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Introduction (150 words)

This report examines the care of Mrs Thompson an 84 years old women living alone in sheltered housing recovering from pneumonia and living with mild dementia.

She receives twice daily domiciliary care, but recent concerns have arisen missed medication leading to confusion and being found unsuitably dressed in cold weather these incidents have triggered incident reporting a medication review and local council review The purpose of this report is to analyse the role of effective communication, administrative skills and multi-agency collaboration in ensuring safe person centered care. It will apply key registration including the equality act 2010 and data protection act 2018 to use recognized practice models and identify strategies to improve outcomes for Mrs Thompson.

Person centered care is a core principle in UK health and social care, requiring that every aspect of support is tailored to an individual's unique preferences, history, and needs, rather than applying A standardized approach. For Mrs. Thompson, this means recognizing not only her clinical conditions, but also her desire to maintain autonomy and dignity while living independently. The incidents described are not isolated errors, they are indicators of gaps in how her care plan is. Being delivered, monitored and communicated across all parties involved. Safeguarding is also a central theme here. The Care Act 2014 places a duty on local authorities and care providers to protect adults with care and support needs who are experiencing or at risk of abuse or neglect, including self-neglect arising from unmet needs or service failures. This report will also explore how embedding safeguarding awareness into daily practice can prevent recurrence of harm and how. Collective practice enables care workers and professionals to learn from events and continuously improve service delivery.

1 Effective communication in care (450 words)

Effective communication is the foundation of safe compassionate care especially for people with cognitive impairment like Mrs Thompson. Poor communication contributed to her medication error: she may not have understood instructions, or careers may not have

confirmed she had taken them correctly. Communication must be adapted to her needs speaking clearly using simple languages allowing time to process information and using visual aids such as pill organisers or picture labels. This aligns with the equality act 2010, which requires reasonable adjustments for disabled people including dementia to ensure they are not disadvantaged the acts protected characteristics include age and disability so care providers must adapt how they share information to enabled Mrs Thompson to participate in her own care.

A suitable model to apply is the communication cycle (argyle 1972)

This involves seeing hearing the message interpreting it responding the checking understanding for Mrs. Thompson this means carer do not just tell her to take medication but observe if she appears confused ask her to repeat instruction or demonstrate what to do then confirm the outcome when speaking to her family communication must be open respectful and transparent respecting their role in supporting her it must also be culturally sensitive and avoid using jargon that creates barriers.

Effective communication also prevents misunderstandings between professionals, ensuring everyone knows Mrs. Thompson's needs and any changes to her condition. It builds trust, reduces anxiety, and helps Mrs. Thompson maintain independence where possible. Without clear, adjusted communication, risks such as missed medication or not recognizing cold weather risks will continue to occur.

2 Administrative skills and record keeping (450 words)

Accurate administrative practice and record keeping are critical to safe care and directly address the issues in Mrs. Thompson's case. The Data Protection Act 2018 sets clear rules. Records must be accurate, kept up to date, stored securely, and shared only with authorized people with a legitimate reason. Mrs. Thompson's missed medication was recorded via the services incident process. This is essential to identify patterns, trigger reviews, and prevent. Repeat incidents If records are incomplete or unclear, the GP, pharmacist and care team cannot see the full picture of her health.

Beyond legal compliance, robust administrative systems provide an audit trail that demonstrates the quality of care delivered and supports accountability at all levels of service provision. Incident reports, in particular, serve multiple purposes. They document exactly what happened, when it occurred, and any immediate action taken. They enable managers and professionals to analyze underlying causes rather than just addressing symptoms. And they provide evidence for audits reviews. Or investigations for Mrs. Thompson's case, consistent documentation of missed doses, changes in presentation or behavior, and any concerns raised by carers or family members will enable the council and

clinical team to assess whether her current care package is sufficient or if adjustments such as more frequent visits, additional support, or modified medication administration arrangements are required. Furthermore, accessible records ensure that if staff changes occur, a common occurrence in. Theory Care good There is no disruption to the continuity of care, and new team members can quickly familiarize themselves with her needs, preferences and risks.

Good record keeping also follows professional standards. The NMC code requires nurses to keep clear, accurate and timely records, while Care Quality Commission regulations state that care records must be complete and accessible to ensure safe care. The Caldecott principles require that information is shared only when necessary, and that privacy is protected at all. Times For Mrs. Thompson, this means documenting every medication dose, any changes in her mood or ability and any concerns such as being unsuitably dressed. This shared record supports the medication review and the council safeguarding assessment.

Poor record keeping creates serious risks. Professionals may repeat mistakes or give conflicting advice. For example, if carers do not record that she has forgotten doses, the GP may not adjust her medication plan or arrange supervised administration.

Administrative practice also includes organizing care visits, updating contact details, and following procedures for reporting concerns, all of which ensure care is consistent and compliant with legal and professional standards.

3 Collaborative working (300 words).

Mrs. Thompson's care involves multiple professionals, her GP, community nurse, domiciliary care workers, pharmacist, sheltered housing staff and social services. Multi agency collaboration is essential to meet all her needs as no single service can address her health, medication safety and housing needs alone. Effective partnership working means sharing information appropriately, holding joint meetings and agreeing a shared. Care plan that everyone follows. For example, the GP can prescribe simpler medication or arrange monitored dosage systems. The pharmacist can deliver medication in easy-to-use packs, care workers can record doses and report any changes, and social services can assess her safety at home.

A shared care plan acts as a single source of truth for everyone involved, outlining agreed goals, specific responsibilities, risk assessments and escalation procedures. It ensures that Mrs. Thompson's own views and preferences are central to decision making, as required by the Care Act 2014 and person-centered care principles. Regular case reviews allow the team to monitor progress, adapt the plan if her condition changes, or address

any new. Challenges that arise Effective partnership also requires mutual respect for the expertise and role of each professional. For instance, care workers provide valuable day-to-day observations that may not be visible to GPs or social workers, while clinical staff provide specialist advice that informs practical care delivery. By building strong working relationships and maintaining open lines of communication, the team can reduce duplication of effort, minimize gaps in support, and. Quickly to any deterioration in her health or well-being.

Common challenges include poor information sharing, conflicting priorities or unclear roles. Strategies to overcome these include using secure shared record systems, regular case conferences, assigning a named care coordinator and agreeing clear communication protocols. For Mrs. Thompson, this would mean everyone works together to reduce confusion around medication, arrange reminders or prompts, and check that she has suitable clothing and heating. Collaborative working ensures care is joined up, not fragmented, and prevents incidents that could harm her health or well-being.

Conclusion(150)

This analysis shows that effective communication, robust administrative practice, and collaborative working are all essential to improving care for Mrs. Thompson.

Communication must be adapted to her dementia. Comply with the Equality Act 2010 and use structured models to ensure understanding. Accurate record keeping follows the Data Protection Act 2018 and professional standards, ensuring care is safe and consistent.

Multi-agency working brings together all the professionals involved to address risks and support her independence. Lessons from this case show that safe, person-centered care depends on following legal requirements, working in partnership and adapting practice to the individual's needs.

Reflecting on these elements demonstrates that quality care is not solely dependent on individual skills, but also on effective systems, processes, and relationships across the whole care network. The challenges Mrs. Thompson has faced highlight the importance of continuous monitoring, learning from incidents, and prioritizing her voice in every decision. By embedding these approaches into daily practice, care providers can not only meet legal and regulatory. Cities, but also enhance her quality of life, preserve her dignity and enable her to live safely and confidently in her own home. Ultimately, this case reinforces that person centered practice, supported by strong communication, governance and collaboration is the foundation of effective adult social care.

References

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