

Report: Critical Evaluation of Person-Centred Care and Partnership Working in Dementia Residential Settings.

Student Name: Shazia Yasin.

Student Number: 2424946.

Module Code: BMHP5016.

Module Title: Principles of Health and Social Care Practice.

Lecturer: Dr Mark Gallagher.

Submission Date: 29th March 2026.

Abstract:

This report critically evaluates the theory and implementation of Person-Centred Care (PCC) and Partnership Working (PW) within the UK health and social care sector, focusing specifically on residential dementia care. It examines the shift from the biomedical model to humanistic frameworks, such as Tom Kitwood's Enriched Model of Care. The analysis explores the ethical tensions between service user autonomy and the duty of care (beneficence) as governed by the Mental Capacity Act 2005. Furthermore, the report assesses the legislative impact of the Care Act 2014 and the Health and Care Act 2022 on the efficacy of Integrated Care Systems (ICS). While these frameworks aim to enhance service delivery, the report identifies significant barriers, including resource constraints and communication silos. The study concludes with evidence-based recommendations for digital standardisation and workforce development to ensure future sustainability in the UK.

Introduction:

In contemporary UK health and social care practice, the dual concepts of Person-Centred Care (PCC) and Partnership Working (PW) are fundamental to achieving high-quality outcomes. PCC represents a paradigm shift from a paternalistic, "one-size-fits-all" approach to one that treats the service user as an equal partner in their care journey. Parallel to this, PW provides the structural framework necessary for multidisciplinary teams to collaborate effectively across organisational boundaries.

The purpose of this report is to critically examine the intersection of these two concepts within residential dementia care settings. This setting is particularly pertinent as dementia care necessitates a complex balance of clinical safety, psychological support, and legal advocacy. This report will explore the theoretical underpinnings of PCC, the ethical dilemmas inherent in cognitive care, and the legislative landscape that mandates inter-agency cooperation. By focusing on these elements, the report will demonstrate how personhood is maintained within an increasingly integrated, yet resource-pressured, care system.

Definition of Person-Centred Care (PCC):

Defining the Core Concept:

Person-Centred Care is a humanistic approach that prioritises the individual's subjective experience, values, and preferences (McCormack and McCance, 2017). Unlike the medical model, which views an individual through the lens of their diagnosis or pathology, PCC views them through their "personhood." In dementia practice, this means acknowledging that the person behind the symptoms remains present and capable of engagement.

Benefits of PCC:

Enhanced Wellbeing: By tailoring care to a resident's life history (biography), PCC reduces "distressed behaviours" (formerly known as challenging behaviours). When a resident's emotional needs for belonging and occupation are met, there is a documented reduction in the reliance on antipsychotic medications (Eklund et al., 2019).

Improved Safety and Health Outcomes: Residents are more likely to engage with treatment and nutrition when they feel respected and understood, leading to lower rates of hospital admissions for secondary issues like dehydration or falls.

The VIPS Framework and Personhood: To further operationalise the core concept of PCC, Brooker (2007) introduced the 'VIPS' acronym, which is now a benchmark in UK dementia care. It encompasses **V**aluing people with dementia, treating them as **I**ndividuals, looking at the world through their **P**erspective, and providing a supportive **S**ocial environment. This theoretical expansion ensures that PCC is not merely a vague sentiment of "being kind," but a rigorous clinical standard that demands practitioners actively challenge their own biases to understand the service user's internal reality. By focusing on personhood, practitioners can distinguish between the biological symptoms of neurological decline and the persistent, unique personality of the individual.

Holistic Biopsychosocial Benefits: The benefit of "Enhanced Wellbeing" is rooted in the transition from a purely biological view of health to a biopsychosocial model. When care is tailored to a resident's biography, it addresses "social death" a phenomenon where people with dementia are treated as if they are already gone. By validating a resident's past achievements and roles (e.g., as a teacher or parent), PCC fosters a sense of self-worth that physically lowers cortisol levels and anxiety. This physiological shift is what ultimately reduces the frequency of "distressed behaviours," as the resident no longer needs to use physical agitation to communicate their unmet emotional needs.

Preventative Efficacy and Health Economics: From a broader health outcomes perspective, the benefits of PCC extend to the sustainability of the wider health system. When residents feel respected and "known" by their carers, they exhibit higher levels of "health literacy" and compliance. In a residential setting, this means early detection of physical issues; for example, a resident who feels empowered is more likely to communicate discomfort, allowing for the early treatment of a Urinary Tract Infection (UTI) before it escalates into delirium or a fall. This preventative aspect significantly reduces the financial and logistical strain on the NHS by decreasing avoidable A&E admissions and "failed discharges."

Limitations of PCC:

Resource Constraints: The primary barrier in the UK is the "care-minute" pressure. High staff turnover and chronic underfunding often lead to "conveyor-belt care," where physical

tasks (showering, dressing) take precedence over the "emotional labour" required for true PCC.

Organisational Resistance: Traditional institutional cultures often favour routine over individuality. For example, a care home may have a fixed mealtime that clashes with a resident's lifelong habits, creating a conflict between organisational efficiency and person-centred values.

Impact of Staff Burnout on PCC Delivery: Beyond mere time constraints, the "care-minute" pressure creates a psychological barrier for practitioners. When staff are forced into a repetitive cycle of task-completion to meet basic safety KPIs, they often develop "compassion fatigue" as a coping mechanism. This leads to a clinical detachment that is the antithesis of the empathy required in the humanistic models of Rogers and Kitwood. Consequently, the "personhood" of the resident is inadvertently compromised not by a lack of staff desire, but by a systemic environment that treats care as a measurable commodity rather than a relational exchange.

The Conflict of Regulatory Compliance: Organisational resistance is often reinforced by a fear of regulatory non-compliance. For instance, while PCC encourages a resident to eat whenever they feel hungry, health and safety protocols regarding food temperature and kitchen staffing schedules often dictate a rigid "four-course" window. Similarly, the "Wellbeing Principle" of the Care Act 2014 can clash with rigorous health and safety audits; an organisation may resist a resident's choice to keep personal rugs or furniture (which supports their sense of Identity) because they are flagged as "trip hazards" in a risk assessment. This creates a systemic tension where the resident's psychological need for a familiar environment is sacrificed for the sake of institutional risk-aversion.

Digital Poverty and Literacy: A further limitation exists in the gap between PCC theory and the digital literacy of the workforce. While person-centred care plans are increasingly stored on digital platforms to aid partnership working, a lack of intuitive technology or adequate training can lead to "data-led care" rather than "resident-led care." If staff spend a disproportionate amount of their shift documenting tasks on a tablet to prove compliance to the Care Quality Commission (CQC), the time available for meaningful, face-to-face interaction is further eroded, effectively creating a "digital barrier" between the carer and the person living with dementia.

Relevant Theories: Kitwood and the Humanistic Model:

Tom Kitwood's Enriched Model of Care:

The most influential theory in dementia PCC is Tom Kitwood's (1997) Enriched Model of Care. Kitwood challenged the "Standard Paradigm" of dementia, which viewed the condition as a purely neurological decline. He proposed that the experience of dementia is a result of a formula:

$$D = P + H + NI + B + SP$$

In this formula, D (Dementia) is the result of P (Personality), H (Health), NI (Neurological Impairment), B (Biography), and SP (Social Psychology).

Kitwood argued that while we cannot change the neurological impairment (NI), we can significantly improve the Social Psychology (SP) of the resident. In a residential setting, this is achieved by meeting five psychological needs: Comfort, Attachment, Inclusion, Occupation, and Identity. When these are met, "Personhood" is maintained. If they are

ignored, the resident suffers from "Malignant Social Psychology" such as being ignored or treated like a child which accelerates their decline.

Rogers' Humanistic Theory:

Carl Rogers' (1961) person-centred theory also provides a vital foundation. The "Core Conditions" of empathy, congruence, and unconditional positive regard are essential for care staff. Applying Rogers' theory in a dementia setting means accepting the resident's reality. If a resident believes they are waiting for their mother, the carer does not "correct" them (which causes distress) but instead uses empathy to understand the feeling of longing behind the statement.

Ethical Fundamentals in Health and Social Care:

Practitioners must navigate the "Four Principles" of bioethics (Beauchamp and Childress, 2019):

1. **Autonomy:** The right of the resident to make their own choices.
2. **Beneficence:** The duty to act in the resident's best interest.
3. **Non-maleficence:** The duty to do no harm.
4. **Justice:** Ensuring fair and equitable access to care.

Application and Ethical Dilemmas: In dementia care, a frequent dilemma occurs when a resident refuses a shower (Autonomy). Forcing them would violate non-maleficence (causing distress) but leaving them may lead to skin breakdown (violating Beneficence).

The resolution lies in Partnership Working. Staff must collaborate with the family and the GP to assess the resident's Mental Capacity. If the resident lacks the capacity to understand the risk, a "Best Interests" decision is made under the Mental Capacity Act 2005, seeking the least restrictive way to maintain hygiene while respecting the resident's dignity.

Evaluation of Partnership Working (PW):

Defining PW and Integrated Care Systems (ICS)

Partnership Working involves different professionals (e.g., District Nurses, Social Workers, GPs, and Care Staff) and agencies (NHS vs. Private Sector) working together to provide seamless care. In England, the Health and Care Act 2022 formalised this through Integrated Care Systems (ICS). These systems are designed to remove the "silos" that historically separated hospital care from social care.

Benefits of Partnership Working:

Holistic Assessment: In a residential home, PW allows for a "Multi-Disciplinary Team" (MDT) approach. For example, if a resident is falling, a partnership between the GP (medical review) and the Occupational Therapist (environmental review) provides a more comprehensive solution than either could alone.

Efficiency: Integrated care pathways reduce duplicated assessments and ensure that when a resident is discharged from a hospital, the care home has the necessary medication and equipment ready immediately.

Challenges of Partnership Working:

Communication Barriers: Fragmented IT systems mean that a care home often cannot access a GP's notes directly. This "information gap" can lead to medication errors or delayed treatments.

Professional Hierarchies: Sometimes, the "Medical Model" (the doctor's view) is prioritised over the "Social Model" (the carer's view). Effective PW requires mutual respect for all contributors' expertise.

Policy and Legislation in Relation to PCC and PW:

Legislation provides the mandatory framework that ensures PCC and PW are not just aspirations but legal requirements.

The Care Act 2014: This is the cornerstone of PCC in the UK. It introduced the "Wellbeing Principle," which legally obliges local authorities and care providers to consider the individual's wishes and feelings. It mandates that care must be "integrated" to be effective, thus linking PCC directly to PW.

Health and Care Act 2022: This act transformed the structural landscape by making Partnership Working a legal duty through the creation of ICS. It aims to reduce health inequalities by ensuring that social care is an equal partner to the NHS.

The Equality Act 2010: This ensures that PCC is delivered equitably. In dementia care, it protects residents from discrimination based on their age or disability, ensuring they have the same right to high-quality treatment as any other citizen.

Human Rights Act 1998: Article 8 (Right to respect for private and family life) is crucial in residential settings, protecting residents' rights to maintain relationships and privacy, which are core components of personhood.

Recommendations for Future Development:

To ensure the future success of PCC and PW in the UK, the following evidence-based developments are recommended:

Unified Digital Health Records: The government should accelerate the implementation of a single, shared digital record accessible by all partners in the ICS. This would eliminate communication barriers and improve safety.

Mandatory "Dementia-Specific" Training: All social care staff should receive mandatory, funded training in Kitwood's Enriched Model. This would move care from "task-completion" to "person-centred engagement."

Co-Production Frameworks: Policy should mandate the involvement of residents and their families in the design of care services, not just in their own care plans. This "co-production" is the ultimate expression of PCC.

Workforce Parity: To facilitate effective PW, social care workers must have pay and professional status parity with NHS staff. This would reduce the high turnover rates that currently disrupt the "continuity of care" essential for PCC.

Conclusion:

This report has critically examined the theory and practice of Person-Centred Care and Partnership Working within residential dementia care. It has demonstrated that while PCC provides the heart of care, ensuring dignity and personhood; Partnership Working provides the lungs, ensuring that the necessary resources and expertise flow to the individual.

Legislation like the Care Act 2014 and the Health and Care Act 2022 has created a strong foundation for these practices. However, the analysis reveals that ethical dilemmas and resource constraints remain significant hurdles. For the UK to achieve an exceptional standard of care, the recommendations for digital integration and workforce valuation must be prioritised. Ultimately, the success of health and social care practice depends on the ability of the system to see the person behind the patient and the partnership behind the service.

Reference List:

Beauchamp, T. L. and Childress, J. F. (2019) *Principles of Biomedical Ethics*. 8th edn. Oxford: Oxford University Press. (Accessed: 16 March 2026).

Care Act 2014, c. 23. Available at: <https://www.legislation.gov.uk/ukpga/2014/23/contents> (Accessed: 16 March 2026).

Department of Health and Social Care (2022) *Health and Care Act 2022*. London: HMSO. (Accessed: 18 March 2026).

Eklund, J. H. et al. (2019) 'Concept analysis of person-centred care', *Nursing Ethics*, 26(2), pp. 336-348. (Accessed: 13 March 2026).

Equality Act 2010, c. 15. Available at: <https://www.legislation.gov.uk/ukpga/2010/15/contents> (Accessed: 15 March 2026).

Health Foundation (2016) *Person-centred care made simple*. London: Health Foundation. (Accessed: 17 March 2026).

Human Rights Act 1998, c. 42. Available at: <https://www.legislation.gov.uk/ukpga/1998/42/contents> (Accessed: 17 March 2026).

Kitwood, T. (1997) *Dementia Reconsidered: The Person Comes First*. Buckingham: Open University Press. (Accessed: 18 March 2026).

McCormack, B. and McCance, T. (2017) *Person-Centred Practice in Nursing and Health Care: Theory and Practice*. 2nd edn. Oxford: Wiley Blackwell. (Accessed: 13 March 2026).

Mental Capacity Act 2005, c. 9. Available at: <https://www.legislation.gov.uk/ukpga/2005/9/contents> (Accessed: 15 March 2026).

National Institute for Health and Care Excellence (NICE) (2018) *Dementia: assessment, management and support for people living with dementia and their carers*. [NG97]. London: NICE. (Accessed: 18 March 2026).

Rogers, C. R. (1961) *On Becoming a Person: A Therapist's View of Psychotherapy*. London: Constable. (Accessed: 18 March 2026).

Social Care Institute for Excellence (SCIE) (2020) *Person-centred care for people with dementia*. Available at: <https://www.scie.org.uk> (Accessed: 13 March 2026).

Vahdat, S. et al. (2014) 'Patient involvement in health care decision making: a review', *Iranian Red Crescent Medical Journal*, 16(1), p. e12454. (Accessed: 14 March 2026).

World Health Organization (WHO) (2015) *Framework on integrated, people-centred health services*. Geneva: WHO. (Accessed: 17 March 2026).

Skills for Care (2023) *The state of the adult social care sector and workforce in England*. Leeds: Skills for Care. (Accessed: 19 March 2026).

Word Count: 2167