

University of Wales Trinity Saint David

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**Report Title: A Reflective Report on Person-Centred Care, Partnership Working
and Ethical Practice in Health and Social Care**

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Introduction

The principles to guide health and social care in the United Kingdom are designed to protect the rights of individuals, ensure that they are kept safe and that services meet their needs. Person-centred care, partnership working and ethics are particularly significant in an NHS hospital setting as the patient may be ill, distressed or reliant on professionals. These principles are mutually interdependent. Person-centred care sets the agenda of what's important to the patient, partnership working sets the agenda for the professional response and ethical and legal frameworks underpin fair and accountable decisions.

This report explores the value of these principles and how they can be applied to the example of an older woman admitted to hospital following a fall, who has dementia as her condition. It takes into account relevant legislation such as the Mental Capacity Act 2005, the Care Act 2014 and the Health and Care Act 2022. The final section is a reflective exercise which will reflect on how this learning will impact my future communication, teamwork, ethical decision making and professional development.

Task One: Importance of Health and Social Care Principles

Person-Centred Care

Person centred care values the individual patient and their personal values, relationships, preferences, abilities and life experiences. Unlike task-centred care, it is participatory, that is, it engages the person in the decision, rather than using the person as the recipient of

services. McCormack and McCance (2017) suggest that three key elements of effective person-centred practice are professional competence, therapeutic relationship and shared decisions making and a supportive care environment. This is particularly the case in hospital settings where schedules and pressures to discharge patients from the hospital may result in clinical work overshadowing personal needs.

This is the way that Rogers' theory (1951) backs up empathy, genuineness, and unconditional positive regard. In practice, the professional should listen without judgment, communicate openly and acknowledge the patient's point of view. But identity, dignity and the right to respected relationships are also significant in Kitwood's concept of personhood in the context of dementia care, as when a person is cognitively impaired, their identity is not lost, nor is their dignity, nor their right to be treated with respect (Kitwood, 1997). Maslow's hierarchy can be used to think about pain, safety, belonging and self-esteem. It should not be applied dogmatically however as there are many differences in cultural and personal priorities. Additionally, organizational pressures can limit the extent to which it is genuinely implemented or integrated, so person-centred care should be assessed on the basis of patient experiences, not just what is stated in the policy (Moore et al., 2017).

Partnership Working

Partnership working is about people, professionals, patients, carers and organizations sharing information, expertise and responsibility. Doctors, nurses, physiotherapists, occupational therapists, pharmacists, social workers and discharge coordinators could all be involved in the care of one patient in an NHS hospital. All medical, functional and social needs are not assessed by a single professional.

Cooperation can minimize duplication of services, miscommunication, medication errors and unsafe discharges. Shared goals, trust and a clear professional responsibility are essential for effective integrated care, not a number of disciplines just around the same patient (Riste et al., 2018). The Health and Care Act 2022 also encourages partnership working between local authorities and community services and the NHS (Health and Care Act 2022). However, hierarchy, late referrals, and conflicting priorities can have a negative effect on partnership. Family members can offer important information, but not take the place of the patient's voice.

Ethical Practice

The views on ethical practice can be approached in terms of autonomy, beneficence, non-maleficence and justice. Autonomy ensures informed choice, beneficence ensures wellbeing, non-maleficence ensures the avoidance of harm and justice ensures fair access to care (Beauchamp and Childress, 2019). These principles may be in opposition to one another. Limiting the mobility of a confused patient can help to prevent a fall but can also be detrimental to dignity, liberty and independence. Decisions need therefore to be proportionate and depend on individual circumstances.

Under the Equality Act 2010, patients cannot be discriminated against and must be made reasonable adjustments if their disability is likely to hinder them from accessing health services. The Data Protection Act 2018 stipulates that information must be processed lawfully and proportionately (Data Protection Act 2018).

Task Two: Application in an NHS Hospital

Case Example and Person-Centred Response

Mrs A is a fictional 79 year old woman with dementia who falls at home and ends up in an NHS acute hospital. She has pain in her hip, bruising, is not able to move as much as she used to, is distressed in the unfamiliar ward and sometimes fails to take her medication and physiotherapy. Her daughter is worried about being able to get home safely.

Mrs A's routine, communication, preferences and independence should be evaluated in a person-centred assessment. Staff should speak clearly, give plenty of time for her to respond and check if pain, fear, fatigue and hearing problems are affecting her behavior. The personalized-care policy in the NHS highlights the importance of engaging people in choice and decision-making, and recognizing their strengths and personal outcomes (NHS England, 2019). Do not assume that a refusal is a refusal to take medication as a sign of non-compliance, it may be due to anxiety, confusion or lack of understanding. Staff should investigate the why, and rethink and rephrase treatment. Her daughter might be

able to give some information; however, professionals should keep involving Mrs A as much as possible.

Partnership and Multidisciplinary Practice

The doctor would examine the fall and treat any injuries. Nurses would be responsible for keeping an eye on pain and nutrition, confusion, skin integrity, and falls risk. The physiotherapist would evaluate balance and rehabilitation, and the occupational therapist would take into account daily living activities and home safety. Medications that might cause dizziness or drowsiness could be reviewed by a pharmacist. The social worker will review safeguarding issues, support needs and community provision with the discharge coordinator.

The multidisciplinary team should agree upon shared objectives, document responsibilities and review agreed upon actions. It would not have been safe to discharge Mrs A if she had not had her mobility improved, if she had not had her home assessed, or if she had not had community support. Partnership therefore needs implementation and evaluation and not just referral. Measures of effectiveness might include falls, mobility, readmissions, feedback and capacity-documentation audits.

Capacity, Consent and Safeguarding

This case is very much focused on the Mental Capacity Act 2005. Mrs A does not automatically have a reduced capacity because she suffers from dementia. If capacity is to be assessed for the purpose of making a particular decision, professionals should take practical steps to assist her in making that decision prior to the assessment of capacity (MCA 2005).

If Mrs A is unable to understand, retain, act on or make a decision regarding the information at hand, or communicate a decision, she may not have the capacity for that specific issue. Any action taken on her behalf must be necessary in her interest, and must be the least restrictive. The current and past desires, beliefs, values and relationships of the individual should be taken into account.

If concerns are raised regarding neglect, unsafe living conditions or unmet support needs, the Care Act 2014 applies. Mrs A's independence must not be taken away unnecessarily while protecting her from safeguarding. People with dementia should be included in

decisions and be offered coordinated support that is appropriate for their communication and cognitive ability, and is safe (NICE, 2018).

Task Three: Reflection and Professional Development

Reflection on Person-Centred Care

Prior to this case, I had basically known about person-centred care in terms of being kind and courteous to patients. The fact that it is also about power, participation, choice and accessible information is something I now understand. Respectful staff does not constitute a patient's being truly involved unless there is a genuine opportunity for the patient to have a say in the decision.

I have also come to reflect in relation to the treatment that was refused by Mrs A, how I might interpret behavior in the future. At first I thought refusal was a sign of reluctance to accept help and now I realize it might be a way to say I am in pain, scared, confused, or I don't have control. I will therefore not use the term difficult patient before finding out why the patient is this way. Will adjust language, take into account sensory needs and give extra time for response.

I have also discovered that person-centred care is not about saying yes to everything! There are still responsibilities for professionals with respect to evidence, safety and accountability. A balance of these responsibilities without excluding the patient is the challenge that needs to be addressed. Compassion and clinical responsibility need to work in harmony as outlined in the NMC Code, which states that professionals must put the patient first, work effectively and keep patient safety in mind at all times (NMC, 2018). I understand that care for the person can be challenging in a hospital where a staff member has multiple patients and multiple things to do. Time pressure does not negate the obligation to explain procedures, obtain valid consent and protect dignity, however. I will incorporate small but meaningful actions in my future practice, for example, introducing myself, checking understanding and asking what is important to the patient.

Reflection on Partnership Working

I learned a whole new concept about teamwork with this case. My previous perceptions of partnership working were largely one of professionals carrying out their own work. I now realize that working in partnership is about having common objectives, communication, documentation and continuous evaluation.

I think a strength of mine is my communication abilities as I listen and try to respect other people's opinions. But communication within the hospital must go beyond casual conversation. Key mobility, medication and/or confusion information needs to be recorded and communicated properly to the right individuals. I will also provide clear input in future to handovers; make observations and record it carefully; and ensure that referrals have been addressed.

Sometimes struggle to be confident when talking to senior staff. This may prove to be a liability if I'm not able to put up a patient safety concern. I have come to understand that the part of the job is to challenge respectfully. Should concentrate on evidence, patient's wellbeing and agreed procedures and not worry that a question might seem disrespectful. I will also keep in mind that patient and family are partners in the partnership. But in the case of relatives, I cannot presume that they can be assumed to be able to make decisions. I will engage the right family member(s) and maintain focus on the patient as the key person.

Reflection on Ethics and Legislation

My conception of capacity has grown a lot. Previously I thought that a person who had dementia would not often be able to make decisions. I now know that capacity cannot be a one-size-fits-all and is subject to change. I am not to presume incompetence in a patient because they make a strange or endangering selection.

In practice I will be able to support decision making before undertaking a capacity assessment. This can include using simpler information, a less noisy setting or giving more time. In situations where someone is not competent, I will take their wishes, beliefs and values into account and not presume that the safest course of action is the best for them.

I've also come to understand how complicated confidentiality is. I shouldn't give information to relatives just because they request it. I need to think about consent, need, and lawfulness. I am aware that there are aspects when confidentiality cannot be maintained, such as those arising in safeguarding and serious risk cases.

Equality and diversity is also a part of my development. A person's entitlement to involvement is not diminished because of their age, dementia, disability, language or culture. I will embrace reasonable adjustments as a normal approach to safe and fair practice, not an extra.

Strengths, Development Needs and Action Plan

I consider empathy, patience and willingness to learn to be personal strengths. These skills can assist me to be sensitive to others who are afraid or disoriented. However, empathic is not all. I need to be compassionate and knowledgeable about the laws, professional limits and evidence-based judgment.

My key development requirements are: Practice in raising concerns; knowledge of mental-capacity law; formal multidisciplinary communication. There is also a need to improve academic writing skills to enable me to compare the evidence critically rather than just describe the evidence.

Development need	Planned action	Evidence and review
Mental-capacity knowledge	Complete capacity and consent training and review the statutory guidance	Certificate and reflective notes within three months
Dementia communication	Complete dementia-awareness training and observe experienced staff	Mentor feedback within four months
Multidisciplinary communication	Practice structured handovers and attend team meetings where appropriate	Feedback and reflective log over twelve weeks
Raising concerns	Study safeguarding and escalation procedures and discuss scenarios with a supervisor	Supervisor review within three months
Academic writing	Attend study-skills support and apply UWTSD Harvard guidance	Improved feedback in the next assessment

I will discuss this plan with tutor, mentor or supervisor. Training alone will not be evidence of competence, so I will evaluate the change in my behavior with feedback and reflection.

Conclusion

Safe NHS hospital care requires partnership working, ethics and person-centred care. Person centred care helps to safeguard identity, dignity and participation, and partnership working brings together clinical, functional and social expertise. Whereby the principle and legislation of autonomy, safety, confidentiality and safeguarding may clash, decisions are made according to ethical principles.

But the case of Mrs A illustrates that dementia should never be interpreted as a sign of being unable to make decisions or unable to cope. Supported communication is a cornerstone of safe care, as is capacity assessment specifically for decisions, and multi-disciplinary planning and proportionate information sharing. But "high quality" care will not be achieved through legislation and policy. They require professional knowledge, communication, leadership and organizational resources for implementation.

This case has inspired me to reflect on my strengths of empathy and patience but also to recognize that I need to be more confident, knowledgeable and have stronger communication skills when it comes to legal matters. I will work towards delivering safe, respectful and truly person-centred care through training, feedback and ongoing reflection.

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