication	Web resources
Section 1 The person	A Practical Guide to Delivering Personalisation– Person – Centred Practice in Health and Social Care www.hsapress.co.uk Person–Centred Dementia Care – Making Services Better by Dawn Brooker www.jkp.com Being (book) http://shop.alzheimers.org.uk/product/being/ Inspiring (book) http://shop.alzheimers.org.uk/product/inspiring/ Enabling (book) http://shop.alzheimers.org.uk/product/enabling/ Nurturing (book) http://shop.alzheimers.org.uk/product/nuturing/	Michael Smull. A series of films on each person–centred thinking tool www.youtube.com/user/helensandersonHSA Think and Plan – A free website for people to use person–centred thinking online www.thinkandplan.com Dementia Videos on Social Care TV www.scie.org.uk/socialcaretv/topic.asp?t=dementia Social Care TV Programme: Personalisation for Older people, Residential Care www.scie.org.uk/socialcaretv/video–player.asp?guid=6848a684ef3–4e7c–9c–a3f029717d93 Social Care TV Programme: Working with lesbian, gay, bisexual and transgendered people www.scie.org.uk/socialcaretv/video–player.asp?guid=CACAAE12–7375–429A–9D9A–1D28E29E65BD The SCIE Dementia Gateway www.scie.org.uk/publications/dementia/index.asp
Section 2 The family	A Practical Guide to Delivering Personalisation – Person–Centred Practice in Health and Social Care www.hsapress.co.uk Person–Centred Dementia Care– Making Services Better by Dawn Brooker www.jkp.com	Michael Smull. A series of films on each person–centred thinking tool www.youtube.com/user/helensandersonHSA Think and Plan – A free website for people to use person centred thinking online www.thinkandplan.com Caring for a Person with Dementia online videos from the Alzheimer's Society http://www.youtube.com/playlist?list=PLA113BFC1DF94B916&feature=plcp Dementia Videos on Social Care TV www.scie.org.uk/socialcaretv/topic.asp?t=dementia Social Care TV Programme: Personalisation for Older people, Residential Care www.scie.org.uk/socialcaretv/video–player.asp?guid=6848a684ef3–4e7c–9c–a3f029717d93 Social Care TV Programme: Working with lesbian, gay, bisexual and transgendered people www.scie.org.uk/socialcaretv/video–player.asp?guid=CACAAE12–7375–429A–9D9A–1D28E29E65BD The SCIE Dementia Gateway www.scie.org.uk/publications/dementia/index.asp
Section 3 The staff and manager	Creating Person–centred Organisations– Strategies and Tools for Managing Change in Health, Social Care and the Voluntary Sector www.jkp.com Let's Get Personal – Personalisation and Dementia: Alzheimer's Scotland www.Alzscot.org/pages/policy/report–personalisation–and–dementia.htm Home from Home – Opportunities for improving standards of dementia care in care homes: Alzheimer's Society www.alzheimers.org.uk/site/scripts/download_info.php?fileD=270 Planning Dementia Care (book) http://shop.alzheimers.org.uk/product /planning–dementia–care/ Inspiring (book) http://shop.alzheimers.org.uk/product/inspiring/ Nurturing (book) http://shop.alzheimers.org.uk/product/nuturing/ Dementia Care Environment (book) http://shop.alzheimers.org.uk/product/dementia–care–environment/	Making it Personal for Everyone (film) www.youtube.com/user/helensandersonHSA Dementia Brain Tour: The dementia brain tour is a free educational video resource that includes films on the brain and how brain cells function www.youtube.com/playlist?list=PL025B66326B7297F7&feature=plcp Dementia Videos on Social Care TV www.scie.org.uk/socialcaretv/topic.asp?t=dementia Dementia Good Practice Exchange www.scie.org.uk/publications/dementia/innovation.asp Social Care TV Programme: Personalisation for Older people, Residential Care www.scie.org.uk/socialcaretv/video–player.asp?guid=6848a684ef3–4e7c–9c–a3f029717d93 Social Care TV Programme: Working with lesbian, gay, bisexual and transgendered people www.scie.org.uk/socialcaretv/video–player.asp?guid=CACAAE12–7375–429A–9D9A–1D28E29E65BD The SCIE Dementia Gateway www.scie.org.uk/publications/dementia/index.asp

Courses or consultancy

Person–centred thinking with people who have dementia www.helensandersonassociates.co.uk

Person–centred reviews and Working Together for Change www.helensandersonassociates.co.uk

Person–Centred dementia care www.alzheimers.org.uk/site/scripts/documents_info.php?documentID=931

Free downloads

Person–centred thinking minibook www.hsapress.co.uk

Community Connecting minibook www.hsapress.co.uk

All Books: http://shop.alzheimers.org.uk/category/books
All Factsheets: www.alzheimers.org.uk/site/scripts/documents.php?categoryID=200137
Alzheimer's Society YouTube Online Video Page: www.youtube.com/user/AlzheimersSociety
Alzheimer's Society Publication Catalogue: www.alzheimers.org.uk/site/scripts/download_info.php?downloadID=77
Daily Living Products from the Alzheimer's Society: http://shop.alzheimers.org.uk/category/daily–living–products

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Person–centred thinking with people who have dementia www.helensandersonassociates.co.uk

Person–centred reviews and Working Together for Change www.helensandersonassociates.co.uk

eLearning: The Open Dementia Programme www.scie.org.uk/publications/elearning/dementia/index.asp

Person–centred thinking minibook www.hsapress.co.uk

Community Connecting minibook www.hsapress.co.uk

Selecting a care home factsheet http://www.alzheimers.org.uk/site/scripts/documents_info.php?documentID=150

Moving into a care home: advice for lesbian, gay and bisexual people http://www.alzheimers.org.uk/site/scripts/documents_info.php?documentID=1099

Person–centred teams, Positive and productive meetings, Person–centred supervision, Person–centred risk, Person–centred recruitment www.helensandersonassociates.co.uk

Champions in Dementia–Leadership in Dementia Care http://www.alzheimers.org.uk/site/scripts/documents_info.php?documentID=1381

Meeting the Complex Needs of people with Dementia http://www.alzheimers.org.uk/site/scripts/documents_info.php?documentID=131

Foundation Certificate in Dementia Awareness www.alzheimers.org.uk/site/scripts/download_info.php?fileID=1331

eLearning: The Open Dementia Programme www.scie.org.uk/publications/elearning/dementia/index.asp

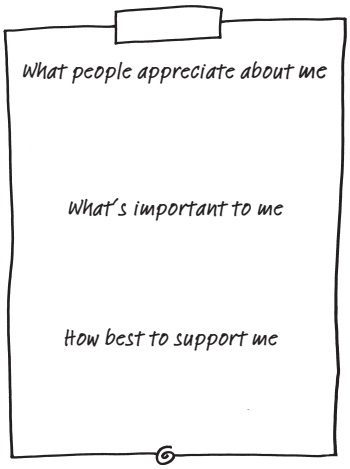
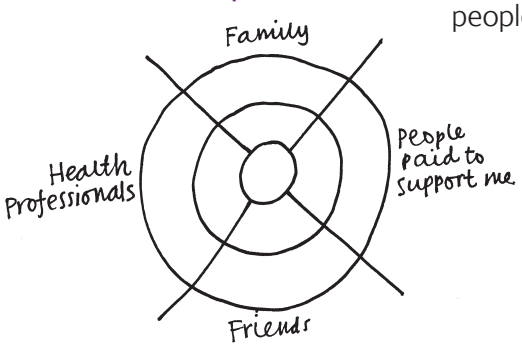
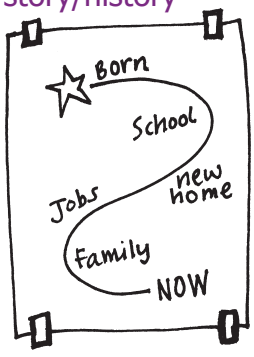
Habits for highly effective staff www.helensandersonassociates.co.uk

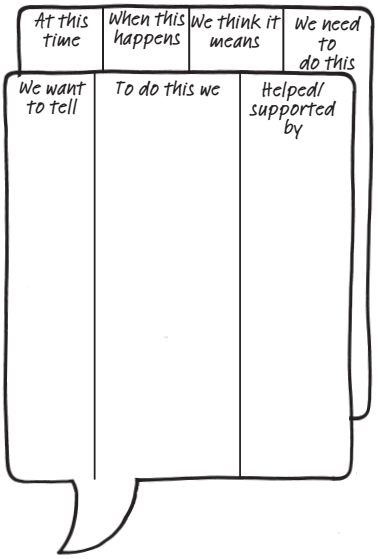
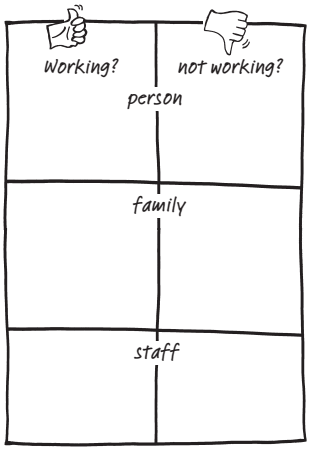
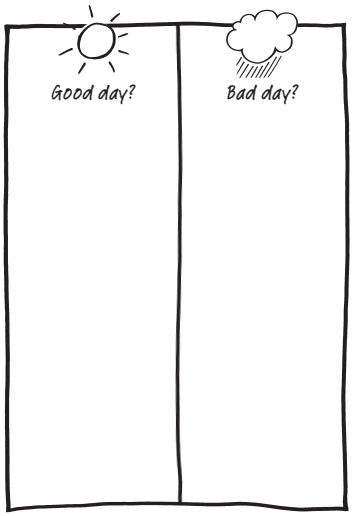
At a glance 20: Personalisation briefing, implications for nursing www.scie.org.uk/publications/ataglance/ataglance20.asp

At a glance 17: Personalisation briefing, implications for residential acre homes www.scie.org.uk/publications/ataglance/ataglance17.asp

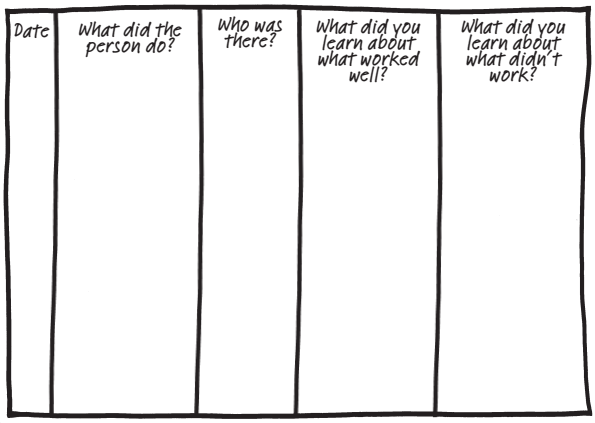
SCIE Research briefing 35: Black and minority ethnic people with dementia and their access to support and service http://www.scie.org.uk/publications/briefings/briefing35/

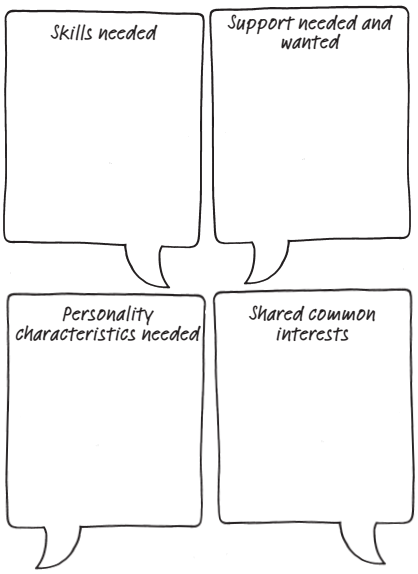
Dementia Supporting people with dementia and their carers in health and social care www.scie.org.uk/publications/misc/dementia/index.asp

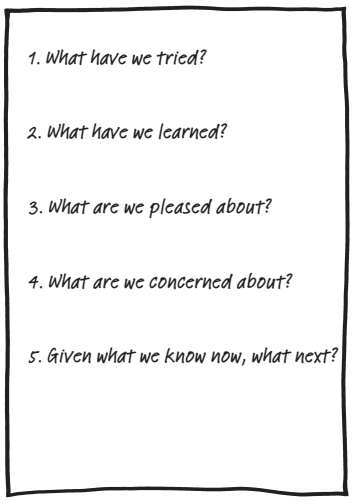
Person-centred thinking tool	What it does	How this person-centred thinking tool helps
One page profile (sorting important to/for) 	Separates what is important TO someone (what makes the person happy, content and increases well being), from what is important FOR them (the help or support they need to stay healthy, safe and well) while working towards a balance between the two.	• Identifies what must be present, or absent, in the person's life to ensure they are supported in ways that make sense to them, whilst staying healthy and safe. • A quick summary of who the person is and how to support them for all staff and others. • The basis for making changes using a one page profile with working/not working.
Appreciations 	Identifies the qualities that people value and admire about the person with dementia. Helps supporters to see what makes the person unique.	• Acknowledges and appreciates a person's gifts and qualities. • Ensures we see people for who they are and counters the frequent focus on what is wrong. • Identifies those who have a personal connection with the person and those who really know what is important to them. • Part of a one page profile.
Relationship circle 	Identifies who the important people are in a person's life.	• Learn who is most important to the person. • Sees if there are any important issues around relationships. • Helps identify who to talk to when gathering information. • Identifies relationships that can be strengthened or supported.
Life story/history 	Our histories make us who we are – with history comes regard. Gives people the opportunity to understand and appreciate the person with dementia in the context of their own story.	• Shows us how best to support the person in the context of their past life which may represent current reality. • Can be used to frame meaningful conversation. • Helps supporters empathise with the person and see their role as ensuring a good quality of life for them.

Person-centred thinking tool	What it does	How this person-centred thinking tool helps
Communication chart 	A quick snapshot of how someone communicates. Important whenever what the person does communicates more clearly than what they say.	• Helps us focus on people's communication whether they use words to speak or not. • Provides clear information about how to respond to the way the person communicates.
Working/not working 	Analyses an issue or situation across different perspectives. Provides a picture of how things are right now, and how this compares with the way people want to live and be supported. Enables us to reflect on what is actually happening in someone's life and to change what needs to be changed.	• Clarifies what to build on (maintain or enhance) and what to change. • Helps in looking at how – any part of a person's life is working medications are working people providing paid support are doing in their work any effort, activity or project is working. • Helps with mediation where there are disagreements. • Use to create actions from a one page profile.
Good days and bad days 	Explores what makes a good day and what makes a bad day. Enables the person and their supporters to make changes which will result in more good days. Helps us explore what the information we capture reflects about what is important to someone and how best to support them from their perspective.	• We see what needs to be present and what needs to be absent in someone's life. • Provides information to someone who may not know the person well. • Gives us ideas for ensuring lots of good moments and experiences that lift a person's spirit are present on a daily basis. • By focusing consistently on a person's feelings in the now rather than over emphasising the loss of memory. • Provides information for a one page profile.

Person-centred thinking tool	What it does	How this person-centred thinking tool helps
Learning log	Directs people to look for ongoing learning through recording specific activities and experiences.	• Provides a way for people to record ongoing learning (focused on what worked well and what didn't work well) for any event or activity. • Tells us what is important to and for individuals and families. • Can replace traditional notes or records to help us see the importance of moving away from focusing on getting tasks done, to truly supporting people to have a good life based on our continual listening and learning. • Can be used to focus on someone's whole life or specific areas of their life, e.g. someone's health, how people like to spend their time.
Matching staff	Provides a structure to look at what skills, supports, people characteristics and shared interests make for good matches.	• Encourages the person, and those around them, to think about what kind of paid support they want and need when recruiting team members. • Ensures the person with dementia likes the people who are supporting them, making it more likely they will have a good quality of life.
4 plus 1 questions	Helps people focus on what they are learning from their efforts. Given this learning, what needs to happen next?	• Gives a structured way for everyone to be listened to and describe what they have learned. • Useful in; review meetings and individual work with families. • To review actions from plans and plan further actions.







Dementia Action Alliance - National Dementia Declaration	Where this is addressed in Progress for Providers
1. I have personal choice and control or influence over decisions about me	1.3 We know and act on what matters to the person 1.5 We know and respond to how the person communicates 1.6 The person is supported to make choices and decisions every day 1.12 We support individuals to be in the best possible physical health
2. I know that services are designed around me and my needs	1.2 We understand the person's life history 1.3 We know and act on what matters to the person 1.4 We know and act on what the person wants in the future (outcomes) 1.7 We know exactly how the person wants to be supported and how to support them to be fully part of everyday life 1.8 We know what is working and not working for the person and we are changing what is not working 1.12 We support individuals to be in the best possible physical health 1.13 There is a person–centred culture of respect and warmth 1.14 People have personal possessions
3. I have support that helps me live my life	1.6 The person is supported to make choices and decisions every day 1.7 We know exactly how the person wants to be supported and how to support them to be fully part of everyday life 1.8 We know what is working and not working for the person and we are changing what is not working 1.9 We support people to initiate and maintain friendships and relationships 1.10 We support the person to be part of their community and civic life 1.15 Mealtimes are pleasurable, flexible, social occasions
4. I live in an enabling and supportive environment where I feel valued and understood	1.1 We see and treat the person with dementia as an individual 1.2 We understand the person's life history 1.3 We know and act on what matters to the person 1.4 We know and act on what the person wants in the future (outcomes) 1.5 We know and respond to how the person communicates 1.6 The person is supported to make choices and decisions every day 1.7 We know exactly how the person wants to be supported and how to support them to be fully part of everyday life

Dementia Action Alliance - National Dementia Declaration	Where this is addressed in Progress for Providers
	1.8 We know what is working and not working for the person and we are changing what is not working 1.9 We support people to initiate and maintain friendships and relationships 1.10 We support the person to be part of their community and civic life 1.13 There is a person–centred culture of respect and warmth 1.14 People have personal possessions
5. I have a sense of belonging and of being a valued part of family, community and civic life	1.1 We see and treat the person with dementia as an individual 1.2 We understand the person's life history 1.3 We know and act on what matters to the person 1.7 We know exactly how the person wants to be supported and how to support them to be fully part of everyday life 1.8 We know what is working and not working for the person and we are changing what is not working 1.9 We support people to initiate and maintain friendships and relationships 1.10 We support the person to be part of their community and civic life 1.13 There is a person–centred culture of respect and warmth

Markers for Progress	Where this is addressed in Progress for Providers
1. Information and advice: having the information I need, when I need it. "I have the information and support I need in order to remain as independent as possible." "I have access to easy-to-understand information about care and support which is consistent, accurate, accessible and up to date." "I can speak to people who know something about care and support and can make things happen." "I have help to make informed choices if I need and want it." "I know where to get information about what is going on in my community."	**Section 2 – The Family** 2.2 Family members have good information
2. Active and supportive communities: keeping friends, family and place. "I have access to a range of support that helps me to live the life I want and remain a contributing member of my community." "I have a network of people who support me – carers, family, friends, community and if needed, paid support staff." "I have opportunities to train, study, work or engage in activities that match my interests, skills and abilities." "I feel welcomed and included in my local community." "I feel valued for the contribution that I can make to my community."	**Section 1 – The Person** 1.9 We support people to initiate and maintain friendships and relationships 1.10 We support the person to be part of their community and civic life **Section 2 – The Family** 2.3 Families contribute their knowledge and expertise **Section 3 – The Staff and Manager** 3.4 We have an agreed way of working that reflects our values
3. Flexible integrated care and support: my support, my own way. "I am in control of planning my care and support." "I have care and support that is directed by me and responsive to my needs." "My support is co-ordinated, co-operative and works well together and I know who to contact to get things changed." "I have a clear line of communication, action and follow up."	**Section 1 – The Person** 1.1 We see and treat the person with dementia as an individual 1.2 We understand the person's life history 1.3 We know and act on what matters to the person 1.4 We know and act on what the person wants in the future (outcomes) 1.5 We know and respond to how the person communicates 1.6 The person is supported to make choices and decisions every day 1.7 We know exactly how the person wants to be supported and how to support them to be fully part of everyday life 1.8 We know what is working and not working for the person and we are changing what is not working

Markers for Progress	Where this is addressed in Progress for Providers
	1.9 We support people to initiate and maintain friendships and relationships 1.10 We support the person to be part of their community and civic life 1.11 The environment is pleasant, homely and busy 1.12 We support individuals to be in the best possible physical health 1.13 There is a person–centred culture of respect and warmth. 1.14 People have personal possessions 1.15 Mealtimes are pleasurable, flexible, social occasions **Section 2 – The Family** 2.3 Families contribute their knowledge and expertise **Section 3 – The Staff and Manager** 3.3 Our team has a clear purpose 3.8 Staff are thoughtfully matched to people and rotas are personalised to people who are supported 3.9 Recruitment and selection is person–centred
4. Workforce: my support staff. "I have good information and advice on the range of options for choosing my support staff." "I have considerate support delivered by competent people." "I have access to a pool of people, advice on how to employ them and the opportunity to get advice from my peers." "I am supported by people who help me to make links in my local community."	**Section 1 – The Person** 1.1 We see and treat the person with dementia as an individual **Section 2 – The Family** 2.3 Families contribute their knowledge and expertise **Section 3 – The Staff and Managers** 3.1 We have knowledge, skills and understanding of person–centred practices 3.2 Staff are supported individually to develop their skills in using person–centred practices 3.3 Our team has a clear purpose 3.4 We have an agreed way of working that reflects our values 3.5 Staff know what is important to each other and how to support each other 3.6 Staff know what is expected of them 3.7 Staff feel that their opinions matter 3.8 Staff are thoughtfully matched to people and rotas are personalised to people who are supported 3.9 Recruitment and selection is person–centred 3.10 We have a positive, enabling approach to risk 3.11 Training and development is matched to staff 3.12 Supervision is person–centred 3.13 Staff have appraisals and individual development plans 3.14 Meetings are positive and productive

Markers for Progress	Where this is addressed in Progress for Providers
5. Risk enablement: feeling in control and safe. "I can plan ahead and keep control in a crisis." "I feel safe, I can live the life I want and I am supported to manage any risks." "I feel that my community is a safe place to live and local people look out for me and each other." "I have systems in place so that I can get help at an early stage to avoid a crisis."	**Section 1 – The Person** 1.1 We see and treat the person with dementia as an individual 1.2 We understand the person's life history 1.3 We know and act on what matters to the person 1.4 We know and act on what the person wants in the future (outcomes) 1.5 We know and respond to how the person communicates 1.6 The person is supported to make choices and decisions every day 1.7 We know exactly how the person wants to be supported and how to support them to be fully part of everyday life 1.8 We know what is working and not working for the person and we are changing what is not working 1.9 We support people to initiate and maintain friendships and relationships 1.10 We support the person to be part of their community and civic life 1.11 The environment is pleasant, homely and busy 1.12 We support individuals to be in the best possible physical health 1.13 There is a person-centred culture of respect and warmth 1.14 People have personal possessions 1.15 Mealtimes are pleasurable, flexible, social occasions **Section 3 – The Staff and Managers** 3.1 We have knowledge, skills and understanding of person-centred practices 3.2 Staff are supported individually to develop their skills in using person-centred practices 3.3 Our team has a clear purpose 3.4 We have an agreed way of working that reflects our values 3.5 Staff know what is important to each other and how to support each other 3.6 Staff know what is expected of them 3.7 Staff feel that their opinions matter 3.8 Staff are thoughtfully matched to people and rotas are personalised to people who are supported 3.9 Recruitment and selection is person-centred 3.10 We have a positive, enabling approach to risk 3.11 Training and development is matched to staff 3.12 Supervision is person-centred 3.13 Staff have appraisals and individual development plans 3.14 Meetings are positive and productive

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