

**MODULE NAME: INTRODUCTION TO HEALTH AND SOCIAL CARE**

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## **A CASE STUDY REPORT: MRS THOMPSON**

### **INTRODUCTION**

Mrs Thompson is an 84-year-old woman recently discharged from hospital after pneumonia, living alone in sheltered housing with mild dementia and twice-daily domiciliary support. Two recent incidents, missed medication leading to increased confusion and being found outside without appropriate clothing in cold weather, have triggered a local authority review and highlight the risks facing older adults with cognitive impairment living independently. This report examines three dimensions of practice central to safeguarding Mrs Thompson: effective communication, administrative and record-keeping practice underpinned by data protection law, and multi-agency working between her GP, community nurse and domiciliary care team. Each theme is considered against relevant legislation and policy frameworks, showing how person-centred, legally compliant and coordinated practice can reduce risk and support Mrs Thompson to remain safely and with dignity in her own home.

### **1. EFFECTIVE COMMUNICATION IN MRS THOMPSON'S CARE**

Effective communication is central to Mrs Thompson's care because her mild dementia already compromises her ability to process and retain information, and the recent missed medication and cold-weather incident suggest her needs are not being consistently understood. Communication must therefore be adapted rather than assumed: staff should use short, simple sentences, allow extra processing time, minimise distraction, and reinforce verbal information with written reminders or visual prompts, in line with national guidance on adapting communication styles for people with dementia (NICE, 2025). Non-verbal cues, including eye contact, a calm tone and unhurried body language, are particularly important for reassurance when Mrs Thompson may already feel confused or frightened after her hospital discharge.

Communication practice should be grounded in the Equality Act 2010, which protects individuals from discrimination on the basis of protected characteristics including age and disability; dementia is widely recognised as a disability under the Act (MDDUS, 2025). Mrs Thompson is therefore entitled to reasonable adjustments in how information is communicated, such as longer appointment times or accessible formats, and staff must avoid assumptions about her capacity based on age or diagnosis alone, instead assessing her understanding for each specific decision. The Act's underlying principles of fairness, respect, dignity and autonomy should guide how staff address her, ensuring she is spoken to as an adult and included in decisions about her own care (MDDUS, 2025).

Argyle's Communication Cycle (Care Learning, 2024) offers a useful model for structuring interactions with Mrs Thompson. It describes communication as six sequential stages: an idea occurs, the message is coded, sent, received, decoded, and finally understood, with feedback closing the loop. In practice, a care worker checking whether Mrs Thompson has taken her medication should code the message simply, observe how she receives and decodes it, and seek feedback, through her response or by checking the pill dispenser, to confirm genuine understanding rather than assuming a nod means comprehension. Where the cycle breaks down, for instance if she appears to understand but later forgets, this signals a need for repeated reinforcement or referral for further cognitive assessment, rather than an assumption of non-compliance.

Communication with Mrs Thompson's family is equally important. Family members can provide collateral history, notice changes in her presentation, and support her decision-making, but information should only be shared in line with her wishes and mental capacity, respecting her autonomy under the Mental Capacity Act 2005 while ensuring they are appropriately informed of safeguarding concerns such as the cold-weather incident. National guidance recommends asking consent to share information, specifying which family members should receive it and what should be shared (NICE, 2025). Honest, timely communication that explains what has happened and invites the family's observations builds trust and strengthens the safety net around Mrs Thompson.

## 2. ADMINISTRATIVE SKILLS AND RECORD KEEPING

Good administrative practice is fundamental to Mrs Thompson's safety because it creates the evidence trail that allows risk to be identified, escalated and reviewed. The missed medication incident was only identified as a pattern because it had been recorded through the service's incident process; without accurate, timely documentation, deteriorating confusion might have been misread as an isolated event rather than a warning sign linked to a wider safeguarding picture that now includes her being found outside inappropriately dressed. Local authorities rely on this documented evidence when deciding whether a Safeguarding Adults Review is required (SCIE, 2023b).

Record keeping in Mrs Thompson's care must comply with the Data Protection Act 2018, which incorporates the UK GDPR and governs how personal and special category data, including health information, is collected, stored, shared and disposed of (NHS Grampian, 2026). The Act's principles require information to be processed lawfully, fairly and transparently, collected for specified purposes, kept accurate and up to date, retained no longer than necessary, and held securely. For Mrs Thompson, this means her medication records and incident reports must be factual and timely, and stored securely with access limited to those directly involved in her care.

The Caldicott Principles provide sector-specific guidance that complements the Data Protection Act 2018 in health and social care. Originating from the 1997 Caldicott Report and now on a statutory footing, the principles direct staff to justify the purpose of any use of identifiable information, use the minimum necessary detail, share strictly on a need-to-know basis, and recognise everyone handling data is responsible for complying with the law (NHS Grampian, 2026). The duty to share information can be as important as the duty to protect confidentiality where withholding it could place someone at risk. This is directly relevant to Mrs Thompson: the incident report and the concern about her being found outside should be shared promptly with her GP, the community nursing team and the local authority, since delay could postpone a necessary medication review or safeguarding response.

Beyond legislation, wider policy frameworks reinforce good administrative practice, including the expectation that providers maintain accurate, contemporaneous records as part of safe, well-led services, and the Care Act 2014's emphasis on local authorities and partners cooperating and sharing information to protect adults at risk. For Mrs Thompson, meticulous record keeping is therefore not an administrative formality but a direct safeguard: it ensures continuity between care visits, provides the factual basis for the requested medication review, and creates the audit trail required for the ongoing local authority review of her case.

## 3. COLLABORATIVE MULTI-AGENCY WORKING

Mrs Thompson's care depends on effective collaboration between her GP, community nurse, domiciliary care workers and the local authority, each holding a different piece of the picture: clinical history, medication management, and day-to-day observation of her functioning at home. No single professional can assess or manage her risk alone, given the combination of post-hospital vulnerability, cognitive impairment and a live safeguarding concern (SCIE, 2023a).

Approaches that foster effective collaboration include regular multi-disciplinary team meetings, shared or interoperable care records, agreed protocols for escalating concerns, and clearly defined roles so each professional understands what others are responsible for. Evidence suggests multi-disciplinary team working adds value through real-time information sharing, shared learning about decision-making, and joint risk management for complex cases (SCIE, 2023a). Effective communication, coordination and patient involvement have also been shown to be strong drivers of successful collaboration and improved wellbeing for older patients (SCIE, 2023a). This duty to cooperate is given legal weight under sections 6 to 7 of the Care Act 2014, which requires local authorities and their partners, including NHS bodies, to cooperate in protecting adults with care and support needs (SCIE, 2023b).

Despite this, multi-agency working faces recurring challenges. Differences in organisational priorities, professional cultures and recording systems between health and social care can create gaps in coordination for older people with complex needs at home (SCIE, 2023a). Time pressures, unclear referral pathways and inconsistent information sharing can mean concerns are not escalated quickly enough. These challenges can be addressed through named care coordinators, shared assessment tools, and a culture that treats information sharing as central to, not in tension with, safeguarding. For Mrs Thompson, ensuring her GP, community nurse and care workers communicate promptly about her medication review and the cold-weather incident is essential to preventing further deterioration.

## CONCLUSION

This report has considered three interlinked aspects of Mrs Thompson's care: communication, administrative practice and multi-agency collaboration. Effective communication, informed by the Equality Act 2010 and structured through models

such as Argyle's Communication Cycle (Care Learning, 2024), helps ensure Mrs Thompson and her family remain informed, respected and genuinely understood despite her dementia. Rigorous record keeping, compliant with the Data Protection Act 2018 and the Caldicott Principles, provides the evidential foundation needed to identify risk and justify intervention, as shown by the incident reporting that flagged her missed medication. Finally, 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 rather than in isolation. Together, these three dimensions of practice form a coordinated safety net supporting Mrs Thompson to live as safely and independently as possible following her hospital discharge.

## **REFERENCE LIST (HARVARD STYLE)**

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