सत्यमेव जयते

Government of India

Ministry of Social Justice and Empowerment

Department of Social Justice and Empowerment

Minimum Standards for Dementia Care Homes

Senior Citizens Welfare Division

GPOA-3, Netaji Nagar, New Delhi 110023

Email: jssrc-msje@gov.in | Ph: 011-26119226

Dementia India *Alliance*


OM SRI SAI RAM 28.03.2026
WISH YOU HAPPY
BIRTHDAY
PURNIMA

Preface

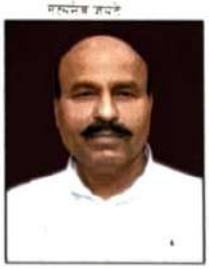
Dementia, is a complex condition that affects lakhs of elderly individuals in India and presents a significant challenge for families, caregivers and institutions. The condition results in progressive cognitive decline, functional dependency, and behavioural and psychological symptoms, which significantly affects the day-to-day functioning of individuals.

While many older adults with dementia are cared for at home, the progression of the condition often necessitates transition into long-term residential care facilities. Recognizing the significance of quality care and living conditions in these facilities, the Ministry of Social Justice and Empowerment has taken stance in formulating the Minimum Standards for Dementia Care Homes.

The development of these minimum standards has been a collaborative effort. The Dementia India Alliance (DIA), with which Ministry has signed an MoU for dementia-screening of elderly in senior citizen homes under Atal Vayo Abhudyay Yojana, convened a National Conclave on Standards of Dementia Care in India on 20th July, 2024, in Chennai.

The document, "Minimum Standards for Dementia Care Homes" has been formulated based on the deliberations of stakeholders who participated in the conclave as well as inputs received from the concerned line Ministries.

डॉ. वीरेन्द्र कुमार
DR. VIRENDRA KUMAR
सामाजिक न्याय और अधिकारिता मंत्री
भारत सरकार
MINISTER OF
SOCIAL JUSTICE AND EMPOWERMENT
GOVERNMENT OF INDIA



कार्यालय : 8619, जोन 6, आठवां तल, जीपीओए-3,
नेताजी नगर, नई दिल्ली -110023
दूरभाष : 011-24105011, 011-24105009
फैक्स : 011-24101052
ई-मेल : min-sje@nic.in

Office : 8619, Zone 6, 8th Floor, GPOA - 3
Netaji Nagar, New Delhi-110023
Tel : 011-24105011, 011-24105009, Fax : 011-24101052
E-mail : min-sje@nic.in

प्रस्तावना

जैसे-जैसे भारत में वृद्धजनों की आबादी बढ़ रही है, वैसे-वैसे संरचित, सहानुभूति और गरिमापूर्ण डिमेंशिया देखभाल की आवश्यकता तेजी से महत्वपूर्ण हो रही है। भारत सरकार डिमेंशिया से पीड़ित व्यक्तियों सहित वृद्धजनों की देखभाल की प्रणाली को मजबूत करने के लिए प्रतिबद्ध है ताकि वे गरिमापूर्ण, सुरक्षित जीवन जी सके और सहायता पा सकें। यह प्रकाशन, *"डिमेंशिया केयर होम्स के लिए न्यूनतम मानक"*, इस दिशा में एक महत्वपूर्ण कदम है।

सामाजिक न्याय और अधिकारिता मंत्रालय के तत्वावधान में "तैयार किए गए डिमेंशिया केयर होम्स के लिए न्यूनतम मानक" प्रस्तुत करते हुए मुझे अत्यंत खुशी का अनुभव और दायित्व बोध हो रहा है। इस दस्तावेज़ का उद्देश्य यह सुनिश्चित करना है कि भारत में डिमेंशिया से पीड़ित प्रत्येक व्यक्ति को सुरक्षित, संवेदनशील, गरिमापूर्ण और व्यक्ति-केंद्रित ऐसी देखभाल प्राप्त हो, जो हमारे देश की सांस्कृतिक पृष्ठभूमि और जमीनी वास्तविकताओं के अनुरूप हो।

इन मानकों को सामाजिक न्याय और अधिकारिता मंत्रालय और डिमेंशिया इंडिया एलायंस (डीआईए) की साझेदारी में चिकित्सकों, विधि विशेषज्ञों, देखभालकर्ताओं, शोधकर्ताओं और नीति निर्माताओं ने मिलकर तैयार किया है। उनके सामूहिक अनुभव और अंतर्दृष्टि ने एक व्यापक रूपरेखा तैयार की है, जिससे डिमेंशिया अनुकूल देखभाल परिवेश स्थापित करने में मार्गदर्शन मिलेगा, ताकि डिमेंशिया पीड़ित प्रत्येक व्यक्ति गरिमापूर्ण और स्वस्थ जीवन जी सके।

मैं उन विशेषज्ञों और हितधारकों के प्रति आभार व्यक्त करता हूं जिन्होंने इस दस्तावेज को तैयार करने में योगदान दिया है। उनकी अंतर्दृष्टि और समर्पण ने एक ऐसे दस्तावेज़ को आकार दिया है जो डिमेंशिया देखभाल (केयर) की विभिन्न आवश्यकताओं के अनुरूप है। ये मानक डिमेंशिया के साथ जीवन जी रहे व्यक्तियों और उनके परिवारों के जीवन की गुणवत्ता में सुधार लाने के लिए आधार के रूप में काम करेंगे और यह सुनिश्चित करेंगे कि डिमेंशिया से पीड़ित व्यक्तियों के साथ वह सम्मान, ध्यान और करुणापूर्ण व्यवहार किया जाए, जिसके वे सही हकदार हैं।

मुझे विश्वास है कि यह दस्तावेज डिमेंशिया देखभाल में लगे संस्थानों, सेवा प्रदाताओं और देखभालकर्ताओं के लिए एक मूल्यवान संसाधन होगा। ये मानक सहानुभूतिपूर्ण देखभाल परिवेश तैयार करने में मार्गदर्शन करेंगे और देश भर में डिमेंशिया देखभाल सेवाओं को मजबूत करेंगे।

(डॉ. वीरेंद्र कुमार)

बी. एल. वर्मा
उपभोक्ता मामले, खाद्य और सार्वजनिक वितरण एवं
सामाजिक न्याय और अधिकारिता राज्य मंत्री
भारत सरकार

सत्यमेव जयते

B. L. VERMA
MINISTER OF STATE FOR
CONSUMER AFFAIRS, FOOD AND PUBLIC DISTRIBUTION &
SOCIAL JUSTICE AND EMPOWERMENT
GOVERNMENT OF INDIA

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संदेश

"डिमेंशिया केयर होम्स के लिए न्यूनतम मानक" का प्रकाशन भारत में डिमेंशिया देखभाल में सुधार की दिशा में हमारी सामूहिक यात्रा में एक महत्वपूर्ण पड़ाव है। यह दस्तावेज देखभाल की सुविधा प्रदान करने के लिए विभिन्न हितधारकों की साझा प्रतिबद्धता को दर्शाता है जो नैतिक, सुरक्षित और डिमेंशिया से पीड़ित व्यक्तियों की जरूरतों के अनुरूप है। यह देखकर प्रसन्नता हो रही है कि सिफारिशें हमारी स्वास्थ्य सेवा प्रणाली और सांस्कृतिक संदर्भ की वास्तविकताओं पर आधारित हैं।

माननीय प्रधानमंत्री के नेतृत्व में हमारी सरकार ***'सबका साथ, सबका विकास, सबका विश्वास और सबका प्रयास'*** के मूल मंत्र पर कार्य करते हुए स्वास्थ्य सेवाओं को अधिक **सुलभ**, **उत्तरदायी** और **मानवीय** बनाने हेतु निरंतर प्रयासरत है। डिमेंशिया से पीड़ित व्यक्तियों के लिए यह मानक न केवल देखभाल की दिशा तय करेंगे, बल्कि सेवा प्रदाताओं के लिए उत्तरदायित्व और पारदर्शिता सुनिश्चित करेंगे।

मैं सभी राज्य सरकारों, संबंधित अधिकारियों, संस्थानों एवं सेवा प्रदाताओं से आग्रह करता हूँ कि वे इन मानकों को प्राथमिकता के साथ अपनाएं और प्रभावी रूप से लागू करें। यह हमारी सामूहिक जिम्मेदारी है कि हम एक ऐसा वातावरण तैयार करें जहाँ डिमेंशिया से पीड़ित प्रत्येक व्यक्ति को गरिमा, सुरक्षा और गुणवत्तापूर्ण देखभाल प्राप्त हो।

आइए, हम सब मिलकर एक संवेदनशील और समावेशी भारत के निर्माण में अपना योगदान दें।

(बी. एल. वर्मा)

रामदास आठवले
RAMDAS ATHAWALE

सत्यमेव जयते

सामाजिक न्याय और अधिकारिता राज्य मंत्री
भारत सरकार

MINISTER OF STATE FOR
SOCIAL JUSTICE & EMPOWERMENT
GOVERNMENT OF INDIA

संदेश

मैं उन सभी के प्रयासों की सराहना करता हूं जिन्होंने "डिमेंशिया केयर होम्स के लिए न्यूनतम मानक" तैयार करने में योगदान दिया है। यह महत्वपूर्ण पहल देश भर में डिमेंशिया देखभाल सुविधाओं के विकास और कामकाज का मार्गदर्शन करने के लिए एक स्पष्ट ढांचा प्रदान करती है। व्यक्ति-केंद्रित देखभाल पर ध्यान केंद्रित करके और मौजूदा कानून के अनुरूप, ये मानक देखभाल गृहों को बेहतर ढंग से सुसज्जित करने और डिमेंशिया से ग्रसित व्यक्तियों की विशेष जरूरतों को पूरा करने के लिए एक रोडमैप प्रदान करते हैं।

इन मानकों की देशभर में डिमेंशिया केयर के तौर-तरीकों को मजबूत करने के लिए एक मार्गदर्शक संदर्भ के रूप में परिकल्पना की गई है। सामूहिक प्रयासों से, ये मानक डिमेंशिया से पीड़ित व्यक्तियों के लिए अधिक करुणामय और समावेशी पारिस्थितिकी तंत्र के निर्माण में योगदान कर सकते हैं।

30/3/21

(रामदास आठवले)

सुधांश पंत, भा.प्र.से.
सचिव
Sudhansh Pant, IAS
Secretary

सत्यमेव जयते

भारत सरकार
सामाजिक न्याय और अधिकारिता मंत्रालय
सामाजिक न्याय और अधिकारिता विभाग
Government of India
Ministry of Social Justice & Empowerment
Department of Social Justice & Empowerment

संदेश

डिमेंशिया एक जटिल स्थिति है जो प्रभावित व्यक्तियों और उनके परिवारों के जीवन को गहराई से प्रभावित करती है। "डिमेंशिया केयर होम्स के लिए न्यूनतम मानक" देश भर में डिमेंशिया देखभाल सुविधाओं की स्थापना करने और उनके प्रभावी कामकाज में सहायता करेंगे। यह दस्तावेज़ डिमेंशिया से पीड़ित व्यक्तियों के लिए उपयुक्त और उत्तरदायी देखभाल प्रदान करने में संस्थानों और सेवा प्रदाताओं के मार्गदर्शन के लिए एक व्यावहारिक ढांचा प्रदान करता है। यह एक महत्वापूर्ण संसाधन के रूप में कार्य करेगा जो डिमेंशिया की देखभाल के तौर-तरीकों में स्थायित्व और गुणवत्ता को बढ़ावा देगा।

सुधांश पंत

(सुधांश पंत)

मोनाली पी. धकाटे
संयुक्त सचिव
MONALI P. DHAKATE
Joint Secretary

सत्यमेव जयते

आज़ादी का अमृत महोत्सव

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सामाजिक न्याय और अधिकारिता मंत्रालय
सामाजिक न्याय और अधिकारिता विभाग
जीपीओए, ब्लॉक–3, नेताजी नगर, नई दिल्ली–110023
GOVERNMENT OF INDIA
MINISTRY OF SOCIAL JUSTICE & EMPOWERMENT
DEPARTMENT OF SOCIAL JUSTICE & EMPOWERMENT
GPOA, BLOCK-3, NETAJI NAGAR, NEW DELHI-110023

संदेश

डिमेंशिया के लिए कारगर देखभाल सुविधा की व्यवस्था करने के लिए एक ऐसे विशेषीकृत दृष्टिकोण की आवश्यकता है, जो शारीरिक सुरक्षा और मनोवैज्ञानिक स्वास्थ्य के बीच संतुलन स्थापित करे। ये न्यूनतम मानक डिमेंशिया-अनुकूल गृहों के लिए अवसंरचना, सुरक्षा प्रोटोकॉल और प्रचालन प्रक्रियाओं के लिए एक सुस्पष्ट रूपरेखा प्रदान करते हैं। इन मानकों को परिभाषित करके हमारा उद्देश्य यह सुनिश्चित करना है कि देखभाल केंद्र सभी निवासियों की विशिष्ट संज्ञानात्मक और व्यावहारिक आवश्यकताओं को बेहतर ढ़ंग से पूरा करने में सक्षम हों। यह मार्गदर्शिका डिमेंशिया से पीड़ित व्यक्तियों की जरूरतों के अनुरूप सुरक्षित, समावेशी और उत्तरदायी परिवेश सृजित करने के लिए एक व्यापक रोडमैप के रूप में कार्य करेगी।

(मोनाली पी. धकाटे)

Dementia India *Alliance*

Bringing Help | Building Hope

Dr Radha S Murthy
President

Message

India stands at a defining moment in its approach to dementia care. As life expectancy rises and the prevalence of dementia increases, the responsibility to ensure safe, dignified, and compassionate care for those affected becomes ever more pressing. This publication, "Recommendations on Minimum Standards for Dementia Care Homes," represents an important step toward that goal.

Emerging from the National Conclave on Minimum Standards for Dementia Care Homes, held in Chennai on July 20, 2024, this document brings together expert recommendations shaped by rigorous discussion and grounded experience. The conclave, hosted by Dementia India Alliance (DIA), drew participation from over 70 stakeholders—including clinicians, care providers, policymakers, family carers, and legal professionals—who shared perspectives on the regulatory and operational challenges in implementing the Mental Healthcare Act (MHCA) 2017 in dementia care settings.

The Ministry of Social Justice and Empowerment (MoSJE) has been at the forefront of promoting elder welfare and long-term care systems in India. We hope this document serves as a valuable resource in shaping future policy directives and national standards for dementia care facilities. These practical, India-contextual standards prioritize rights, dignity, autonomy, trained staff, infrastructure, and ethical practices.

Contents

A. Introduction

Dementia is currently the seventh leading cause of death among all diseases and one of the major causes of disability and dependency among older people worldwide. It has physical, psychological, social and economic impacts, not only for people living with dementia, but also for their carer-givers, families and society at large.

Worldwide, around 55 million people have dementia, with over 60% living in low- and middle-income countries. As the proportion of older people in the population is increasing in nearly every country, this number is expected to rise to 78 million in 2030 and 139 million in 2050.

There are an estimated 10 million new cases of dementia each year worldwide, implying one new case every 3.2 seconds (WHO, 2019).

B. What is Dementia?

Dementia describes a range of neurological conditions where brain cells and their connections are damaged, leading to impaired communication and function. It causes a progressive decline in cognitive functions such as memory, thinking, and reasoning, interfering with daily life and activities. It's not a normal part of ageing, though age is a risk factor. Alzheimer's disease is the most common type of Dementia.

C. Understanding the Indian Data

The main documents which help us to understand the prevalence data in India are

(i) Census of India (2011),

(ii) Dementia India Report (2010)

(iii) World Alzheimer Report (2015)

(iv) LASI DAD Study (2022)

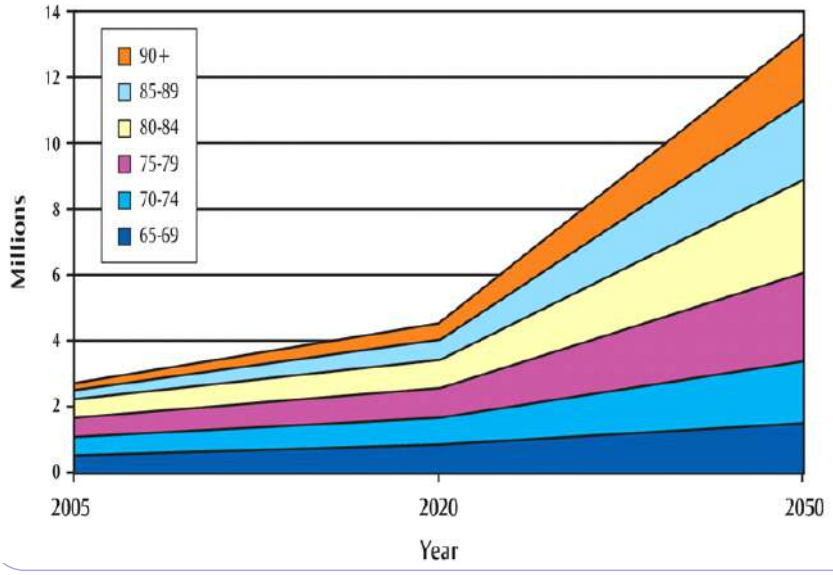


Figure 1:
It was estimated that 5.3 million people above the age of 60 have dementia in India in 2020. It equals to, one in 27 people above the age of 60 in India, has dementia.
Dementia India Report (2010)

There are nearly 104 million elderly persons (above the age of 60 years) in India, 53 million females and 51 million males. More than 73 million elderly persons (71%) live in rural areas. The proportion of elderly persons has increased from 5.8 per cent to 8.8 per cent in rural areas, and from 4.7 percent to 8.1 percent in urban areas during 1961 to 2011. Kerala has the highest proportion of elderly people in its population (12.6 %) followed by Goa (11.2 %) and Tamil Nadu (10.4 %) as per Population Census 2011.

Dementia India Report (2010) conducted a detailed review of literature and it was estimated that 3.7 million people lived with dementia in India in 2010 and this figure was estimated to increase to 4.41 million in 2015, 5.29 million in 2020, 6.35 million in 2025, 7.61 million in 2030, 9.07 million in 2035, 10.69 million in 2040, 12.47 million in 2045 and 14.32 million in 2050.

Because age is the strongest and best-known risk factor for dementia, India faces an alarming potential increase in the number of people with dementia. As per the LASI-DAD Study (2019), estimated dementia prevalence for people above the age of 60 in India is 7.4%. These numbers are expected to increase from 8.8 million to 17 million by 2036. The treatment or service gap for dementia in India is thought to be nearly 90%, with only one in 10 people with dementia receiving a diagnosis, treatment, or care.

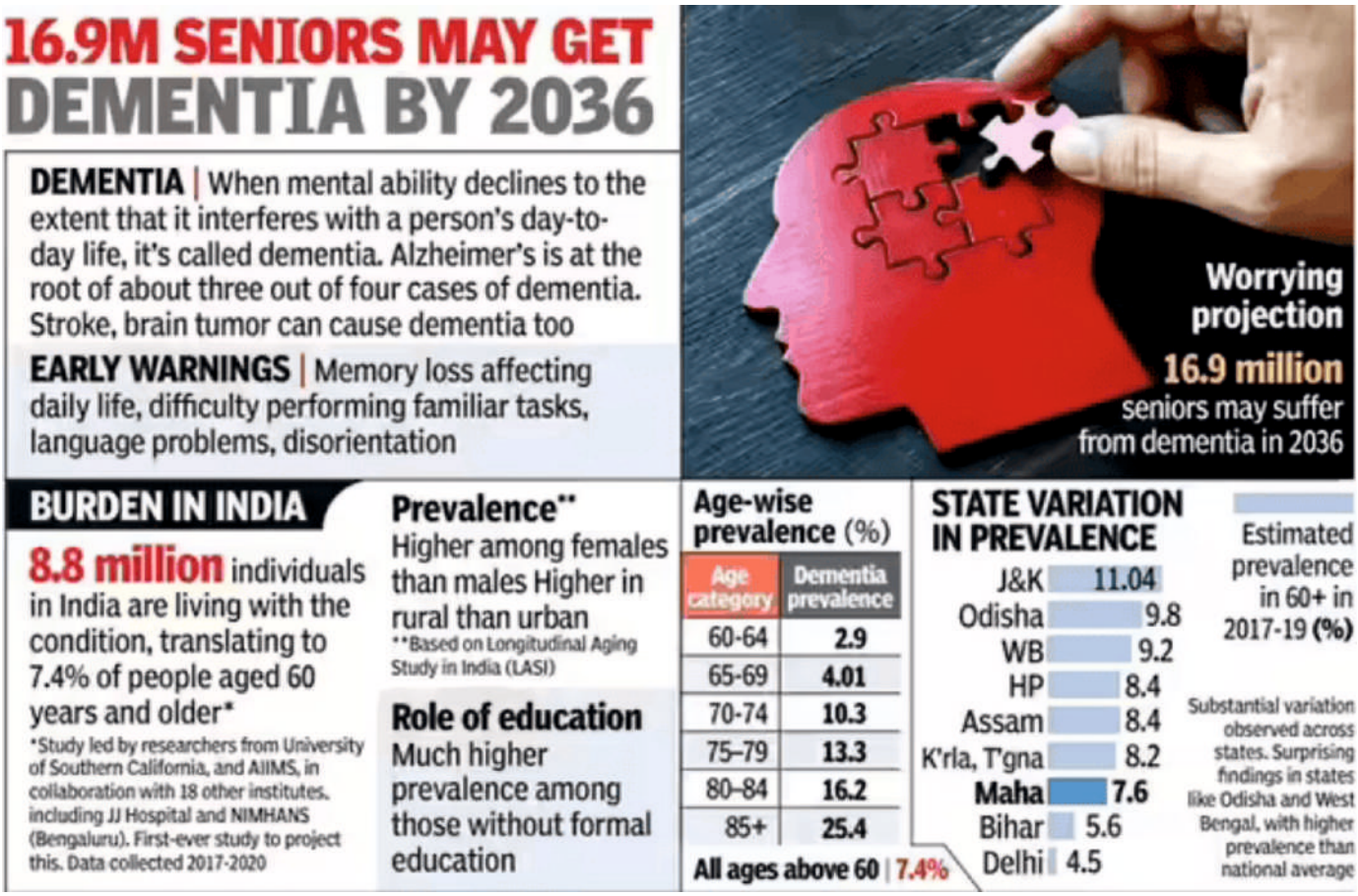


Figure 2: Estimated Dementia Prevalence of 7.4% of seniors / 8.8 million elderly in India. The study highlights prevalence double among women, and links to education and early-life nutrition. Times of India, 20.02.2023

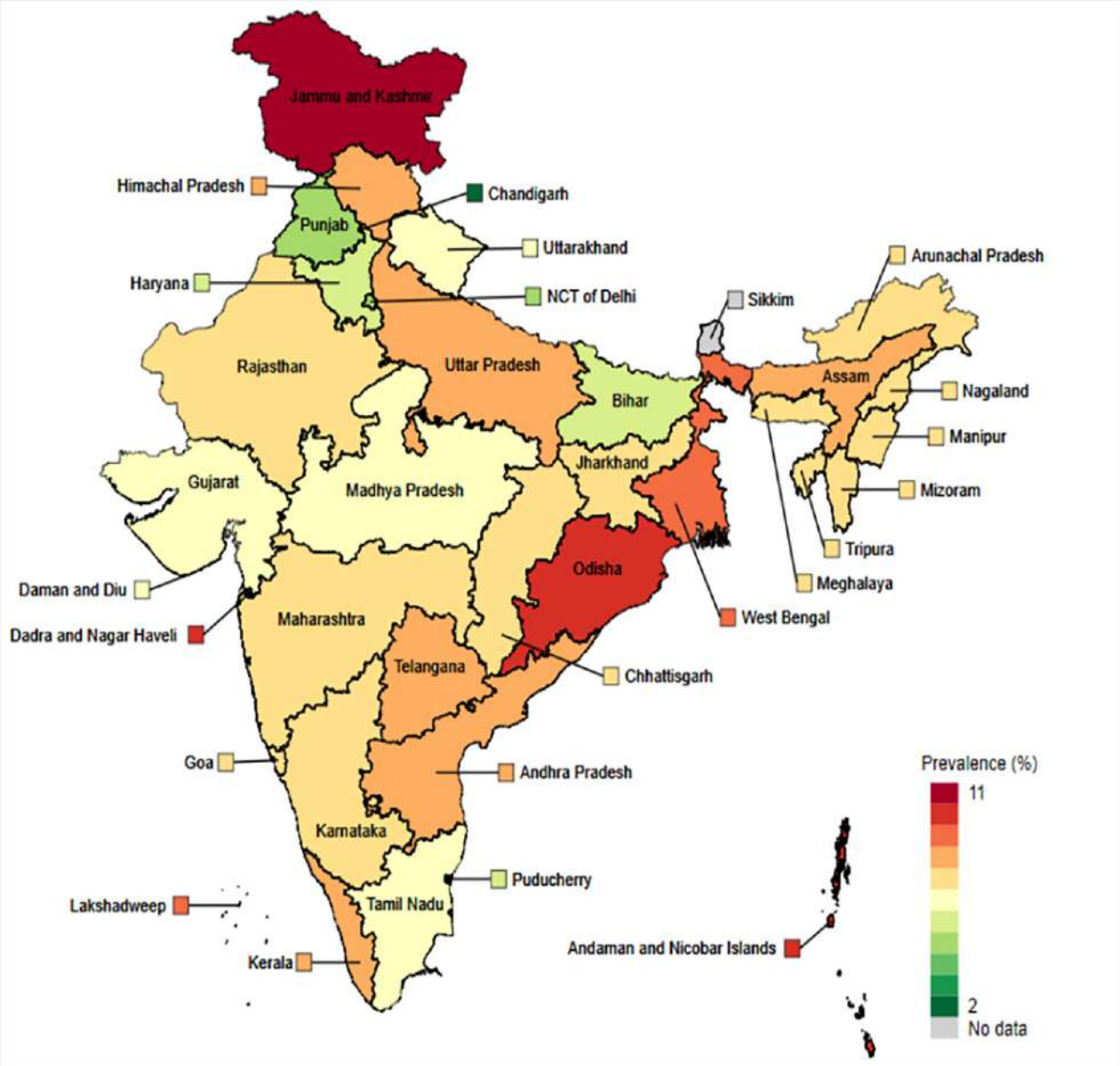


Figure 3: Map showing the prevalence of dementia by state in India with dark red signifying the highest prevalence and dark green the lowest. While 7.4% is the estimated dementia prevalence rate for adults aged 60 and older across the country, the map shows it is unevenly distributed across Indian states.

Figure 4: Projected increase in prevalence based on previous estimates. Predicting the accelerated doubling rate and cost of care, underscoring the pressing need for better care and support.

D. Signs of Dementia

The most common early signs are memory loss difficulty in concentrating, finding it hard to carry out familiar daily tasks such as getting confused over the correct change when shopping, struggling to follow a conversation or find the right word, being confused about time and place and mood changes etc.

E. Stages of Dementia

Dementia is a non-reversible, progressive condition, which means that it typically worsens over time. The rate of progression can vary depending on the underlying cause of dementia and other factors such as age and overall health. Here are some general stages of dementia progression.

Mild (Early Stage)

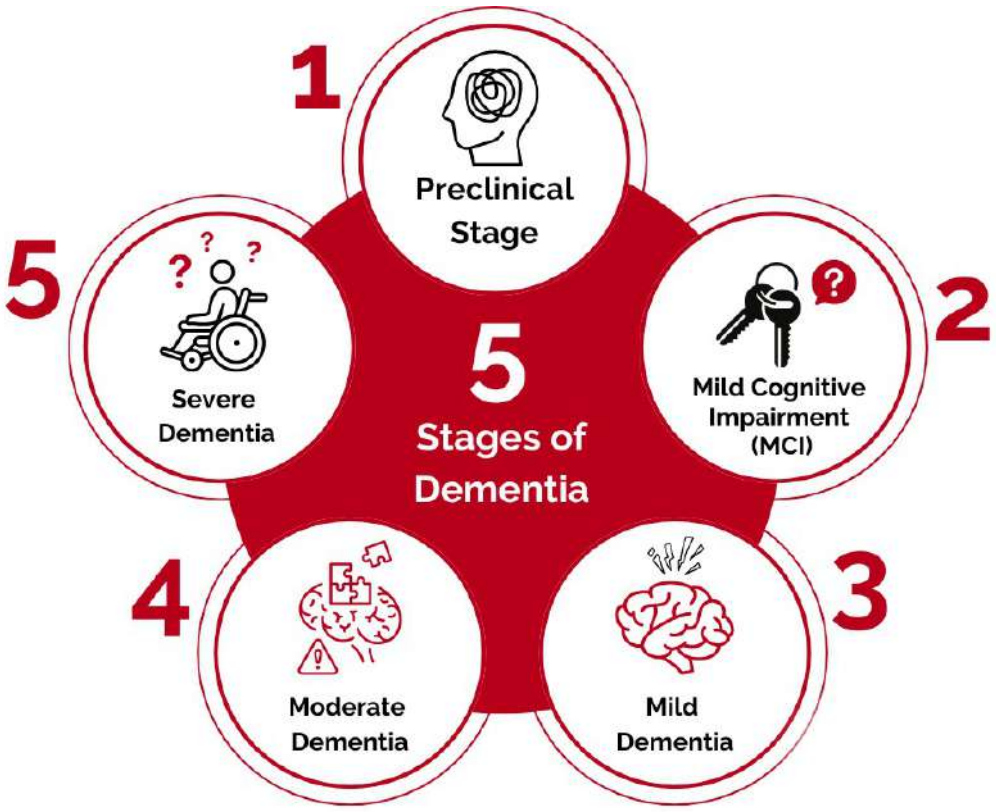
- Still largely independent
- Diffficulty thinking of the right word or name
- Forget material that was just read
- Difficulty in performing tasks in social or work settings

Moderate (Middle Stage)

- Feel moody or withdrawn
- Unable to recall information about themselves
- Experience confusion about where they are
- Personality and behavioural changes

Severe (Late Stage)

- Require round-the-clock assistance
- Experience changes in physical abilities
- Difficulty in communicating
- Vulnerable to infections



F. Legal and Ethical Issues in Dementia

Dementia is associated with significant cognitive impairment. Those affected by dementia are more vulnerable to loss of mental capacity, homelessness, wandering in society, neglect, exploitation, abuse, violence, institutionalization, inadequate medical and psychiatric care and violation of their human rights. In this scenario, there is a need for focused health-related policies and programs as well as legal and ethical frameworks to protect the interests of elderly people with dementia.

1. National Policy on Older Persons, 1999

It looks into the provision of

a) financial Security (old-age pension, retirement benefits);

b) healthcare and nutrition;

c) shelter;

d) welfare; and

e) protection of life and property.

2. Maintenance and Welfare of Parents and Senior Citizens Act, 2007 (MWPSC Act, 2007)

This Act places a legal obligation on children and heirs to provide sufficient maintenance to senior citizens, Mandates State Governments to establish old-age homes in every district with a minimum capacity of 150 senior citizens per home. It also contains provisions for speedy disposal of maintenance claims through dedicated Tribunals

3. National Council of Senior Citizens

The National Council of Senior Citizens is an autonomous body headed by the Minister for Social Justice & Empowerment, Government of India. This was set up to identify and address the concerns of older persons. The council advises Governments on issues related to the welfare of senior citizens like a) Policies, programs and legislative measures related elderly; b) Promotion of physical and financial security, health and independent and productive living; and others.

4. Mental Health Care Act, 2017

The Mental Healthcare Act (MHCA), 2017 replaces the Mental Health Act 1987. It was enacted to be in line with the United Nations Convention on the Rights of Persons with Disabilities in 2007.

The provisions of MHCA, 2017 that are relevant to the care of persons with dementia are:

a) Psychiatric Advance Directives;

b) Nominated Representatives and

c) Consent for Admission and Treatment and

d) Right to access mental health care

5. The Rights of Persons with Disabilities Act, 2016

India signed the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD) and subsequently ratified the same on October1, 2007. To comply with UNCRPD, the Government of India ratified the Rights of Persons with Disabilities Act, 2016 (RPWD Act 2016) to replace the Persons with Disabilities (PWD) Act 1995.

It has provisions for persons with dementia, who have a disability, for a) Guardianship; b) Disability welfare and social benefits provision and c) Right to access to justice.

6. Memorandum of Understanding with Dementia India Aliance (DIA)

The Ministry of Social Justice and Empowerment has an MOU with DIA for screening all the elderlies in the senior citizen homes funded through Atal Vayo Abhudaya Yojana. The elderlies are screened or assessed for possible dementia, which can be a valuable measure in improving diagnosis rates and helping them access the service they need.

G. Need for Minimum Standards for Dementia Care Homes

The Alzheimer's and Related Disorders Society of India (ARDSI), in collaboration with the Neurology Department of Indira Gandhi Cooperative Hospital, Cochin, established India's first Memory Clinic in 1999. Patients with memory disorders were referred from general practitioners, hospitals, NGOs, and the public; psychiatric social workers screened them, with potential cases advancing to neurologists for diagnosis and management.

Government-run Memory Clinics remain scarce in India. The Dementia India Report (2010) estimated around 100 such clinics, mostly in super-specialty hospitals—one per 37,000 people—with limited data on their functioning or team composition. Development has been sporadic, often tied to medication prescription rather than comprehensive care, leaving a shortage of specialized service providers.

Most people with dementia receive care at home initially. However, behavioral issues and disease progression often lead to long-term care facilities, spurring a rise in dementia-specific homes.

Mental Health Act 2017 provides a regulatory framework for minimum standards in mental health facilities. However, specific regulations for care facilities are an area yet to be explored in the Indian context. Without mandatory standards for infrastructure, management, licensing, and care—especially for dementia facilities—residents face risks, and providers encounter disputes over care quality. Establishing uniform Minimum Standards for Dementia Care Homes is essential to ensure consistent, high-quality service provision nationwide.

Dementia India Alliance (DIA) convened a National Conclave to formulate and propose uniform minimum standards and regulations for dementia care facilities across India. The conclave brought together around 70 stakeholders from across the country, including dementia and elder-care providers, clinicians, legal experts, family carers, and policymakers, whose deliberations have directly informed the development of these minimum standards for dementia care.

H. Minimum Standards for Dementia Care Homes

I. Licensing

1.1. Mandatory Registration under MHCA, 2017: All facilities catering to people with mental health issues have to be registered under the provisions of Mental Healthcare Act (MHCA), 2017. Dementia care homes must comply with MHCA, 2017. The state mental health rules need to be taken into consideration during registration of such homes.

Distinction between Old Age Home/Senior Citizen Home and Dementia Care Home should be clearly made. Places where elderly are not receiving any psychiatric treatment may not be covered by the Mental health Care Act, 2017.

1.2. Compliance requirements: Licensing involves securing various clearances and compliances including:

- NOC from fire department, pollution control board and neighbours.
- Bio-management approvals and occupancy certificate for facility safety.

1.3. Legal Admission procedures

- All sections of the Mental Healthcare Act, 2017 (MHCA 2017) apply to a Mental Health Establishment (MHE) once it is registered under the Act.
- Section 89 of the MHCA allows the admission of a person with dementia (considered under mental illness) for a period of 30 days only. If the mental health professional in charge of the mental health establishment feels the person require further treatment beyond the period of 30 days, then such medical officer or mental health professional shall be duty bound to refer the matter to be examined by two psychiatrists for his admission beyond 30 days.
- Section 90 of the MHCA also allows maximum of 180 days of admission. In the current situation, if any admissions are lasting longer than the above-mentioned period, mental health authorities have to be informed.
- Voluntary admission under Section 86 is also applicable.

1.4. Rights and Ethics of individuals

- The provisions and Directives of MHCA, 2017, on the Consent for Admission and Treatment, Nominated Representatives and the Right to access mental health care have to be scrupulously followed.
- Advanced directive and nominated representative needs to be in place during the admission stage, given the inability to consent in dementia during later stages.
- Data privacy has to be maintained in the Dementia care homes / centers as the patients have a fear of stigmatization.
- Third party assessment is also vital as it confirms the need of patients like admission, care needs met at home, reasons for admitting, capacity of patients, is the patient coming voluntarily, etc.

2. Infrastructure

All facilities shall comply with the Minimum Standards of Facilities for the registration of Mental Health Establishments, as notified in the Schedule of the Mental Healthcare (Central Mental Health Authority) Regulations dated 18th December, 2020, as amended from time to time. These standards may vary from State to State.

2.1. Physical features: Creating a safe environment for persons with dementia is essential for their well-being and peace of mind. Cognitive decline can make basic tasks challenging, and a supportive, structured environment can help minimize risks and promote a sense of security.

2.1.a. Dementia friendly design

- Infrastructure should be dementia friendly prioritizing an environment that supports the safety, mobility, and orientation of persons with dementia.
- All rooms are well-lit, ventilated with natural lighting.
- Secure indoor and outdoor spaces providing freedom of movement while encouraging exploration.
- The dementia care facility shall be a pucca structure.
- Proper connectivity to public and private transport shall be ensured, and the complete address (including the name, implementing agency, contact details, and accreditation details) shall be displayed at an appropriate place;
- A ramp facility shall be provided at the entrance. If steps are additionally provided, there shall be handrails along the steps at a minimum height of 900 mm and a maximum height of 1000 mm from the floor level.
- Periodic fumigation, pest control, and installation of wire meshes shall be ensured to keep out pests.
- At least one wheelchair shall be available in well-maintained working condition.

- No inflammable materials such as kerosene, petrol, or similar substances shall be stored anywhere within the facility.
- Residents with dementia shall be encouraged to use identification cards or wearable ID tags to ensure their safety in case they wander or get lost.

2.1.b. Floor Plans

- Floor plans should be simple, but not repetitive in order to increase way-finding ability.
- Avoid flooring with patterns and reflective shine and high glare as the patients often mistake dark markings on floors as holes, bugs, etc., and glare is often mistaken for icy surfaces.
- There should be non-slippery floors to provide freedom of movement in the common areas and to their personal spaces.
- Create straight and direct layouts to functional destinations, with limited changes in direction to assist with better wayfinding ability.
- Overcrowding shall be avoided, and elderly residents shall not be allowed to sleep on the floor.
- Daily sweeping, swabbing, and dusting of the entire premises shall be carried out.

2.1.c. Safety and comfort

- Strategically place ramps and grab bars to reduce fall risks.
- Use noise-reducing materials to create quiet zones and minimize stress.
- The facility shall not lock residents out of or inside their rooms.
- Consider installing baby monitors to alert caregivers if the patient attempts to leave the home unexpectedly.
- Gender-segregated sleeping facilities shall be provided. Couples may be accommodated in a single room.

- Beds shall have side rails to prevent residents from falling off
- Sufficient space shall be provided for wheelchair movement.
- Easy-to-grip door knobs or large lever-type handles shall be used.
- Lift/elevator facilities shall be provided with generator, inverter, or other power backup.
- Elevators shall have Braille buttons and auditory announcement systems.
- Heaters and coolers may be provided, subject to safety considerations and the health needs of elderly residents, according to seasonal requirements.
- Avoid sharp edges on hospital furniture, fittings, and equipment.

2.1.d. Hallway designs

- Hallways need to be clutter-free, with few decision points between destinations and clearly visible endings to provide a safe pathway.
- Sufficient space shall be provided for wheelchair movement. At minimum, the width of hallways should be 6ft – 8ft to provide adequate accessibility for persons using wheelchairs.
- Signage at the end of the hallway to reorient the patients and lead them back to activity areas.
- Use handrails throughout hallways to assist with general wayfinding and transition from room to room while including different shapes and textiles.
- Keep corridors clear of equipment to avoid distractions.
- Keep corridors and passageways through common use areas free of objects which may cause falls.
- Avoid dead ends in corridors by creating comfortable seating, activities (e.g. life skill station)

2.1.e. Signage & Wayfinding

- Clear labels and signs can greatly assist dementia patients in navigating.
- Use clear, contrasting signage and simple, direct layouts with minimal changes in direction. Place signage at eye level, using large, bold fonts and contrasting colours, with images wherever possible.
- Labelling drawers, cabinets, and rooms can reduce confusion and help them maintain a sense of independence.
- Incorporate landmark objects, such as memorabilia and artwork, to aid hospital wayfinding.

2.1.f. Toilet accessibility

- Toilets should be visually accessible and easy to find with anti-skid tiles
- The setup of the toilet areas should encourage and cue independent use through visual access and legibility.
- Consider installing alarm systems to alert caregivers if the patient has any difficulty unexpectedly.
- Bathroom doors should be sliding or outward opening

2.1.g. Promoting familiarity and independence

- Design spaces to feel homelike, with fewer doors and simple layouts.
- Encourage natural lighting to provide a view of outdoor greenery.
- Use meaningful engagement to draw familiar life experiences, past roles and include everyday life events.
- Activities should be significant to the patients and not just used as a diversion.

2.1.h. Community Integration

- Dementia care homes should be flexibly designed to promote social interactions while maintaining safety, independence and changes overtime.
- Communal areas for activities, dining, and socialization.
- Sensory rooms and engagement spaces tailored to PWD's abilities and preferences.

2.1.i. Special Provisions

- End-of-Life Care (EOL): Dedicated spaces for compassionate care.
- Isolation Wards: For infection control or special medical requirements.
- Green Spaces: Accessible outdoor areas for safe, therapeutic experiences.
- Emergency lights on all critical locations.

Creating a safe and supportive environment takes some effort but it's crucial for the health and happiness of dementia patients. It not only minimizes risks but also supports caregivers in providing the best possible care.

2.2. Support Services: The dementia care homes should have support services to ease their working and also to take care of the care givers and support workers enough space to provide the services. These support services include:

- Stores for medicines, consumables for residents
- Kitchen cum canteen space for cooking and common dining
- Reception/Office space for agreements/paper work and to provide information about care homes
- Memory clinic/assessment space
- Laundry space
- Waste management provisions for solid waste and appropriate treatment of sewage should be present.
- Full time ambulance service
- Tie up with medical facilities for emergency management
- Adequate water availability shall be ensured in wash basins and bathrooms

3. Staffing and Training

3.1. Staffing: Effective staffing is critical to ensure high-quality care and support for individuals with dementia in care homes. The following outlines the recommended staff categories, roles, and approximate staff-to-resident ratios to maintain an optimal standard of care:

3.1.a. Doctors (Psychiatrist, Neurologist, Geriatrician, Physician)

Role: Provide medical oversight, manage co-morbidities, prescribe medications, and address complex health needs.

Engagement: Part-time or full-time.

Staff-to-Resident Ratio: 1:50.

3.1.b. Mental Health Professionals (Psychologists, Social Workers)

Role: Offer psychological support, facilitate counselling, address behavioural challenges, and provide family support services.

Engagement: Full-time.

Staff-to-Resident Ratio: 1:50.

3.1.c. Skilled Nurses

Role: Deliver nursing care, monitor health conditions, administer medications, and support residents with daily medical needs.

Engagement: Full-time.

Staff-to-Resident Ratio: 1:10.

3.1.d. Nurse Aides / Trained Caregivers

Role: Assist with activities of daily living (ADLs), such as bathing, dressing, and feeding, while offering emotional support and companionship.

Engagement: Full-time.

Staff-to-Resident Ratio: 1:5.

3.1.e. Administration and Management

Role: Oversee facility operations, manage staff schedules, ensure compliance with regulations, and coordinate resident care plans.

Engagement: Full-time.

Staff-to-Resident Ratio: 1:15.

3.1.f. Therapists (Physiotherapist, Speech Therapist, Occupational Therapist, Dietician / Nutritionist)

Role: Provide rehabilitative and restorative therapies, improve residents' functional abilities, and promote physical and nutritional well-being.

Engagement: Part-time or full-time.

Staff-to-Resident Ratio: Dependent on specific needs.

3.1.g. Support Staff (Laundry, Housekeeping, Kitchen, Volunteers, Others)

Role: Maintain cleanliness, ensure meals are prepared, and provide logistical and auxiliary support to the care home. Volunteers may contribute to meaningful engagement activities.

Engagement: Part-time or full-time.

- An emergency response system and evacuation plan shall be in place. The plan shall be prominently displayed within the facility, with clear instructions written in the local language(s) and in English.
- Regular training shall be provided to all staff members to ensure they are prepared to respond effectively during emergencies. Residents who are not very sick and are capable of learning shall also be trained in basic emergency procedures to the extent possible.
- Hospital staff shall operate in compliance with the Mental Healthcare Act, 2017 and provides care accordingly.

3.2. Training Standards: To uphold care quality and safety, all staff must undergo robust, interdisciplinary training emphasizing both technical competence and person-centered approaches.

Core Training Areas

3.2.a. Person-Centered Care Principles

- Respect for individuality, dignity, and autonomy.
- Enabling independence and enhancing quality of life.

3.2.b. Care Planning and Delivery

- Competence in collecting & documenting clinical, personal& social histories.
- Skills to create, implement, and periodically update personalized care plans.

3.2.c. Health Monitoring and Reporting

- Ability to identify and document changes in residents' behaviour, physical health or emotional well-being.
- Competence in handling incidents like falls, injuries, and health emergencies.

3.2.d. Recreational and Therapeutic Activities

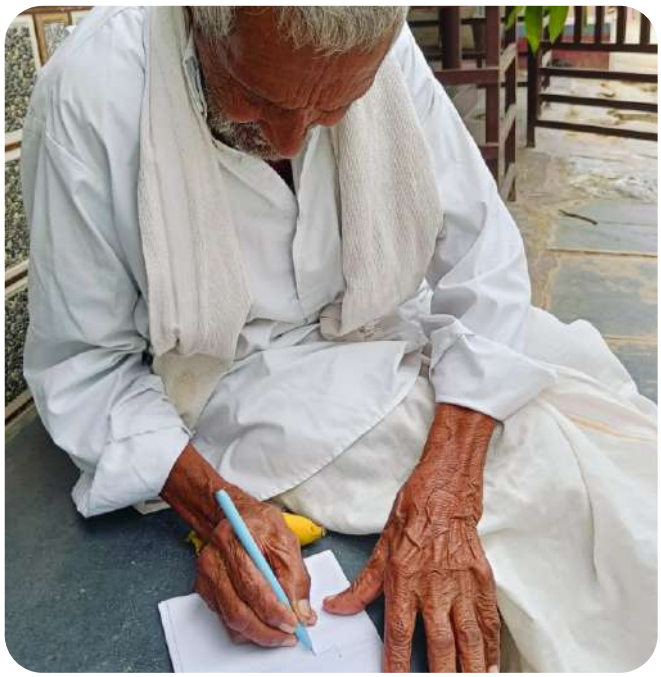
- Facilitate meaningful engagements, cognitive stimulation, social interactions, and physical activities.

3.2.e. Communication Skills

- Proficiency in verbal and non-verbal communication, especially for residents with sensory impairments.
- Ability to communicate empathetically with residents, families, and interdisciplinary teams.

3.2.f. Behavioural and Psychological Symptoms of Dementia (BPSD)

- Knowledge of triggers, non-pharmacological management strategies, and de-escalation techniques.



3.2.g. Ethics, Privacy, and Safety

- Awareness of ethical caregiving practices, safeguarding residents from abuse/neglect, and promoting environmental safety.
- Training on fire safety, fall prevention, and emergency protocols.

3.3. Training Program Structure

3.3.a. Eligibility:

- Age: 18–35 years.
- Education: Minimum 8th-grade pass.
- Language: Fluency in the local language.

3.3.b. Duration: 6 weeks (2 weeks theory, 2 weeks practical training, and 2 weeks on-the-job experience).

3.3.c. Content:

- Basics of geriatric nursing.
- Dementia care practices.
- First aid and emergency response.
- Ethics, privacy, and dignity in care.
- Palliative care fundamentals.

3.3.d. Retraining and Evaluation:

- Quarterly retraining sessions to address practical challenges.
- Pre- and post-assessments to ensure competency.

4. Communicating Effectively with Persons with Dementia

Effective communication with Persons with Dementia often requires patience, understanding, and adaptability. Here's how the staff needs to be trained to make meaningful connections with the Dementia patients:

4.1. Use Simple and Clear Language: Opt for straightforward sentences and familiar words. Avoid complex phrases and technical jargon. Repeat key points if necessary, and be prepared to explain things multiple times.

4.2. Maintain Eye Contact: Making eye contact helps to hold the person's attention and shows them that they are valued. It also allows to gauge their emotional responses more effectively.

4.3. Listen Actively: Offer full attention when the person is speaking. Nodding, maintaining eye contact, and responding with empathy can make them feel heard and respected. Resist the urge to interrupt or finish their sentences.

4.4. Be Mindful of Your Body Language: Non-verbal cues can be just as important as what you say. Ensure gestures and facial expressions are open and reassuring. A calm demeanour can help soothe the person if they are feeling agitated or confused.

4.5. Minimize Distractions: Hold conversations in quiet, calm environments to help the patient focus. Turn off the TV and other background noises that might compete for their attention.

4.6. Stay Positive: Positive and supportive language can greatly impact the patient's emotional well-being. Try to focus on what the person can do rather than what they cannot, and offer praise and encouragement whenever possible.

4.7. Use Non-Verbal Communication: Touch, hugs, and other forms of gentle physical affection can convey your care and support, especially when words fail. However, always be considerate of the person's comfort level with physical contact.

4.8. Remember to Be Patient: Communicating with a dementia patient can sometimes be challenging and might require additional time. It's important to stay calm and composed. Patience often leads to more rewarding interactions.

Practicing these techniques not only helps in communicating effectively but also strengthens your relationship with your patients. Remember, your empathy and understanding can make a world of difference.

5. Quality of Care: Standard Operating Protocols

5.1. Admission and Discharge Procedure/documents: History sheet and all details emergency contact numbers, nominated representatives' details, medical history with prescriptions should be duly documented.

5.2. Assessment:

5.2.a. A holistic assessment of the resident's abilities and background is necessary to provide care and assistance that is tailored to the resident's needs.

5.2.b. A comprehensive assessment will include understanding a resident's: Cognitive health, physical health, physical functioning, behavioural status, sensory capabilities, decision-making capacity, communication abilities, personal background, cultural preferences, spiritual needs and preferences.

5.2.c. The history collected should also document the reason for admitting the person into care home, preferences for life sustaining treatment, legal and financial decision making. The assessments should acknowledge that the resident's functioning might vary across different staff shifts.

5.3. Integrative Care Overview: Integrative care combines the best of modern science with traditional healing systems to offer a holistic approach to patient care. It involves:

5.3.a. Incorporating diverse healing systems: Including local and culturally accepted practices alongside modern medical interventions.

5.3.b. Customizable care models: Allowing for patient choice within care plans.

5.3.c. Combining modern and traditional wisdom: Utilizing technological advancements with ancient healthcare practices.

5.3.d. Tracking outcomes: Monitoring and evaluating the effectiveness of various interventions.

5.4. Multidisciplinary Approach to Integrated Care

5.4.a. Baseline Assessments:

- **Physician:** History, comorbidities, general & neurological examination, relevant past investigations, medication list, and blood work review.
- **Psychologist:** Cognitive and mood evaluations using tools like HMSE (Hindi Mental State Examination), ACE (Adenbrooke's Cognitive Examination) and NPI (NeuroPsychiatric Inventory)
- **Physical Therapist:** Physical evaluation for pain, weakness, fall risk, frailty index, and ADLs (Activities of Daily Living) using EASI (Everday Abilities Scale for India) / Barthel's Index.
- **Investigations:** Lab work, EEG (electroencephalogram), imaging, ECG (electrocardiogram).

5.4.b. Diagnosis and Treatment Plan:

- Clinical Diagnosis: Confirm presence of dementia and Identify reversible causes
- Determine type (e.g., Alzheimer's, vascular dementia, mixed).

5.4.c. Treatment Plan:

- Develop an individualized management plan including pharmacological and non-pharmacological interventions.
- Schedule both individual and group therapy sessions.

5.4.d. Education and Counselling:

For Patients and Families: To provide detailed information about diagnosis, prognosis, and advanced care planning and discuss support services available.

5.4.e. Routine Monitoring Schedule

Daily Monitoring (by nurses/attendants):

- Vitals: Temperature, blood pressure, pulse, respiratory rate.
- Observations: Behaviours, mood, activity levels, signs of infection, bed sores, RT/catheter changes.
- Medication: Allergies, consolidated medication list, refills.
- Red Flags: Immediate reporting and escalation.

Weekly Monitoring (by Doctor and Dietitian):

- Medication: Adherence and side effects.
- Nutrition: Intake and hydration status, lab work.

Quarterly Monitoring (by Multidisciplinary Team):

- Cognitive Screening: Repeat tests (e.g., Montreal Cognitive Assessment / HMSE / ACE, NPI).
- ADLs: Evaluate using Barthel's index / EASI, fall risk, frailty index.
- Caregiver Update: Collated report on general condition, new ailments, treatments, investigations, and current status.

Annual Monitoring (by Specialists):

- Checks: Eyes, dental, lab work.

5.4.f. Pathway for Escalation

Communication and Documentation:

- Medical Records: Record history, complaints, comorbidities, medications, and investigations.
- Care Plans: Tailor to specific needs and preferences with regular updates. (detailed below)
- Daily Logs: Document daily activities, meals, medication administration, and incidents.

Emergency Preparedness:

- Information: Keep emergency contact details up-to-date.
- Crisis Response: Document care plans for quick action during emergencies.

Privacy and Confidentiality:

- Records: Maintain strict confidentiality and access control.
- Authorized Personnel: Ensure only authorized individuals access records.

Family Communication:

- Records: Document family interactions and updates.
- Involvement: Ensure transparency and involve family in care decisions.

Legal and Financial Documentation:

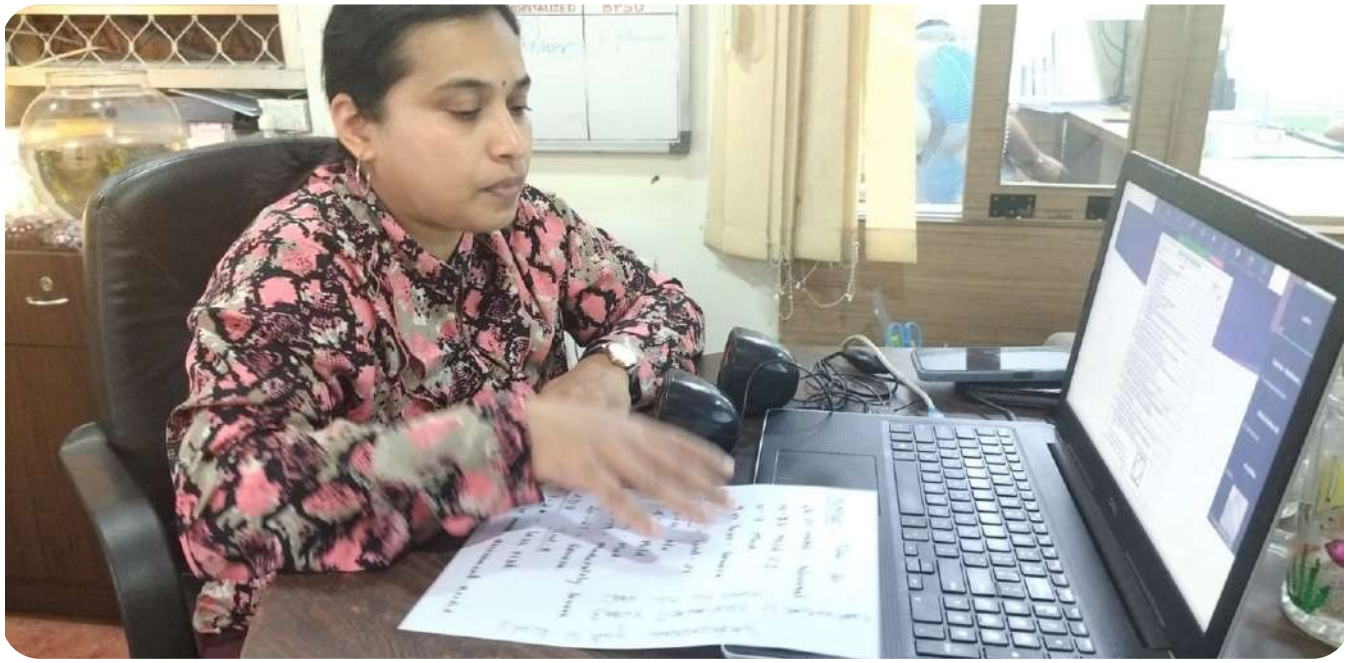
- Powers of Attorney: Document decision-making authorities.
- Guardianship: Manage legal and financial affairs.

Continuous Quality Improvement:

- Review and Feedback: Regularly assess monitoring effectiveness. Incorporate insights from caregivers, staff, and healthcare providers.

Update Policies and Procedures:

- Revisions: Adapt protocols based on the latest research and best practices.



5.5. Care Plan

5.5.a. Care plan is generated from a comprehensive assessment and drawn up for each resident and this provides the basis for the care to be delivered.

5.5.b. The care plan sets out in detail the action which needs to be taken by care staff to ensure that all aspects of the health, personal and social care needs of the person with dementia are met.

5.5.c. The care plan must concern with the care of older people, and includes a risk assessment, with particular attention to prevention of falls.

5.5.d. The care plan is reviewed by care staff in the home at least once a month, updated to reflect changing needs and current objectives for health and personal care and actioned.

5.5.e. An effective care plan builds on the resident's abilities and incorporates strategies such as task breakdown, fitness programs and physical or occupational therapy to help residents complete their daily routines and maintain their functional abilities as long as possible.

5.5.f. When all staff involved in a resident's care are familiar with the care plan, they will be better equipped to provide appropriate care to the resident.

5.v.g. Care plans need to be flexible enough to adapt to daily changes in a resident's needs and wishes.

5.6. Activities

5.6.a. Residents should be encouraged to use their remaining skills in their daily activities. Goal of activities is to restore sense of purpose, control, and makes task familiar. Such activities will enhance the sense of well-being and autonomy.

5.6.b. Use techniques that encourage residents to be as independent as possible.

5.6.c. Frequent, meaningful activities are preferable to a few, isolated programs.

5.6.d. Activities should proactively engage residents.

5.6.e. The outcome of an activity or social interaction is not as important as the process of engaging the residents. Offering activities that accommodate the resident's level of functioning can promote participation in them.

5.6.f. When an activity includes multiple participants, consider the group dynamic and the overall mood of the group, and be flexible in adapting the focus and purpose of the activity.

5.6.g. Foster community involvement to enhance social connections and the sense of being part of a community.

5.6.h. Staff can offer opportunities for families to be involved in activities.

5.6.i. Group sizes and lengths of time for the activity need to be tailored to the functional level of residents.

5.6.j. Efforts need to be put for providing better quality of life of persons with dementia, which may impact the well-being of the care givers too.

5.6.k. All sorts of activities like physical, mental, social and creative will help persons with dementia for their well-being and to live with dignity.

5.6.l. Behavioural management with constructive, individualized, and appropriate psycho-social activities seem to be more effective.

5.6.m. It is important to provide holistic care and attend to the personal needs, communicate well, and give independence, privacy, and safety for persons with dementia.

5.6.n. Music and dance uplift mood and engagement effectively. Gardening offers therapeutic benefits.

5.6.p. Non-pharmacological interventions in dementia care should encompass a wide range, including personal life histories, daily caregiver interactions, influences of physical and social environments, and diverse therapies.

5.7. Medical Management: A policy on medical management has to be maintained by the care homes. Treatment procedures and records shall be maintained and implemented in accordance with the provisions of the Mental Healthcare Act, 2017.

The staff should adhere to procedures for the receipt, recording, storage, handling, administration and disposal of medicines. Records are kept of all medicines received and administered, that leave the home or are disposed of, to ensure that there is no mishandling or hoarding. A record is maintained of current medication for each resident. All medicines are administered by a registered nurse. SOS medications usage should be clearly documented. Every day administration of all drugs should be duly recorded including side effects. Regular Visits by Qualified Physicians is a must to ensure appropriate medical oversight.

- Basic Training for Physicians: Require all doctors in care home settings to undergo basic training in geriatric and dementia care management.
- Staff Training: Train care home staff to recognize and respond to common medical conditions (e.g., urinary tract infections, constipation) and the adverse effects of medications.
- Drug Information Awareness: Provide drug information sheets for prescribed medications and ensure care home staff are trained to understand and use them.
- Early Detection and Intervention: Implement processes for early identification of cognitive impairment (e.g., delirium, mild cognitive impairment, dementia), as well as depression and anxiety disorders, with appropriate medical interventions.

5.8. Psychosocial Interventions

5.8.a. Staffing Ratios: Enforce mandatory adherence to recommended staff-to-resident ratio standards to ensure sufficient staffing levels.

5.8.b. Tiered Staff Training Programs:

- Tier 1: Train all staff in essential communication and caregiving skills, including personal care, mobility assistance, fall prevention, feeding, skin care, monitoring vitals, and administering medications. Incorporate training on basic interventions such as implicit orientation, use of orientation boards, music, games, and physical activities.
- Tier 2: Provide advanced training on delivering structured psychosocial interventions like Cognitive Stimulation Therapy, Reminiscence Therapy, and Validation Therapy, focusing on meaningful engagement for persons with dementia.
- Tier 3: Equip staff with skills to prevent and manage Behavioural and Psychological Symptoms of Dementia (BPSD) through non-pharmacological approaches.

5.8.c. Infrastructure Support: Ensure care home facilities include designated spaces for the delivery of psychosocial interventions to foster an appropriate and supportive environment.

5.8.d. Awareness Initiatives: Conduct awareness programs for staff and families to highlight the benefits and importance of psychosocial interventions in improving the quality of life for residents with dementia.

5.9. End of life Care

5.9.a. Advanced care planning should be part of initial assessment.

5.9.b. Persons' wishes about life sustaining procedure should be documented.

5.9.c. Quality care and comfort should be provided to people with palliative care needs in the care home.

5.9.d. Their spiritual needs, rights to rites and functions have to be taken into consideration.

5.9.e. Standard protocols have to be developed for advanced care, dealing with increasing infirmity and arrangements after death.

5.9.f. Privacy and dignity of the person with dementia have to be upheld at all times.

5.10. Maintenance of Records:

5.10.a. Physical state, mental status and social care status along with the risks and care plans need to be documented.

5.10.b. At the time of admission, documentation of the need for admission, period of admission, goals to achieve through the admission and assessment of risk is required.

5.10.c. During the stay in the home the physical state including injuries and falls needs to be recorded carefully.

5.10.d. Pre-existing conditions during admission, and conditions during discharge to be documented to avoid medico legal problems.

5.10.e. The documentation can be done by everyone who is involved in the care and treatment viz; Medical doctor, psychiatrist, nurses, physiotherapist, occupational therapist, psychologist and social worker.

5.10.f. All professionals involved in the treatment need to maintain regular documentation whenever in contact with the client. If required more than once in a day.

5.10.g. Provisional care plan needs to be prepared on admission and proper care plan should be ready within a week.

5.10.h. Care plan needs to be reviewed at least once a week.

5.10.i. The records can be paper based or digital according to the care facility.

5.10.j. Maintenance of records, including documentation and confidentiality practices shall be in accordance with the Mental Healthcare Act, 2017

I. Conclusion

Quality dementia care in residential settings must be rooted in dignity, person-centred support, safety, and compassion. These minimum standards aim to ensure that every individual living with dementia receives consistent, respectful, and evidence-based care that enhances quality of life. Care homes play a critical role not only in managing symptoms but also in enhancing meaningful engagement, autonomy, and emotional well-being.

Alongside care, there is a growing need to promote awareness of dementia risk reduction through healthy lifestyles, early screening, and management of conditions.

Addressing factors such as physical inactivity, social isolation, depression, poor nutrition, poorly managed hypertension or diabetes, smoking and alcohol use, hearing and vision impairment, and limited cognitive stimulation, are crucial for Dementia Risk Reduction.

By integrating good care practices with a prevention-oriented approach, there can be a move towards a more responsive and resilient system of dementia care.