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COMPONENT 2

WRITTEN ASSIGNMENT

A CASE STUDY REPORT: MRS THOMPSON

INTRODUCTION

Mrs Thompson is an 84-year-old woman who has recently returned home to sheltered housing following hospital treatment for pneumonia. She lives alone, has a diagnosis of mild dementia, and receives domiciliary care visits twice each day. Two recent events, a missed dose of medication that left her more confused than usual, and a separate occasion on which she was found outdoors without adequate clothing during cold weather, have prompted a formal review by the local authority and illustrate the vulnerability of older people with cognitive impairment who continue to live independently. This report examines four areas of practice central to keeping Mrs Thompson safe: communicating with her effectively, keeping accurate and lawful records, coordinating care across the agencies involved, and supporting her right to make decisions under the Mental Capacity Act 2005. A final section draws together the practical challenges that can undermine each area, before a conclusion evaluates which response should be prioritised.

1. EFFECTIVE COMMUNICATION IN MRS THOMPSON'S CARE

Effective communication is particularly important for Mrs Thompson because her mild dementia may affect how she processes and retains information, especially while she readjusts to being home after hospital. NICE (2025) recommends clear, unhurried speech and reassuring non-verbal cues such as eye contact, since these are valuable for someone who may already feel disoriented. A carer checking whether she has taken her medication should speak slowly, rather than assuming a quick reply reflects genuine understanding.

The Equality Act 2010 is also directly relevant. MDDUS (2025) explains that the Act gives Mrs Thompson a right to reasonable adjustments in how information is shared, such as longer appointments or accessible formats, and that staff should not assume her capacity based on her age or diagnosis alone but should assess her understanding decision by decision. The values behind the Act, fairness, respect, dignity and autonomy, should shape how staff speak to her, treating her as an adult included in choices about her own care (MDDUS, 2025).

Argyle's Communication Cycle offers a practical framework for checking that communication with Mrs Thompson has actually succeeded (Care Learning, 2024), breaking it into stages from an idea forming through to being coded, sent, received, decoded and understood, with feedback closing the loop. A carer checking whether she has taken her tablets should keep the message simple and look for feedback, such as checking the pill dispenser, rather than treating a nod as proof of understanding. Where she appears to understand but forgets soon after, this points to a need for repetition or further cognitive assessment, not non-compliance.

Family involvement forms a further strand of good practice, and NICE (2025) guidance supports open, prompt communication that welcomes the family's own observations, which helps build trust around her.

2. ADMINISTRATIVE SKILLS AND RECORD KEEPING

Accurate record keeping is essential to protecting Mrs Thompson because it creates the evidential trail that allows risks, such as her missed medication and the cold-weather incident, to be identified and acted upon. Robust documentation directly supports the safeguarding duties set out under the Care Act 2014, since decisions about her care can only be justified if they rest on accurate, up-to-date information (SCIE, 2023a).

The Data Protection Act 2018 sets the legal framework for how her records must be handled (NHS Grampian, 2026). Its principles require that information be processed lawfully, fairly and transparently, gathered for specified purposes, kept accurate and current, held for no longer than necessary, and stored securely. In Mrs Thompson's case this means her medication records and incident reports must be factual, completed promptly, and accessible only to those directly involved in her care.

The Caldicott Principles add a further layer of guidance on confidentiality and information sharing (NHS Grampian, 2026). Crucially, the duty to share information can matter as much as the duty to keep it confidential where withholding it would leave someone at risk. This applies directly to Mrs Thompson: the incident report and the concern about her being found outdoors should be passed promptly to her GP, the community nursing team and the local authority, since any delay could hold up a needed medication review or safeguarding response.

3. COLLABORATIVE MULTI-AGENCY WORKING AND SAFEGUARDING

Mrs Thompson's care depends on several professionals working together rather than one practitioner managing her needs alone. Coordinated multi-agency input allows risks to be identified earlier than any single service could achieve alone (SCIE, 2023b), and no single role carries sole responsibility for her safety. Her GP contributes clinical oversight, including reviewing her medication, but this sits alongside, not above, the contributions of others: the community nurse monitors her physical recovery, while domiciliary carers, who see her most frequently, are best placed to notice day-to-day changes and report these promptly. The local authority coordinates the safeguarding response, judging whether her current care package remains sufficient.

The cold-weather incident raises safeguarding concerns beyond a single lapse in judgement. Being found outdoors in inadequate clothing could indicate self-neglect, confusion linked to her dementia, or a care package that no longer matches her needs, and each possibility carries a different risk of harm, from hypothermia to falls or further wandering. A formal safeguarding enquiry should consider whether the incident was isolated or an emerging pattern, with a risk assessment weighing her wish for independence against the likelihood of harm if it recurs, including whether her existing twice-daily visits remain sufficient (SCIE, 2023a).

This typically takes the form of a safeguarding case conference, in which her GP, community nurse, care provider and social worker share observations and agree a coordinated plan combining a medication review with the risk assessment above. A shared care record lets each professional see decisions made by others in real time, reducing the chance an incident is acted upon in isolation, while a lead professional or coordinator gives the network a single point of contact and a clear review date.

Person-centred practice requires that Mrs Thompson's own views inform this plan, rather than one built solely around professional risk management (SCIE, 2023a). This means asking her directly how she feels about both incidents and what support she would find acceptable, then feeding her preferences into the multi-agency discussion rather than deciding on her behalf.

4. MENTAL CAPACITY AND DECISION-MAKING

Mrs Thompson's diagnosis of mild dementia raises important questions about her capacity to make decisions concerning her medication, her safety outdoors and her wish to continue living independently. The Mental Capacity Act 2005 provides the legal framework for these questions, and its starting presumption is that she has capacity unless established otherwise. A diagnosis of dementia does not itself mean she lacks capacity; capacity is decision-specific, so she may be able to decide, for example, what to wear, while needing more support to understand the risks of missing her medication.

Where staff are unsure whether Mrs Thompson can make a particular decision, the Act requires that she be given all practicable support to make it herself before any conclusion is reached that she lacks capacity, for example through the clear, unhurried communication discussed above. If, following this support, she is assessed as lacking capacity for a specific decision, such as whether to accept a change to her care package, any decision made on her behalf must be in her best interests and the least restrictive option available that still protects her safety. This is

directly relevant to the safeguarding response to the cold-weather incident, since any change to her care arrangements should support her independence as far as possible rather than defaulting to more restrictive supervision than necessary.

5. CHALLENGES TO EFFECTIVE PRACTICE

- Time and resource pressure: Short domiciliary visits leave little room for the slower pace that dementia-friendly communication requires, and the same pressure can mean documentation is completed later from memory, increasing the risk of inaccuracy and falling short of the complete, contemporaneous records that good practice requires (SCIE, 2023a). Where staff cover several visits back to back, small but significant details can go unrecorded simply because there is no time to observe them properly.
- Inconsistent systems and coordination between agencies: Differences in recording formats and IT systems across health and social care can create gaps in the overall picture of Mrs Thompson's needs and slow joint decision-making, even where every professional wants the best outcome for her (SCIE, 2023a). A note made by a domiciliary carer may not automatically reach her GP or community nurse, so a pattern that would be obvious if seen together can instead appear as unconnected, minor concerns.

These challenges do not remove the duty to communicate well, keep sound records, cooperate across agencies and respect Mrs Thompson's decision-making rights; rather, they indicate where safeguards such as named care coordinators, shared assessment tools and protected time for documentation are most needed if the same pattern is not to be repeated.

CONCLUSION

Effective communication, shaped by the Equality Act 2010 and Argyle's Communication Cycle (Care Learning, 2024), helps ensure Mrs Thompson and her family remain informed and genuinely understood. Rigorous record keeping, compliant with the Data Protection Act 2018 and the Caldicott Principles, supplies the evidential foundation needed to identify risk, as shown by the incident reporting that flagged her missed medication. Multi-agency working, underpinned by the Care Act 2014's duty to cooperate, ensures her GP, community nurse and care team act on shared, timely information, while the Mental Capacity Act 2005 ensures that decisions about her care respect her autonomy wherever possible.

Of these areas, the safeguarding response to the cold-weather incident is the most urgent priority, since it carries the most immediate risk of serious harm and should not wait for the next scheduled review. A prompt, formal risk assessment, combined with a decision-specific capacity assessment where her understanding of that risk is in doubt, would do most to reduce the chance of a similar event recurring. Strengthened documentation and multi-agency communication would then sustain this over time, allowing her to continue living at home as safely and independently as possible.

REFERENCE LIST (HARVARD STYLE)

Care Learning (2024) Outline Theories of Communication. Available at: <https://carelearning.org.uk/qualifications/level-3-extended-hsc/hsc-cm4/2-1-outline-theories-of-communication/> (Accessed: 17 July 2026).

Legislation.gov.uk (2005) Mental Capacity Act 2005. Available at: <https://www.legislation.gov.uk/ukpga/2005/9/contents> (Accessed: 8 August 2026).

MDDUS (2025) Equality Act 2010 in Healthcare: Advice and Guidance. Available at: <https://www.mddus.com/advice-and-support/advice-library/equality-act-2010> (Accessed: 29 July 2026).

National Institute for Health and Care Excellence (NICE) (2025) Dementia: Assessment, Management and Support for People Living with Dementia and Their Carers (NG97). Available at: <https://www.nice.org.uk/guidance/ng97> (Accessed: 2 August 2026).

NHS Grampian (2026) Data Protection. Available at: <https://www.nhsgrampian.org/about-us/data-protection/> (Accessed: 6 August 2026).

Social Care Institute for Excellence (SCIE) (2023a) The Care Act: Safeguarding Adults. Available at: <https://www.scie.org.uk/safeguarding/adults/care-act-safeguarding-adults/> (Accessed: 10 August 2026).

Social Care Institute for Excellence (SCIE) (2023b) Multidisciplinary Teams Working for Integrated Care. Available at: <https://www.scie.org.uk/integrated-care/research-practice/activities/multidisciplinary-teams/> (Accessed: 14 August 2026).