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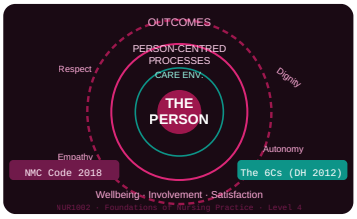
UK LEVEL 4 — YEAR 1 UNDERGRADUATE NURSING | APA 7TH



Person-Centred Care in Nursing Practice: Principles, Application, and Professional Values

An Examination of Foundational Frameworks for Compassionate, Evidence-Based Nursing — Applied to a Clinical Scenario

MODULE CODE	NUR1002
MODULE TITLE	Foundations of Nursing Practice
ACADEMIC LEVEL	UK Level 4 (Year 1 Undergraduate Nursing)
TARGET GRADE	Distinction — 70%+
WORD COUNT	Approximately 1,500 words (excl. references)
KEY FRAMEWORKS	McCormack & McCance (2010) · Roper-Logan-Tierney (2000) · ADPIE Nursing Process
PROFESSIONAL STANDARDS	NMC Code (2018) · 6Cs of Nursing (DH 2012)
REFERENCING STYLE	APA 7th Edition (American Psychological Association)

⚠ **Academic Integrity Notice:** This is an original educational sample for reference purposes only. Students must not submit this work as their own. Mrs Dorothy Chambers is a wholly fictitious patient; all clinical details are invented. AssignProSolution.com promotes responsible academic practice.

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1. INTRODUCTION

Person-centred care is a foundational principle of contemporary nursing practice in the United Kingdom, embedded in professional regulation, national policy, and the core values of the nursing profession. Rather than viewing the patient as a passive recipient of clinical interventions, person-centred care recognises each individual as a unique human being with their own values, beliefs, cultural background, and capacity for self-determination (McCormack & McCance, 2010). This approach is mandated by the Nursing and Midwifery Council (NMC) Code (NMC, 2018), which requires registered nurses and nursing students to prioritise the interests of people in their care and to treat them with dignity and respect at all times.

This essay examines the theoretical frameworks underpinning person-centred care, explores the professional values articulated in the NMC Code (2018) and the 6Cs of Nursing (Department of Health, 2012), and applies these principles to the fictitious case of Mrs Dorothy Chambers — a 72-year-old patient admitted to an acute medical ward following a fall at home, with a background of hypertension and

mild cognitive impairment. The essay argues that effective person-centred care requires not only technical clinical competence but also the relational skills, ethical commitment, and self-awareness that distinguish compassionate nursing practice.

2. DEFINING PERSON-CENTRED CARE: THEORETICAL FOUNDATIONS

Person-centred care has its philosophical roots in humanistic psychology, particularly the work of Carl Rogers (1961), whose concept of unconditional positive regard — accepting and supporting another person irrespective of what they say or do — has profoundly influenced therapeutic relationships in healthcare. In nursing, the concept was developed theoretically by Kitwood (1997) in the context of dementia care, where he argued that personhood — the standing and status bestowed on a human being by others — must be unconditionally maintained even when cognitive capacity is diminished. This insight has broad application to nursing practice beyond dementia care, establishing the principle that the patient's humanity and dignity are not contingent on their functional status or clinical condition.

2.1 McCormack and McCance's Person-Centred Nursing Framework

The most influential theoretical model of person-centred care specific to nursing is McCormack and McCance's Person-Centred Nursing Framework (2010). The framework identifies four interconnected

constructs arranged in a concentric structure. The outermost construct — *prerequisites* — refers to the attributes of the nurse: professional competence, developed interpersonal skills, commitment to the job, clarity of beliefs and values, and self-awareness. These prerequisites must be in place before person-centred care can be delivered effectively. The second construct — the *care environment* — encompasses the context in which nursing takes place, including appropriate skill mix, shared decision-making systems, and the supportive organisational culture without which person-centred practice is difficult to sustain. The third construct — *person-centred processes* — describes the activities through which care is delivered: working with the patient's beliefs and values, engaging authentically, sharing decision-making, being sympathetically present, and providing holistic care. Together, these processes generate the fourth construct — *expected outcomes* — which include patient satisfaction, involvement in care, a sense of wellbeing, and a care environment that is therapeutically supportive (McCormack & McCance, 2010). The framework provides student nurses with a systematic understanding of what person-centred care requires at the level of individual nurse attributes, team environment, and direct patient interaction.

2.2 The Roper-Logan-Tierney Activities of Living Model

The Roper-Logan-Tierney model of nursing (Roper et al., 2000) is widely used in UK nursing practice as a framework for holistic patient assessment. The model

identifies twelve Activities of Living (ALs) — including breathing, eating and drinking, eliminating, mobilising, sleeping, maintaining a safe environment, and communicating — and places each activity on an independence-dependence continuum. The model also recognises the influence of biological, psychological, sociocultural, environmental, and politicoeconomic factors on the individual's ability to perform each activity. For nursing students, the Roper-Logan-Tierney model offers a structured approach to identifying care needs that goes beyond purely biomedical concerns, encouraging the nurse to consider the whole person and the contextual factors that shape their health experience (Roper et al., 2000). Applied to an elderly patient following a fall, the model prompts the nurse to assess not only injury and physiological stability but also the patient's ability to mobilise safely, maintain continence, communicate effectively, and preserve their social identity and independence.

3. PROFESSIONAL VALUES: THE NMC CODE AND THE 6CS OF NURSING

The professional framework within which student nurses and registered practitioners operate is defined primarily by the NMC Code (NMC, 2018), which articulates four domains of professional standards: prioritise people; practise effectively; preserve safety; and promote professionalism and trust. The first domain — prioritise people — is the most directly

relevant to person-centred care, requiring nurses to treat people as individuals and uphold their dignity, listen to and address the concerns of people in their care, and act as an advocate for the vulnerable. The Francis Report (Francis, 2013), which examined catastrophic failures of care culture at Mid Staffordshire NHS Foundation Trust, underscored the importance of these standards: many of the failures documented arose not from individual clinical errors but from a culture in which patient dignity and individuality were systematically disregarded. For student nurses, the Code thus serves not only as a regulatory instrument but as a moral compass for professional practice.

Table 1: The 6Cs of Nursing — Values, Definitions, and Application to the Clinical Scenario (Fictitious)

Value	Definition	Application to Mrs Chambers (Fictitious)
Care	The core business of nurses; meeting individuals' needs, physical, emotional, social	Attending to Mrs Chambers's physical injuries, mobility needs, and psychological anxiety following the fall
Compassion	Intelligent kindness; empathy and sensitivity to suffering	Recognising Mrs Chambers's fear and disorientation; offering reassurance without dismissing her concerns
Competence	Clinical knowledge, skills, and evidence-based practice	Conducting NEWS2 observations accurately; completing a falls risk assessment; medication reconciliation
Communication	Verbal and non-verbal skills; active listening; information sharing	Using clear, jargon-free language; allowing additional time to account for mild cognitive impairment
Courage		Raising concerns about Mrs Chambers's discharge readiness

Value	Definition	Application to Mrs Chambers (Fictitious)
	Speaking up; advocating for patients; challenging poor practice	if the home environment remains unsafe
Commitment	Dedication to continuous improvement; collaboration; professional development	Liaising with the physiotherapy team and social worker; documenting care accurately and updating the care plan

Source: Adapted from Department of Health (2012) *Compassion in Practice*. Patient scenario: entirely fictitious.

4. APPLICATION TO PRACTICE: THE CASE OF MRS DOROTHY CHAMBERS

// FICTITIOUS PATIENT SCENARIO — ALL DETAILS INVENTED FOR EDUCATIONAL PURPOSES

Mrs Dorothy Chambers is a 72-year-old retired schoolteacher admitted to a medical assessment unit following a fall in her kitchen at home. She lives alone in a two-storey house and has a background of hypertension, mild cognitive impairment (diagnosed 18 months previously), and osteoarthritis of the knees. On admission, Mrs Chambers is visibly anxious and distressed, repeatedly asking for her daughter. Her NEWS2 score on arrival is 3 (elevated blood pressure, mild tachycardia). She is independent in most Activities of Living at baseline but has noticed increasing difficulty with mobilising over recent months. She speaks English as her first language, is slightly hard of hearing, and uses spectacles for reading.

4.1 Assessment and the Nursing Process (ADPIE)

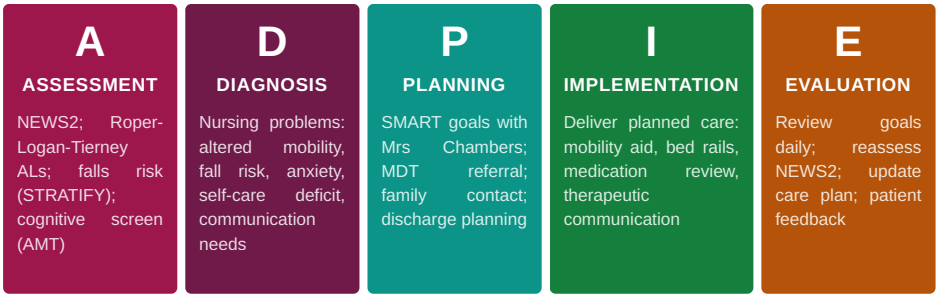

Figure 1: ADPIE Nursing Process applied to Mrs Chambers's admission (fictitious scenario). Source: Author's original design; informed by Levett-Jones (2018).

The nursing process provides the structural scaffold for delivering person-centred care systematically. On admission, the priority nursing action for Mrs Chambers is a thorough assessment. This involves completing a National Early Warning Score 2

(NEWS2) to identify any deteriorating physiology (Royal College of Physicians, 2017), conducting a structured falls risk assessment using the STRATIFY tool, and performing an Abbreviated Mental Test Score (AMTS) to establish a baseline cognitive assessment. Crucially, within a person-centred approach, assessment is not a unidirectional clinical procedure but a collaborative process: the nurse should explain each element of the assessment to Mrs Chambers in clear, accessible terms, inviting her to share her perspective on what precipitated the fall and what concerns her most about her current situation (Levett-Jones, 2018).

Using the Roper-Logan-Tierney model (2000) as a framework, the nurse assesses each relevant Activity of Living against Mrs Chambers's usual baseline. Her mobility is significantly compromised following the fall; her ability to maintain a safe environment is impaired; her communication needs are affected by hearing loss and anxiety; and her maintaining of psychological wellbeing — self-esteem, control, and sense of identity — requires particular attention given the disorienting effect of the hospital admission compounded by her cognitive impairment (Kitwood, 1997).

4.2 Communication and Therapeutic Relationship

Effective communication is central to person-centred care and is identified as one of the 6Cs of Nursing (Department of Health, 2012). For Mrs Chambers, the

nurse must attend carefully to both the content and the manner of communication. Peplau's (1952) interpersonal relations model of nursing identifies the nurse-patient relationship as the therapeutic medium through which nursing care is delivered, moving through phases of orientation, identification, exploitation, and resolution. In the orientation phase — immediately on admission — the nurse establishes trust by introducing themselves, explaining their role, and acknowledging Mrs Chambers's emotional distress without dismissing or minimising it. Given Mrs Chambers's hearing difficulty, the nurse should ensure face-to-face positioning, adequate lighting, and a quiet environment to maximise communication effectiveness. The NHS Communication Skills Framework (NHS England, 2021) emphasises the importance of active listening: paraphrasing, checking understanding, and allowing the patient time to respond without interruption or hurry.

4.3 Involving the Patient in Care Planning

A defining feature of person-centred care is the involvement of the patient as an active partner in care planning rather than a passive recipient of professionally determined decisions. Coulter and Collins (2011) describe shared decision-making as the process by which clinicians and patients make decisions together, integrating the clinician's expertise with the patient's knowledge of their own values and preferences. For Mrs Chambers, this means ensuring that the care plan — including her mobilisation goals,

pain management approach, and discharge planning — reflects her own priorities and preferences, not solely the clinician's clinical judgements. Given her mild cognitive impairment, the nurse must apply particular skill in this process: using simple language, visual aids where helpful, and involving her daughter (with Mrs Chambers's consent) as an appropriate support while remaining alert to ensuring that Mrs Chambers herself remains the primary decision-maker to the extent her capacity allows, consistent with the principles of the Mental Capacity Act 2005.

5. BARRIERS TO PERSON-CENTRED CARE

Despite its theoretical appeal and professional mandate, person-centred care faces significant structural and cultural barriers in acute care settings. Time pressure and high patient-to-nurse ratios — documented by the Royal College of Nursing (RCN, 2019) as a persistent challenge — may constrain the duration and depth of nurse-patient interactions, pushing care towards task-based efficiency at the expense of relational quality. For Mrs Chambers, cognitive impairment introduces additional communication complexity that requires time and skill, yet the acute medical environment may not always afford the unhurried space that person-centred interaction demands.

Environmental factors — including the noise, unfamiliarity, and routinised structure of hospital wards — can compound the disorientation

experienced by older patients with cognitive impairment (Kitwood, 1997). The evidence-base for delirium prevention in hospitalised older adults (NHS England, 2021) highlights the importance of environmental modifications, regular reorientation, and consistent nursing staff as protective factors — interventions that align closely with person-centred principles. Finally, attitudinal barriers — including ageist assumptions about older patients' capacity for autonomous decision-making or their preferences for information — may unconsciously undermine person-centred practice even among well-intentioned practitioners (Francis, 2013). Awareness of these barriers is itself a component of professional competence and reflective practice (Gibbs, 1988).

6. CONCLUSION

Person-centred care is not merely a theoretical aspiration but the organising principle of professional nursing in the United Kingdom. As this essay has demonstrated through the application of McCormack and McCance's framework, the Roper-Logan-Tierney model, the NMC Code (2018), and the 6Cs of Nursing to the fictitious case of Mrs Dorothy Chambers, effective person-centred practice requires the integration of clinical competence, relational skill, ethical commitment, and reflective awareness. The nurse who treats Mrs Chambers as a unique individual with her own history, values, and preferences — and who actively involves her in every aspect of her care

— is not only fulfilling their professional obligations but delivering care that is therapeutically more effective, more dignified, and more likely to result in positive outcomes. For student nurses at the outset of their professional journey, developing this integrated, person-centred orientation is arguably the most important foundation of nursing practice.

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