

Module: Principles of Health and social care

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Reflective Report on the Principles of Health and Social Care in UK Practice

Introduction

Working as a healthcare assistant in a nursing home has forced me to think differently about what “good care” actually means. Before entering practice, person-centred care, partnership working and ethics sounded like textbook terminology. Clean. Definable. Almost obvious. They are far more complicated. They are negotiated in busy corridors, in half-whispered handovers, and sometimes in moments of quiet disagreement between staff who all believe they are acting in someone’s best interest.

In the UK, these principles are not just professional ideals. They are written into law through the Care Act 2014, the Health and Care Act 2022 and the Mental Capacity Act 2005. Legislation gives them authority. Practice, however, gives them meaning. What follows is a reflection on how these principles operate both in theory and in the very ordinary, very human setting of a nursing home.

In reality, “good care” is not generally achieved by dramatic actions, but by paying attention to subtle changes, such as a resident no longer wanting to eat breakfast, a resident seeming different after a family visit, or a change of mood that could easily be explained as a usual fluctuation of confusion. It means balancing the need to keep someone safe with the need to give them autonomy, even if the choice entails a certain level of risk, and speaking up on behalf of the person whose voice is less loud than the system around them. While the law offers a framework, it’s the day-to-day interactions, such as patience during personal care, communication with families, and working together to make decisions with nurses and GPs, that put the principles into practice. Through these experiences, I have come to realise that good care is not fixed, but dynamic, a reflection of the need to be constantly evolving.

Task 1: The Significance of Core Principles in Health and Social Care

Person-Centred Care

At its heart, person-centred care asks a deceptively simple question. Who is this individual beyond their diagnosis? The answer is rarely straightforward.

Psychologically, the idea connects to Maslow's hierarchy of needs, which proposes that human beings require not only safety and physical survival but also belonging, esteem and a sense of identity (Maslow, 1943). In residential care, it is tempting to focus on the lower levels of the hierarchy. Nutrition charts. Fall prevention. Medication rounds. Yet residents continue to crave recognition and dignity long after their physical independence has declined.

The Care Act 2014 embeds wellbeing as a statutory duty. Wellbeing, interestingly, is defined broadly. It includes dignity, control over day-to-day life and participation in decision-making (Care Act 2014). That breadth matters. It signals that care is not only about preventing harm but also about preserving identity.

In theory, person-centred care appears self-evident. In practice, it competes with routines. A nursing home runs on structure. Breakfast times, medication times, staffing ratios. I have seen how easily care can become task-focused, not because staff lack compassion, but because the system rewards efficiency. Manley and McCormack (2008) argue that organisational culture strongly influences whether person-centred ideals become reality. I recognise that tension. On a short-staffed morning, spending ten extra minutes talking through choices with a resident can feel like a luxury. Yet those minutes often make the difference between cooperation and distress.

What I have come to understand, though, is that person-centred care isn't the absence of structure, but the creative use of it. Person-centred care is the difference between choice, even when time is of the essence, the taking the time to learn a person's history to understand their behaviour, and the ability to distinguish distress as a sign of unmet need, as opposed to "challenging behaviour." These moments need attention, not resources, to remind me that dignity isn't a grand gesture, but a subtle one, a tone of voice, a willingness to see the person before the task, the person beyond the need.

Partnership Working

If person-centred care is about seeing the individual clearly, partnership working is about recognising that no single professional sees the whole picture.

The Health and Care Act 2022 promote integrated care systems designed to improve coordination across services (Department of Health and Social Care, 2022). Conceptually, this reflects systems theory, particularly Bronfenbrenner's ecological model, which situates individuals within interconnected social and institutional environments (Bronfenbrenner, 1979). Health outcomes, in other words, rarely stem from one intervention alone.

In a nursing home, partnership working involves nurses, healthcare assistants, GPs, physiotherapists, social workers and families. The Cochrane review by Reeves et al. (2017) suggests that interprofessional collaboration improves professional practice and patient outcomes. That may be so, but collaboration is not always seamless. Professional hierarchies can silence quieter voices. Information does not always travel as smoothly as policy documents assume.

Still, when partnership functions well, it prevents fragmented care. It reduces the risk of unnecessary hospital admissions and ensures that decisions reflect multiple perspectives rather than isolated judgement (Glasby and Dickinson, 2014).

Ethics in Health and Social Care

Ethics, in some ways, is the thread that binds everything together. Beauchamp and Childress (2019) outline four central principles of biomedical ethics: autonomy, beneficence, non-maleficence and justice. These are not abstract concepts in a nursing home. They appear daily, sometimes uncomfortably.

The Mental Capacity Act 2005 translates ethical theory into legal obligation. It insists upon a presumption of capacity and requires decisions to be made in the least restrictive way possible (Mental Capacity Act 2005). That principle has changed how I interpret resistance. A resident refusing care is not automatically "difficult." They may be exercising autonomy. Or they may lack capacity at that moment. The distinction matters.

Ethical practice is rarely dramatic. It lives in small choices. Lowering one's voice during handover. Closing a door fully, not halfway.

Task 2: Practical Application in a Nursing Home

One resident in our home, an 82-year-old woman living with moderate dementia, often became distressed during early morning personal care. Initially, staff described her as resistant. I remember one morning. She repeatedly pushed hands away and shouted, "Leave me." The instinct, especially on a busy shift, was to proceed quickly and complete the task.

Later, during a conversation with her daughter, we learned that she had worked night shifts for over thirty years. Early mornings had never suited her. That detail, small as it seems, changed everything.

Person-Centred Care in Practice

Adjusting her routine to allow a later start reduced her agitation significantly. She became calmer, more cooperative, even conversational. The change aligned directly with the wellbeing focus of the Care Act 2014. Moreover, guidance from NICE on dementia care supports adapting routines to personal history and preferences (NICE, 2018).

There was no new medication. No specialist intervention. Just listening.

Yet even here, nuance exists. Flexibility is easier when staffing levels permit it. Not every preference can be accommodated fully. Person-centred care sometimes involves negotiation, not complete freedom. Even this, however, is nuanced to the extent that flexibility is more easily achieved when staffing levels allow. Some wishes cannot be fully met. Person-centred care may also involve compromise, not choice. It may also involve a balance of individual responsibility to the community. For example, giving someone a late start may have consequences for others, such as the staffing levels or the timing of drug rounds or mealtimes. Ethical care, therefore, is not simply the agreement to all requests but the balance of benefits and harm to the overall community of the care home. It requires reflective practice, not only asking what the person wants but also asking how this can be achieved safely and sustainably. Person-centred care, therefore, is a shared commitment rather than an individual right, based on respect, practicality, and compromise.

Partnership Working in Practice

The shift in her care plan required communication across the team. Nurses updated documentation. Healthcare assistants adjusted morning allocations. Her GP was informed of behavioural improvements to avoid unnecessary pharmacological treatment. This coordination reflects the integrated care approach promoted by NHS England (NHS England, 2022).

When collaboration works, it prevents escalation. In this case, avoiding sedative medication preserved her alertness and quality of life.

Furthermore, this model of cooperation helped to advance the application of person-centered care through the development of care plans that were not based on fragmented information but on the totality of the individual's needs and requirements. This is because the constant inter-professional meetings helped to identify the slight changes in the patient's

behavior and moods, which in turn helped to advance non-pharmacological measures to address the situation in good time. For instance, the care team was able to avoid the adverse effects of drug interactions, such as increased confusion and the risk of falls, through the application of inter-professional cooperation and the resultant care plans that were not only effective in delivering care but also in promoting the dignity and autonomy of the care delivery process.

Ethical Considerations

An ethical dilemma arose when she later refused medication. A capacity assessment was conducted in accordance with the Mental Capacity Act 2005. Capacity was deemed fluctuating. A best-interest discussion followed, involving family and senior staff. The least restrictive approach was adopted, prioritising explanation and reassurance over compulsion.

Balancing autonomy and safety felt uncomfortable. There is rarely a perfect solution. Ethical decision-making often means choosing the least imperfect option.

Task 3: Self-Reflection as a Healthcare Assistant

These principles have shaped me more than I anticipated. Person-centred care has changed how I interpret behaviour. I am less likely to label a resident as “non-compliant.” Instead, I ask what might be happening beneath the surface. Fatigue. Pain. Fear. Memory. confusion.

I have also become more aware of the small ways dignity can erode. Rushing. Speaking over someone. Referring to a resident by room number rather than name. These habits creep in easily. Reflecting using Gibbs’ cycle (Gibbs, 1988) has helped me recognise and correct such patterns.

Partnership working has expanded my sense of responsibility. As a healthcare assistant, I spend more continuous time with residents than most professionals. Subtle changes in appetite or mood are often first visible to me. Reporting these accurately contributes to collaborative decision-making, aligning with the integrated approach outlined in the Health and Care Act 2022.

Confidence remains an area for growth. Speaking up in multidisciplinary meetings can feel intimidating. Yet silence can compromise care. Developing assertiveness is not about ego but about advocacy. Ethical awareness has perhaps altered me most. Understanding the Mental Capacity Act 2005 has reframed how I approach consent. I now pause more often. I check understanding. I question assumptions. Age and diagnosis do not automatically remove autonomy. Emotionally, working in end-of-life care requires resilience. Compassion

fatigue is real. I have learned that reflective practice is not indulgent but protective. Without it, empathy dulls.

My strengths lie in patience, observational attentiveness and rapport-building. Residents often relax when conversations move beyond clinical needs. Yet I am aware that knowledge must deepen. Ongoing engagement with guidance from NICE and further training in dementia and safeguarding will strengthen my competence.

Professional growth, I suspect, is less about mastering policy and more about sustaining curiosity. Asking why. Listening fully. Remaining open to being corrected.

Conclusion

Person-centred care, partnership working and ethical practice are woven into UK legislation, notably the Care Act 2014 and the Mental Capacity Act 2005. Yet their real significance emerges in ordinary encounters. A delayed wake-up time. A careful capacity assessment. A quiet conversation with a family member.

These principles are neither static nor simple. They require negotiation, reflection and sometimes courage. Within the nursing home setting, they shape not only the quality of care delivered but also the kind of professional I am becoming. Ultimately, the law provides the context, but the practice is what truly informs and determines the content. Each situation is significant in ethical terms: whether to advocate for the resident's preference, to make contributions to multidisciplinary discussions, and to recognise the need for best interest decisions. From these lived experiences, I have gained an understanding that the quality of care is not necessarily determined by the achievement of outcomes and the meeting of policy requirements but by the maintenance of dignity, autonomy, and trust.

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