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Table of Contents

Introduction.....	3
Task 1: Critical Discussion on Team Development Theories and the Performance of Teams in Upholding Systems and Structures that Promote Rights, Responsibilities, and Diversity in Care UK.....	3
Tuckman's Theory and Team Maturity in Care UK.....	4
Belbin's Team Roles and Healthcare Functionality	5
The Performance of Teams in Maintaining Ethical Structures.....	6
Strategies to Develop, Maintain, and Evaluate Systems for Diversity and Rights.....	7
Task 2: Critical Appraisal of the Continuous Quality Improvement Tools Used in Care UK ..	8
CQI in Practice.....	9
CQI Tool 1: PDCA	10
CQI Tool 2: Zero Defects Management (ZDM).....	10
Strict medication-safety practices	11
Task 3: Analysis of the Need for Social Care Organisations and Teams to Achieve Person-Centred Care for Service Users.....	12
Person-Centred Care	12
Principles of Person-Centred Care.....	13
Importance of Person-Centred Care for Organisations and Teams	13
Maslow's Hierarchy of Needs in Social Care.....	14
Herzberg's Two-Factor Theory in Social Care.....	15
Implications of Person-Centred Care.....	16
Conclusion	16
Bibliography	18

Introduction

Care UK is one of the independent health and social care providers in the United Kingdom with more than 150 care homes providing residential, nursing, dementia and respite care (Care UK, 2024). The organisation was established more than 40 years ago, and it has established a good reputation in providing person-centred services, based on the national quality standards and evidence-based practice. With the UK under pressure from an ageing population, the activities of Care UK have become more significant related to helping older people with complex health and social requirements (Age UK, 2019). This essay is a discussion on the Care UK operational model, the external and internal strategic environment, service quality processes, and upcoming issues. Based on critical analysis, it intends to evaluate the effectiveness with which Care UK holds up against the changing regulatory requirements and demands in the UK care homes sector. Care UK has more than 150 care homes throughout England, Scotland and Wales, with more than 8,000 residents in care each year (Care UK, 2024).

Task 1: Critical Discussion on Team Development Theories and the Performance of Teams in Upholding Systems and Structures that Promote Rights, Responsibilities, and Diversity in Care UK

In the health and social care arena, especially in the setting of care-homes, like in the case of care-homes run by Care UK, the process of team development and its performance form a core premise of the shadowing of the rights, responsibilities, and diversities of service users. Care UK is one of the largest independent sectors in the UK, with more than 150 care homes where the residents have different physical, emotional and cultural needs (Care UK, 2024). To effectively work through such complexity, teams should not only operate as a functional unit but should also implement their practice following the ethical and legal frameworks of the Care Act (2014), the Health and Social Care Act (2012), and the Equality Act (2010).

This essay critically evaluates the applicability of the theories of team development, viz., Tuckman Team Development Model and Belbin Team Roles theory, to measure team performance and subsequently improve team performance.

Moreover, it also assesses how teams sustain systems and frameworks that protect user rights, promote answers and facilitate inclusive care provision. Critical thinking examines how teams are formed, maintained, and evaluated in practical environments, such as Care UK.

Tuckman's Theory and Team Maturity in Care UK

According to the **team development model** by Tuckman, **five stages are** defined, namely **forming, storming, norming, performing and adjourning**; this is directly applicable in the discussion of the lifecycle of care teams in Care UK. During the forming stage, interpersonal relations are being developed by new teams in Care UK homes, particularly when onboarding or following a restructuring. At Care UK, this is achieved through orientation programmes, protective training and shadow shifts, which promote the early formation of a team (Skills for Care, 2024).

At the storming stage, role conflicts and interpersonal tensions could occur. This is particularly evident in the Care UK setting, where team members are multicultural and have a diverse approach to care. At Care UK, managers countermand the risk of such friction through thoughtful supervision and inclusion-oriented workshops so that teams can deal with power relationships and communication barriers (Zirar et al., 2025, p.442).

Teams that are norming rest into known patterns within the team in terms of trust and accountability. These are the areas where operational activities, such as working on eMAR (electronic medication records) systems and CQC-compliant documentation, can become a routine. In Care UK, there is also the use of trained team meetings and peer review systems managed by the managers to check that the expectations are universally maintained. Within the performing stage, high-functioning teams behave proactively, i.e., they absorb and control crises, including protecting issues related to resident medical crisis, with their autonomous response and organised action. These teams are resilient, open and exchange knowledge, as well as match the CQC quality standards (Care Quality Commission, 2023).

Lastly, the stage of adjourning emerges when there is discharge of residents or when there is staff turnover. The Care UK advocates closure of teams by carrying out post-resident grooming and check-ins of emotional wellbeing. The similarities between Care UK and the framework offered by Tuckman enable the former to promote more maturity and ability among the members of its team to defend the rights of service users and ensure diversity-based care frameworks (Bloomfield et al., 2020, p.278).

Belbin's Team Roles and Healthcare Functionality

Whereas Tuckman has addressed the evolution of the team, Belbin and Brown (2022), has classified the team performance in terms of specialisation of roles. At Care UK, to have a successful functioning team, it is necessary to maintain a balance in meeting Belbin roles.

- The Home Manager serves as the coordinator, aligning the goals of the team, protecting policies and supervising adherence to the principles mentioned in the Care Act.
- Those who implement, including healthcare assistants and support workers, conduct critical care practices, including hygiene, nutrition, and emotional support.
- The Monitor-Evaluator, who is the clinical lead in most cases, guarantees that person-centred care is relevant to the NICE instructions (NICE, 2020).
- Team Workers will aid in solving interpersonal issues, especially in a diverse team and will also offer inclusive support across cultures and identities.
- Completer-Finishers take care of such fine-grained work as monitoring medications and caring for recording wounds, which minimises clinical risk.

The Below figure shows that 1 in 5 staff working in adult social care in England have a non-British nationality.

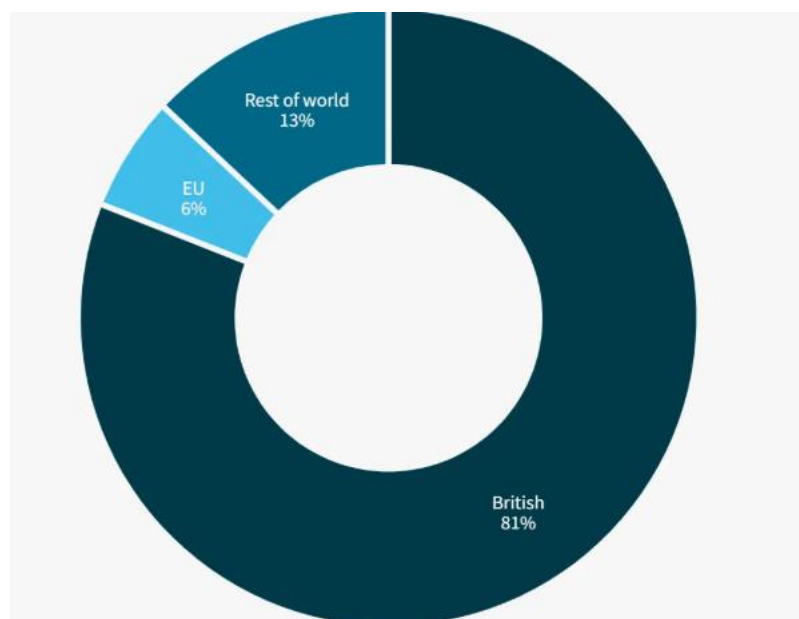


Figure 1: Workforce Diversity in the UK

Source: The King's Fund (2023)

The model by Belbin promotes the cultivation of team role consciousness and functional role division; it promotes appreciation of unique distinctions in cognitive and cultural styles of thinking. The model, however, is criticised in that it fails to address systemic inequalities. As an example, roles of assigned distribution may be limited by cultural or gender stereotypes

(Kirton and Greene, 2021). Care UK is aiming to solve these limitations by training staff on cultural competency and applying blind recruitment.

Through immersing Belbin principles within recruitment systems, training systems and assessment systems, Care UK can make sure that its teams are not only functionally efficient, but also can maintain systems that recognise and further the rights and differences of both staff and residents.

The Performance of Teams in Maintaining Ethical Structures

Within a regulated service such as that provided in Care UK, one does not only measure performance through the achievement of tasks but also through systems put in place to ensure that the residents are treated with dignity, given autonomy, and feel included. They are influenced by five standards of Care Quality Commission (CQC): Safe, Effective, Caring, Responsive, and Well-led (CQC, 2023).

- The teams preserve risk management systems by keeping the safeguarding referrals, incident logs, and fall risk assessments current. The competent teams know that it is their duty to take an action as long as the rights of one of the residents are violated; either in the care plans or consent.
- Regarding diversity, the teams use equality surveillance in resident admission procedures and advocate for culturally proper meals, assisting them to practice their faith, and communication in specific languages.
- Performance can also be measured, and it includes communication systems (i.e. handovers and care coordination meetings). Daily handover tools, shared care planning software help Care UK to reduce errors and create transparency (Busse et al., 2019).
- Digital competency is a team performance measure as well. An eMAR system, online care plan and mobile documentation will not only make teams more efficient, but it will eliminate record-keeping errors that have the potential of compromising the legal rights of residents (Care UK, 2024).

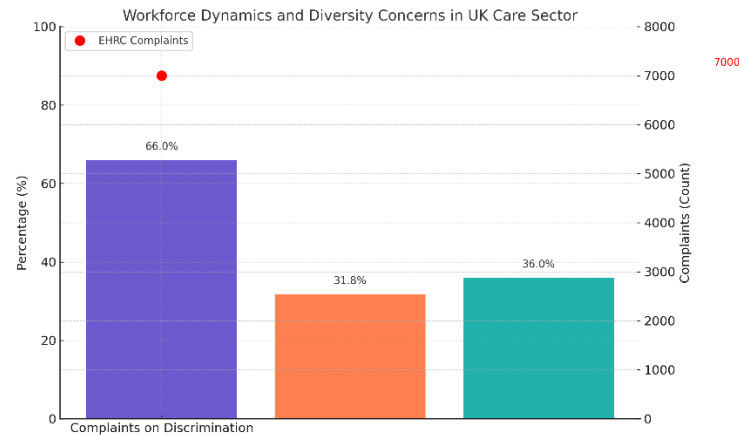


Figure 2: Workforce Dynamics and Diversity

Source: GOV.UK (2021)

The evaluation of performance is supported through audits, training logs, and feedback devices with residents. Besides, high-performing teams are proactive- they ensure that whenever they come across gaps within systems at monthly governance meetings, they come up with suggestions. Low-scoring teams are assessed during CQC inspection and internal key performance indicators (KPIs) (NHS England, 2020).

Rights-based care is also delivered successfully through effective team performance. The Care UK teams can make sure that the residents are respected, protected, and empowered by following the systems and structures based on ethical obligations.

Strategies to Develop, Maintain, and Evaluate Systems for Diversity and Rights

Care UK has some interconnected strategies to reinforce its structures to empower its service users' rights and diversity:

1. **Development Strategies:** New teams receive diversity training and orientation that incorporates major legislations- these include: **Equality Act 2010 and Mental Capacity Act 2005**. Managers are taught to apply the Expectancy Theory developed by Vroom in order to comprehend personal motivation and direct tasks to employee interests and professionally aspirations (NHS Confederation, 2021).
2. **Maintenance Approaches:** Systems are maintained through regular supervision of the staff, reflective practice, and multi-agency cooperation. An example is monthly diversity audits that are used to detect inadvertent bias in service/staffing delivery. The Human Resources teams of Care UK also consider the policy inclusiveness and non-discrimination.
3. **Evaluation Techniques:** Teams adopt methods of evaluation that comprise of service user feedback systems, such as questionnaires and interviews with the family to determine

whether cultural, religious, or gender-related needs are satisfied. Preventive SMART goals are also employed in staff appraisals, so that managers can monitor the progress of raising diversity awareness and cohesion.

Although Care UK aims at providing inclusive practices, there are a number of obstacles, which have been identified both in the context of studies and in the internal analysis, that continue to affect healthcare teams. The PowerPoint is correct when it says that the fear of discrimination deters diverse applicants from applying to the positions in the care settings, especially when teams are not displayed with cultural representation. The same can be said about opposition to change in the case of long-time employees who pose a cultural barrier that separates recruits of diverse backgrounds (EHRC, 2020).

Leslie and Flynn (2024) explain that institutional bias may be subtle, as in assigning all leadership of the team to one individual, stereotyping foreign-born workers as task-only employees, or the assumption that neurodivergent workers should be considered inferior. To fight this, Care UK suggests reflective supervision sessions and diversity education at every level so that structural biases can be detected and corrected.

Other motivational obstacles are a lack of appreciation, ambiguity of progression paths, and inadequate cultural and linguistic leadership. Using the Two-Factor Theory by Herzberg, Care UK has implemented some motivational practices that include peer recognition boards, flexible timetables, and spiritual accommodation to accommodate intrinsic, extrinsic motivators. Learning to dismantle these barriers and recognise them as a valued part of collectively improving morale and thus building a system-wide dedication to diversity, equity, and quality of care, Care UK also enhances—not slows down-- its high morale (Marcus et al., 2024, p.26).

Task 2: Critical Appraisal of the Continuous Quality Improvement Tools Used in Care UK

Continuous **Quality** Improvement (CQI) is an evidence-based, systematic procedure that aims at continuously and constantly advancing health and social care service delivery. When I assume the role of a physician in an organisation like Care UK, CQI can help to create an evidence-based culture, a person-centred culture, and a culture of evaluation. It facilitates repeated improvements of clinical safety and care effectiveness and resident satisfaction by integrating the mechanisms of reflection, staff involvement, and the closing of feedback loops inside the routine provision of care. This strategy is congruent with the mission of Care UK to

38 provide high-quality and individual care, combined with compliance with such frameworks as the Care Act 2014 and the Health and Social Care Act 2012. Being an indispensable part of governance in adult care homes, CQI makes improvements proactive as opposed to reactive, promoting dignity and a good life to service users (Aggarwal et al., 2019, p. 180).

26 Furthermore, CQI is an organised way of ensuring adherence to industry requirements, professional guidelines and intramural standards. CQI will allow staff to develop the awareness of identifying a possible problem prior to the intensity of the challenge and permit resilience within service enrichment systems in the ever-expanding field of adult social care. It establishes the trust of the residents and their family members, who can notice that the atmosphere of care is receptive and constantly works to achieve greater results (Skills for Care, 2022).

CQI in Practice

Care UK. The type of CQI used at Care UK was structured, collaborative, with data being collected, stakeholders being involved in decisions and regular audits. The organisation works in a cyclical framework which is plan, monitor, evaluate and change so that services are up to date according to regulatory requirements and emergent new resident requirements. Some of the core CQI mechanisms are resident feedback tools, safeguarding audits, and outcome-focused reviews. Such technologies as digital care plans and electronic medication administration records (eMAR) improve the accuracy, accountability, and continuity of care (Busse et al., 2019).

The main characteristics of the CQI system by Care UK are the following:

- Regular clinical audits in such areas as falls prevention and pressure care
- Regular reviewing of the staff to navigate individual improvement and recognise areas of training shortage
- Resident and family engagement sessions to tailor care to individual preferences
- The use of technology to get real-time performance measures
- Disciplinary faculty meetings to carry out comprehensive reviews of cases and plan holistically

This multi-layered approach promotes adaptability, staff engagement, and consistent improvement across service sites. It also reflects the organisation's commitment to inclusivity and transparency, ensuring that everyone from care workers to senior managers is aligned in the pursuit of excellence (Endalamaw et al., 2024).

CQI Tool 1: PDCA

PDCA Cycle (Plan Do Check Act) Plan Do Check Act (PDCA) cycle forms the main pillar of CQI because it helps organise change without necessarily causing a significant disturbance in the process. At Care UK, PDCA will start with knowing areas that should be improved--as in the case of frequent omissions of medications. The second stage, the so-called phase of the “Plan”, implies establishing goals by care leaders and plotting the intervention plans, including potentially the re-education towards eMAR systems. The “Do” stage is characterised by a trial of intervention on a small scale. In the course of the “Check,” the information about the frequency of errors is gathered and examined. The last stage is the “Act”, where successful strategies are standardised and spread throughout the domestic world (Tamher et al., 2021, p.S627).

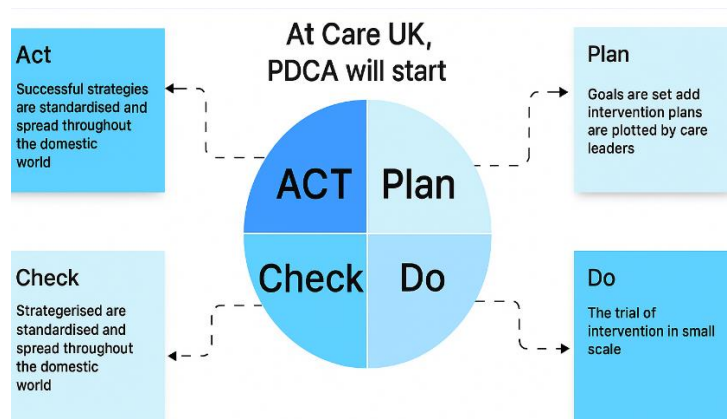


Figure 3: PDCA

In case of the inconsistent documentation of pressure ulcer prevention identified, the PDCA cycle will enable the effective piloting of the specific training, step-by-step assessment, and adjustment of training to a wider scope of coverage. It is simple, flexible, and well organised in terms of feedback. It needs to be done accurately, and the time-consuming nature of it might negatively impact its effectiveness in high-stress situations, such as those in palliative care, wherein emotional labour might be of a higher priority than improvements made through metrics. Reviews should be done frequently to keep practitioners to be kept updated since there will be changes in care needs (King and Young, 2020, p.123).

CQI Tool 2: Zero Defects Management (ZDM)

Zero Defects Management (ZDM) is an active quality philosophy focused on the prevention of errors and stressing process reliability. Despite the unrealistic nature of absolute perfection in complex care, the ZDM method motivates employees to work on the first time-right

performance and supports the system to avoid rather than fix a mistake (Psarommatis et al., 2020, p.1)

ZDM is operationalised at Care UK through:

- Strict medication-safety practices
- Tracking nutritional and hydration amounts to eliminate service inadvertence
- Protective measures that encourage the early identification of risk and speedy action
- Briefings after the handover each day, so that communication is not broken and information is not lost.



Figure 4: ZDM

Strict medication-safety practices

These projects are built into the clinical governance systems, and are assisted by training programmes, real-time audits and digital alert systems. In addition to procedural protection, ZDM forms the ethos of a psychologically safe work environment in which employees are empowered to report an incident or near-miss without the fear of being punished. This is an essential feature of this culture, as it proceeds to enhance transparency and learning.

However, ZDM is associated with risks. The unrealism of the expectations might stress out the teams and cause them to experience stress at least, and even burnout. Care UK counters this by rewarding small achievements, peer recognition and providing mentorship. These are processes of balancing quality and sustainability. Moreover, Care UK leadership pays a lot of attention

to the opinions of the staff, integrating front-line knowledge into the decision-making process and resource deployment (NHS England, 2020).

Continuous Quality Improvement is a framework as well as a culture included in the Care UK operational model. Such patients as PDCA and Zero Defects Management provide the framework to improve service delivery, ensure the resident's wellbeing and cultural change. Utilised as a whole, CQI creates a climate in which the process of quality improvement becomes part and parcel of the organisational system that results in safer, more humane, and person-centred healthcare. With the inclusion of feedback, performance data, and innovation, Care UK pursues the idea that continuous improvement is not a goal, as it is a long-lasting practice (Aggarwal et al., 2019, p.180).

Task 3: Analysis of the Need for Social Care Organisations and Teams to Achieve Person-Centred Care for Service Users

The provision of **person-centred care** (PCC) is central **to the** attainment of the best outcomes in contemporary health and **social care provision** to **service users**. **Person-centred care** has three priorities focused on the value, preferences, and dignity of individuals, and their programs should be oriented to answering their needs not only in a clinical aspect but also in the emotional, cultural, and social well-being. To social care organisations and their teams, affirming PCC in daily activities is a key to further improving the quality of life of the residents, particularly those with complex and long-term needs (Backman et al., 2021).

Maslow's Hierarchy of Needs and Herzberg's Two-Factor Theory of motivation **are** some of the **theories that** will come in handy to criticise this need. These theories can guide us to comprehend **the influence of staff** motivation **on the quality of care** and collaboration, along with the outcomes for service users. The provision of value and support to care teams that motivates them to provide compassionate, consistent care and individualised care is most likely. (Ihensekien and Joel, 2023,p.32).

Person-Centred Care

Person-centred care is an **approach** which observes the whole person and the fact that a person is a professional in his/her affairs and thus has a right **to be involved in** making **decisions related to** his/her **care**. It goes beyond standardisation of the procedures, where in fact active engagement of service users is promoted in the establishment of objectives, selection of

routines and the nature of provision of support. The Care Act 2014 and NHS England (2020) encourage PCC as one of the major care planning and delivery standards, in particular, in terms of services supporting older adults, people with disabilities, or individuals with long-term conditions (Van Loon et al., 2023, p.747).

As a more realistic example, PCC encompasses such points as listening to what a person says, valuing his or her culture and values and seeing the care plans recreated in the person. In nursing facilities such as those of Care UK, this could be in assisting with religion, acknowledging past history in dealing with dementia or adjusting meal schedules to the convenience of a resident. Finally, person-centred care promotes dignity, trust and improved health and well-being outcomes (NHS England, 2020).

Principles of Person-Centred Care

The fundamental values of person-centred care show that care workers are committed to subjecting the service users with dignity, self-worth and empathy. These include:

1. **Respecting Values and Preferences** – Professionals in caring should hear and respect the will of people. Be it the food, style of communication, or religious beliefs, acknowledging such choices only enhances autonomy.
2. **Physical Comfort** – Physical well-being is achieved through the provision of basic needs such as pain management, mobility, hygiene and access to assistive devices.
3. **Emotional Support** – The service users appear stressed out, depressed or disoriented. Employees are expected to use empathy, reassurance, and emotional presence when there are hard moments (The Health Foundation, 2021).
4. **Access to Care** – Interpretations of the service user and the provision of the right kind of care to the right person at the right time, consistent workers in the care provision area, and open channels of communication make the service users feel like they are not being left behind.
5. **Involving Families and Communities** – The person is usually known by families. When involved, the care will not be strange since they will know what to expect.
6. **Holistic Well-being** – PCC is not only about illness but about the entire individual, such as mental, emotional and social involvement.

Importance of Person-Centred Care for Organisations and Teams

Person-centred care is not for social care organisations and their teams a regulatory demand only but it is a key to quality. When services adopt PCC, they undergo an improvement of:

- The fishbone diagram below illustrates the root cause of barriers to person-centred care in health and social care settings.

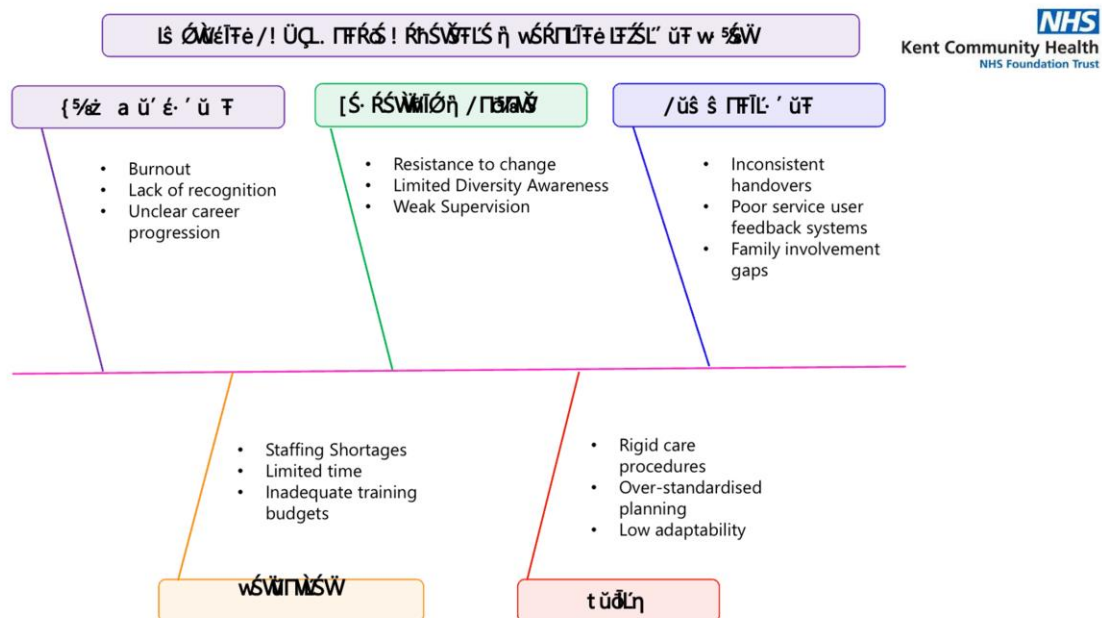


Figure 5: Fishbone Diagram

Maslow's Hierarchy of Needs presents a model of five levels of motivation of human beings, namely; physics: safety, love/belonging, esteem and self-actualisation. When used in a care environment, this theory may be applied to staff and the service users.

- **Physiological Needs:** These are fundamental needs. To the service users, this takes the form of nutrition, hygiene, rest and medication. Employees need just remuneration and lunchtime breaks.
- **Safety Needs:** People should be able to feel that they will not be abused or neglected. The personnel should have well-defined procedures, education, and protective gear to feel safe.
- **Belonging Needs:** Person-centred care encourages emotional connections between staff and residents. Consistency in staffing helps build rapport and trust (Bowen, 2021, p.538).
- **Esteem Needs:** Emotion is something person-centred care promotes between the staff and residents. Stipulated staffing consistently facilitates rapport and trust.
- **Self-Actualisation Needs:** Celebrating the accomplishments (e.g., a resident accomplishing the goals of physiotherapy or a staff member receiving praise for their compassion) gives confidence and a sense of worth. This is personal development. To the service users, it could imply rediscovering independence. In the case of the staff, it may be training or promotion.

When organisations satisfy these needs (not just to the carers but also to the residents they provide), then there is a naturally occurring high-performing, motivated care environment that is aligned with PCC objectives (Hale et al., 2019, p.109).

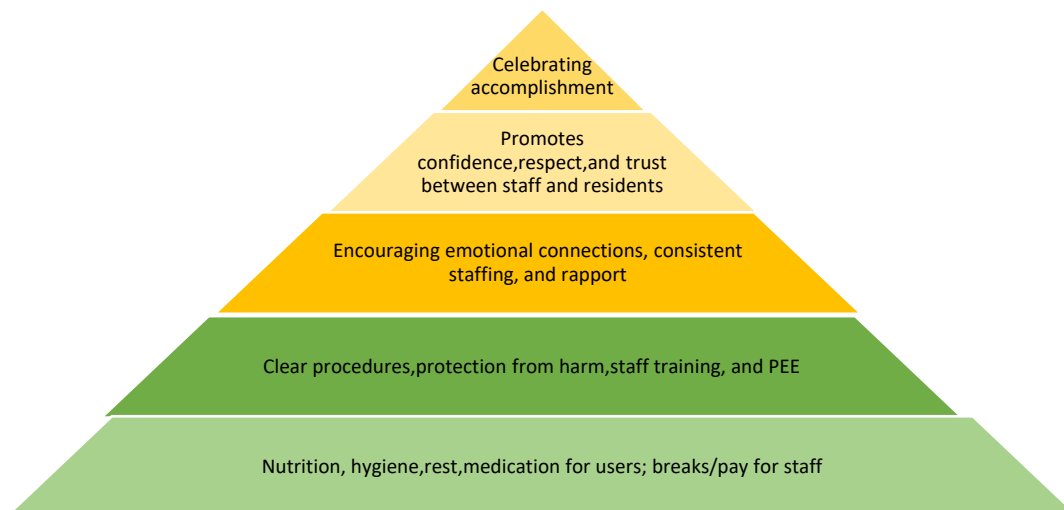


Figure 6: Maslow's Hierarchy

Herzberg's Two-Factor Theory in Social Care

The Two-Factor Theory, developed by Herzberg (1959), classifies motivation into two types: Hygiene Factors and Motivators.

- Hygiene Factors are the external factors which include salary, security, policies, and conditions of work. Lack of them brings about dissatisfaction, and the existence of them in and of itself does not enhance motivation.
- Motivators are those factors such as growth, recognition, and achievement which are already within a person. These are motivators of involvement, work satisfaction and excellent performance (Alrawahi et al., 2020).

The two categories are essential in the context of social care:

- In case a care assistant is underpaid (hygiene factor) or not provided with PPE, there will be a decline in motivation and a decrease in the quality of care.
- When a worker who is of the same rank is praised for assisting a distressed resident (motivator), they feel even more purposeful and driven to do more.

Companies such as Care UK use the Herzberg model to offer well-defined appraisals, training routes, awards of recognitions and are associated with beneficial supervision (Rai et al., 2021)

Implications of Person-Centred Care

Although person-centred care has a lot going positively, practice implications are there. PCC involves a big commitment, as its implementation is time-consuming and takes additional attention, flexibility, and emotional labour on the part of the staff. Every employee might not be ready to leave the patterns of tradition-based forms to more dynamic and adaptable patterns. A possibility of burnout is another risk when the emotional needs of staff cannot be satisfied. Unless there is a support mechanism in place, such as peer reflections, supervision, or counselling, emotional requirements of PCC could diminish employee well-being (Malenfant et al., 2022, p.80).

Nevertheless, when used effectively, PCC establishes more robust therapeutic connections, augmented service satisfaction, and advocates a holistic result. Organisationally, it makes complaints diminish, helps in positive reports of the inspection and increases staff retention. (Tehranineshat et al., 2019, p.546).

Conclusion

In conclusion, the concepts of team development, quality improvement, and person-centred care described by Care UK demonstrate a sound and changing model tackling regulatory and individual care requirements. Using Tuckman and Belbin theories, Care UK creates team

cohesion and enhanced team performance that does not violate user rights, diversity, and inclusivity. The organisation provides safety, responsiveness and outcome-driven services through Continuous Quality Improvement tools like the PDCA cycle and Zero Defects Management. Other motivation theories, such as the Maslow Hierarchy of Needs and the Two-Factor Theory identified by Herzberg, also contribute to the explanation of how team spirit and personal development are the sort of things that lead to the provision of person-centred care. Overall, all these approaches contribute to the image of Care UK as a care provider that is high-performing, ethical, and resident-centred. The incorporation of the reflective practice, digital innovation, and inclusion into its aspects makes the organisation adaptive in the difficult care environment.

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