

Mr Ahmed is a 68-year-old man recovering from a stroke, whose needs sit at the intersection of communication, administration, and interprofessional collaboration. His limited English proficiency, reliance on domiciliary care, and involvement of multiple professionals highlight both the strengths and vulnerabilities of community-based health and social care. Effective communication is essential not only for person-centred care but also for upholding the principles of the Equality Act 2010. Robust administrative practice, particularly accurate record keeping and lawful information sharing under the Data Protection Act 2018, is central to safe, accountable care. Finally, multi-agency working between the GP, district nurse, care workers and speech and language therapist is critical to continuity and safety, especially in light of the missed visit and delayed medication. This report critically examines these three dimensions, drawing on legislation, policy and academic literature, and applies them directly to Mr Ahmed's situation.

Effective communication is fundamental to safe, person-centred care, particularly for stroke survivors who may experience cognitive, language or swallowing difficulties (Kagan et al., 2008). In Mr Ahmed's case, communication is further complicated by his first language being Bengali and his limited understanding of complex English. Without thoughtful adaptation, there is a real risk of disempowerment, misunderstanding of treatment, and reduced adherence to medication and rehabilitation (Silverman et al., 2013). Good practice therefore requires staff to adjust their communication style, pace and medium to his needs, rather than expecting him to fit the system.

The Equality Act 2010 places a legal duty on services to avoid discrimination and to make reasonable adjustments for people with protected characteristics, including disability and, indirectly, race and language where these intersect with access to services (HM Government, 2010). For Mr Ahmed, reasonable adjustments might include access to an interpreter, translated written information, and allowing extra time for consultations. Failure to provide such adjustments could amount to indirect discrimination if standard processes disadvantage him compared with English-speaking service users. Critically, relying solely on his wife as an informal interpreter may be convenient but risks compromising his autonomy, privacy and accurate understanding (Flores, 2005). Professional guidance increasingly cautions against over-reliance on family members for interpretation in complex clinical discussions.

One useful framework for structuring communication with Mr Ahmed is the Calgary - Cambridge model, which emphasises building rapport, exploring the patient's perspective, providing information in a structured way, and checking understanding (Silverman et al., 2013). Applied here, care workers and clinicians should begin by establishing rapport in a culturally sensitive manner, perhaps using simple Bengali greetings where possible, and by acknowledging his stroke-related challenges. They should explore his concerns and goals such as regaining independence in personal care, using short sentences, visual prompts, and supported conversation techniques recommended for people with aphasia (Kagan et al., 2008).

When providing information, staff should avoid jargon, break explanations into small chunks, and use teach-back methods to confirm understanding, for example asking Mr Ahmed to show or explain how he will take his medication. Written prompts in large font, possibly bilingual, could reinforce verbal instructions. Involving his wife is important, but professionals should still address Mr Ahmed directly, maintaining eye contact and giving him time to respond, rather than speaking over him. This respects his dignity and aligns with person-centred care principles (McCormack and McCance, 2017).

Critically, communication is not a one-off event but an ongoing process that must adapt as Mr Ahmed's condition, confidence and language abilities change. The speech and language therapist's input should be actively integrated into everyday care, with domiciliary staff trained in using agreed communication strategies. Without such integration, the benefits of specialist therapy risk being lost in day-to-day practice.

Good administrative skills are not merely bureaucratic; they are central to patient safety, continuity of care and legal accountability (Griffith and Tegnah, 2020). In Mr Ahmed's case, the missed home visit and delayed medication highlight how administrative failures, such as poor rota management, inadequate documentation or lack of escalation can translate directly into clinical risk. Accurate, timely and legible record keeping enables professionals to track interventions, monitor changes, and evidence that care has been delivered in line with agreed plans and standards (NMC, 2018).

High-quality records for Mr Ahmed should include clear documentation of his stroke diagnosis, current medications, communication needs, language preferences, and the roles of each professional involved. Domiciliary care notes should record visit times, tasks completed, any refusals or concerns, and actions taken when problems arise. Critically, the missed visit incident should be documented transparently, including the reason, immediate actions (e.g. informing the GP or district nurse), and any learning or changes implemented. From a governance perspective, such documentation supports incident investigation, organisational learning and regulatory scrutiny (CQC, 2021).

The Data Protection Act 2018, incorporating the UK GDPR, provides the legal framework for processing Mr Ahmed's personal and health data. Health and social care providers must ensure that information is processed lawfully, fairly and transparently; collected for specified purposes; limited to what is necessary; accurate; kept no longer than necessary; and stored securely (Information Commissioner's Office, 2021). For Mr Ahmed, this means that only relevant professionals such as the GP, district nurse, speech and language therapist and care agency should have access to his records, and only to the extent needed to provide care.

There is an inherent tension between information sharing for safe, coordinated care and the obligation to protect confidentiality. Best practice is to share information on a "need-to-know" basis, with Mr Ahmed's knowledge and, where possible, consent, while recognising that in some circumstances information may be shared without consent to prevent serious harm (Department of Health and Social Care, 2018). Given his communication difficulties, extra care is needed to explain, in accessible language, how his information is used and who can see it, thereby supporting his rights under data protection law.

Administrative competence also includes maintaining up-to-date care plans and ensuring that electronic and paper systems align. For example, if the district nurse adjusts Mr Ahmed's

antihypertensive medication, this change must be promptly recorded and communicated to the care agency to avoid errors. Critically, the missed visit suggests a possible breakdown in scheduling or handover processes. A reflective review might examine whether staff shortages, unclear responsibilities, or inadequate digital systems contributed, and whether tools such as electronic rostering, alerts for missed calls, or clearer escalation protocols could reduce recurrence (Dixon-Woods et al., 2014). Thus, administrative systems are not neutral; they actively shape the reliability and safety of Mr Ahmed's care.

Mr Ahmed's care involves a GP, district nurse, domiciliary care workers and a speech and language therapist, each bringing different expertise. Effective collaboration is therefore essential to avoid fragmented care, duplication or gaps, particularly around medication management and communication support. Interprofessional working has been associated with improved outcomes, greater patient satisfaction and more efficient use of resources, but only when underpinned by clear roles, shared goals and mutual respect (Reeves et al., 2017).

Approaches to foster collaboration in Mr Ahmed's case could include regular multidisciplinary reviews, face-to-face or virtual where professionals jointly review his progress, adjust care plans and agree responsibilities. Shared care plans accessible to all relevant providers can support this, ensuring that communication strategies recommended by the speech and language therapist are embedded in domiciliary care routines, and that the GP and district nurse are aware of any adherence issues or changes in function. Structured communication tools such as SBAR (Situation, Background, Assessment, Recommendation) can improve the clarity of handovers between care workers and clinical staff, particularly when escalating concerns like missed visits or deteriorating swallowing (Haig et al., 2006).

However, multi-agency working is often challenged by organisational boundaries, differing priorities, time pressures and incompatible IT systems (Glasby and Dickinson, 2014). Care agencies may feel peripheral to "core" NHS services, leading to power imbalances and reluctance to challenge decisions. In Mr Ahmed's case, the missed visit incident could expose such tensions: was the care agency comfortable escalating the issue to the GP or district nurse, and did they receive a timely response? Addressing these challenges requires not only protocols but also relational work building trust, recognising each other's expertise, and creating a culture where concerns are welcomed rather than blamed (Hudson, 2007).

Critically, Mr Ahmed and his wife should be seen as central partners in this collaborative network, not passive recipients. Involving them in goal-setting and review meetings, with appropriate language support, can enhance adherence, surface unrecognised issues, and ensure that services align with their cultural values and preferences.

Mr Ahmed's case illustrates how communication, administration and collaboration are deeply interwoven in contemporary health and social care. Effective, person-centred communication grounded in the Equality Act 2010 and supported by structured models such as Calgary - Cambridge can mitigate the risks posed by language barriers and stroke-related impairments, while preserving dignity and autonomy. Robust administrative practice, including accurate record keeping and lawful, transparent information sharing under the Data Protection Act 2018, is essential to safety and accountability, as the missed visit incident demonstrates.

Multi-agency collaboration between the GP, district nurse, domiciliary care workers and speech

and language therapist offers significant benefits but is vulnerable to organisational and relational challenges. A reflective, systems-focused response to the missed visit, involving Mr Ahmed and his wife as partners, can turn a safety incident into an opportunity for learning and improvement. Ultimately, high-quality care for Mr Ahmed depends on aligning legal duties, professional standards and genuinely humanised practice.

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