Practicalities and Possibilities!

Person centred thinking and planning with older people

How Person Centred Thinking & Planning are Helping Older People Get Good Support and A Full Life!

Practicalities and Possibilities is an 18 month development programme which has been designed to support 9 local authority areas and their partners to work with older people and their families to develop and embed person centred approaches across a range of services and communities.

The nine areas taking part in *Practicalities and Possibilities* are working with local partners, older people and their families to find out "what works" in providing great support that helps people get on with their lives.

The stories shared in this paper show what's working well and what people are learning about providing truly person centred support that gives older people greater choice and control over any assistance they need. This is crucial as we know that the more people of any age rely on others to do everyday things (to get out and about, to go shopping, get dressed, stay in touch with family and friends etc), the less likely they are to carry on doing the things that are really important to them. It is all too easy for services' routines and priorities to take over the lives, wishes, hopes and dreams of older people who need support. These nine areas are committed to turning this around so that older people have a life, not a service.

The people taking part are receiving very different kinds of support, including from voluntary and community sector groups and networks, day services, intermediate care and extra care housing facilities, care homes, and domiciliary care services. Every area is doing something different; and every area is doing this as part of their usual activities and services. This is not a pilot or a research programme – it's for real!

The nine areas taking part are:-

- Bournemouth
- Buckinghamshire
- Cheshire
- Cumbria
- Dorset
- Enfield
- Hounslow
- Leicester City
- Tameside

Find out more about Practicalities and Possibilities on the following websites:
www.opp-uk.org.uk;
www.helensandersonassociates.co.uk;
www.cpa.org.uk.

Or contact Helen Bowers, OPP's Director, on 01202 416032; Helen.Bowers@opp-uk.org.uk

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What Are We Learning? Stories that are Full of Life!

Vi's Story - Tameside

Vi is a warm, loving and lively woman who lives on her own in Tameside. She is very close to her daughter, Janine, who lives in Spain, and her grand-daughter Maria, who has recently moved to live around the corner. Vi became involved in the Practicalities and Possibilities work very early on, when a **one page profile** was drawn up to identify the things that were most important to Vi in getting really good support. She lives in a sheltered housing scheme in Tameside, and she receives a lot of help with day to day things like getting dressed, shopping and cooking from the scheme's service provider.

Here is a taster of some of the things from Vi's profile:

What people who know Vi like & admire about her

- She laughs so easily
- The warmest person I know, you instantly care about her
- She always lifts my spirits
- You feel better for talking with her
- A smashing character

What's important to Vi?

- Vi loves to go out, shopping in town, bingo, church
- Having lunch at Harvey Nichols on a Monday
- Going to the Mecca Bingo club every Tuesday evening, on Oldham Road
- Janine, her daughter who lives in Spain. Vi really looks forward to Janine's telephone call from Spain every Thursday at 6pm

How best to support Vi?

- Vi needs support to go out of her home & will be really disappointed if she is unable to go to church, bingo or shopping
- She feels strongly that life shouldn't stop because she needs support to continue living at home
- Vi likes privacy when chatting with Janine: time your visit so you have left by 6pm

Vi's ability to get around is not what it used to be. She says *''at 86 my legs have given up on me''* which has meant that her visits to town, lunch at Harvey Nichols and going to bingo have recently stopped happening. This has left Vi feeling very low and isolated.

Vi's story illustrates the difference that can be made in someone's life when services, family and friends work together.

Maria and the staff team supporting Vi at home continued to think with her about what was **important to** her. They noticed that Vi talks very fondly of her old church in Bradford, which she started attending in the 1950s! She was at the heart of this church community for many years, and during her time here experienced many of the significant events in her life.

Since Vi moved away from her Bradford home 5 years ago, she has lost touch with her old friends at St Lukes. Going to the local church near her new home is not the same, and she only gets there occasionally when a neighbour is able to give her a lift.

The staff supporting Vi began to develop a timeline to capture some of Vi's **History** – with contributions from Maria and Janine (who still lives in Spain). They began to think together about what it would take to reconnect Vi with this huge part of her life.

They developed a **Relationship Map** including the names of all Vi's old friends. Once they had identified the key relationships and connections, Vi's support staff and Maria helped her write to these old friends. As they responded with cards and letters, Vi felt increasingly confident and excited about reconnecting with St Lukes.

They also used the **Presence to Contribution** tool to think about what it would take for Vi to get more involved at St Lukes – not just attending, but contributing once more. One of the staff team rang St Lukes to find out about the current activities, and told the Vicar about Vi's interest in helping with the weekly flower arrangements, polishing the brass and joining in with the coffee mornings. This meant giving some thought to how she could afford taxis to and from church each Tuesday and Thursday, as well as on Sundays.

This challenged Vi, Maria and the staff to think more deeply and carefully about what would it take to make these opportunities for reconnecting with others and contributing to the community at St Lukes a reality.

They decided that if Vi took a packed lunch prepared at her breakfast call, she could go the coffee mornings on Tuesday and Thursday and have her sandwiches whilst waiting for the other people who look after the flowers to arrive. There are always people around the church to sit and have a chat with over a sandwich. The saving she made from not having to pay for two lunch calls covered her taxi fares 3 days a week.

Now Vi is doing something she really enjoys; she is contributing and being appreciated by others for the wonderful floral displays she creates; and is gradually beginning to feel accepted as a full member of St Lukes' community once more.

Vi says:

> *'Its been like a sunbeam coming into my life, when I was beginning to feel that nothing was worth getting up for, now I spring out of bed – well as far as these old legs will let me spring!'*

Maria can see the changes in Vi and has loved being part of this planning process:

> *'I am delighted to see my Gran looking forward to her Tuesdays & Thursdays, spending time at St Luke's. She worked in a florists shop for many years so arranging the flowers in church is something that really lets her share her gifts. She meets so many people and loves watching the children play in the crèche while she eats her lunch… everyone has a word to say to her.*
>
> *Attending church every Sunday & having a coffee afterwards is a real highlight too – something she took for granted for so many years that she thought was lost…. it's fantastic, especially the feeling of independence it gives her not having to be ''taken'' or relying on the*

kindness of others to take her, I think she has a real feeling of empowerment.

I loved the presence to contribution tool we used - it really helped us think about how my Gran could return to that happy place of really giving. I know she was worried that she was receiving more and more support from health and social care providers and deep down desperately wanted a life outside of this too, she obviously felt her life was spiralling out of her control and felt that she faced a bleak future of being at the mercy of others. My Gran wanted to have a part to play, a greater say about how she lived, playing a full and active role, hopefully she has achieved this to some extent.

I have also learnt so much from this approach which will be so useful to me as I am in the second year of my social work training and have shared this with the rest of my group'.

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Kitty's Story - Leicester

Kitty is 90 years old and lives on her own in a sheltered housing scheme in Leicester, where she moved 5 years ago from Wigan to be nearer to her brother's family. Kitty receives help with personal care from Leicester City Council's Older People's team. Her family help with her shopping, cleaning, laundry and finances, as well as helping her manage various NHS appointments that she needs to take care of her health. She visits her family in Leicester every week.

Kitty's husband died several years ago, and it was around this time that her health began to deteriorate, including her sight and increasing arthritis in her legs, hands and back. She particularly suffers from stiff joints in the mornings. Kitty has had a cataract operation and has been diagnosed with glaucoma, so she receives daily visits from a district nurse to administer eye drops.

Following a bad fall Kitty was admitted to Wigan Hospital suffering from head injuries. It was whilst she was here that the medical staff suggested that she should move to Leicester to be near her brother's family. As Kitty was feeling vulnerable and dependent, she agreed although this was not really what she wanted to do. You can see how easy it is in times of crisis to lose fundamental choice and control such as where you live and being at the centre of key decisions about your life.

Since moving to Wigan, Kitty has had 3 further serious falls in the last 3 years. When staff from the Older People's Team first got to know her, she was feeling very unsure about what had caused her falls and very nervous about the prospect of further falls. She uses a delta frame to get around inside and outside her home, and needs a lot of support with her daily personal care routines.

Kitty's husband's grave is in Wigan, and she sends some money every month to a friend to buy flowers to put on his grave. It is Kitty's wish, one day to visit her husband's grave herself to take her flowers for him.

Bhartti, Kitty's Social Worker told us:

'When I first visited Kitty, her main wish was to regain her independence and have the freedom to go out and be a 'FREE SPIRIT' '

The person centred thinking tool **Wishing** was used to find out what Kitty's hopes and dreams are now, and to identify how best to support Kitty to have a good life in her new home town.

> *'The wishing tool was chosen because Kitty had lost all her confidence, was feeling very low and had poor self esteem. She had not gone out of her flat unescorted for almost a year. She was solely dependent on her family and care staff. She felt she had no choice or control over her life, and she felt angry because of this – she felt she was totally dependent on others'.*

After talking with Kitty about her wishes – some of which were very practical whilst others were more emotional – a number of actions were taken:-

Members of her family helped her to sort out an eye test, and made a referral and appointment (through her GP) with the local physiotherapy services.

Bhartti helped Kitty work out how to adjust to wearing her new glasses, and also considered other kinds of support and things to do during the day (e.g. joining the local Age Concern day centre to meet other people and get out of the house).

Kitty desperately wanted to visit her husband's grave in Wigan, so everyone helped and encouraged her to talk to her old school friend in Wigan to arrange this.

For the staff involved, there was no cost involved in helping Kitty to make these dreams come true, apart from the time to sit and listen, and to help Kitty make her plans. Time they would have spent with Kitty anyway.

What's different now?

Kitty tells us she feels like a new person – someone who is in charge and confident.

With Physiotherapy input, Kitty is now able to get out outside on her own, and to sit in the gardens where she likes watching the world go by. She loves being out amongst all the people and activity.

Kitty wears her glasses every day now, which helps her confidence and mobility: she makes her own way to the lounge in the sheltered housing scheme where she lives, taking part in Bingo and other communal activities that she enjoys.

As for visiting her husband's grave, Kitty has spoken to her old school friend and they are planning to go to Wigan together soon. She can't wait.

Bhartti told us:

> *"When I visited Kitty recently she looked a different person!*
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> *She had a sparkle in her eyes and was full of life"*

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Pat's Story - Cheshire

Pat's story is told by Su, Pat's daughter, who works for as a Care Arranger for Cheshire County Council.

"This is my mum, Pat, who is 69 years old and has lived in a warden controlled bungalow in Broughton, near Chester, since March 2003.

Pat is an outgoing, confident, independent and stylish woman who lives an interesting, wind swept and full life doing the things she loves: spending time with her granddaughter, Jessica, socialising with friends, drawing, travel, gardening, good food, watching reality TV (she's a huge BB fan!) and the odd glass of Leibfraumilch wine. She also has an honorary degree in 'Pottering', a pastime she has mastered admirably and which can take up a large part of her day.

Mum has suffered with Raynaud's in her feet since in her early 30's which has affected her mobility for years. She has managed without the need of walking aids until recently. In December 2002 she was diagnosed with Chronic Obstructive Pulmonary Disease (COPD) and recently with Diabetes Type 2, which is controlled by a combination of her diet and medication. This has affected her mobility greatly and her condition can vary almost daily. On a bad day, generally mid winter, it can take Mum an hour or more to get dressed and she is unable to leave the bungalow; she may need oxygen and/or nebulisers and will need help with almost everything. I look after her during these times, unless she is hospitalised.

When Mum moved into her bungalow, I arranged all the practical and sensible alterations I thought she would need: ensuring safe and easy access in/out and around her home, that lifelines were in the right place, fitting grab rails and purchasing bathing equipment (bath hoist, shower attachment and non-slip mats). We also purchased an outdoor scooter after a lengthy debate and a successful trip to the Trafford Shopping Centre - where Mum tried and tested a mobility scooter to within an inch of its life and was lucky not to get a speeding ticket!

Mum doesn't have homecare or other formal services, as between me, the warden (a good friend), neighbours, district nurse (on occasion) and a very chatty private gardener, she feels she has lots of support.

To be honest, when we made these arrangements I went through a check list in my head of what I thought was best for Mum and how to keep her safe practically. Mum felt at that time that it was best that I make the decisions about what was best for her… or (thinking back) was that my decision?!

Then came my Person Centred Thinking training where I heard about the experiences of different people who had been supported using this approach. I learnt about person centred thinking and planning tools, and became really excited about how I could better understand Mum's world from *her* perspective. I wanted to apply the approach at home, and look at whether there were any chances we could make that would make a difference to Mum in her life.

So, over a couple of glasses of wine, we talked about it and looked at some stories of how the approach had made a difference to different people, and the tools which we could use.

We have a good, honest and open relationship with each other so it was easy to talk about our responsibilities and what we were both worried about. This gave us a better understanding of where we were starting from. We looked at the tools in more detail, and Mum chose 3 which she thought could work for her:

Important to/for helped us realise that what I thought was important <u>to</u> my mum was in fact important <u>for</u> her. My mum, although very grateful for everything I had arranged felt there were things that she need for 'peace of mind' and other things to be 'content' and 'happy'. She thought I would think these were silly little things, but when put into the context of her life they were in fact incredibly important to her. The tool gave my Mum the opportunity to tell me about these things without it feeling like she was 'bothering me'.

Working and not working helped us realise there were things we could easily improve in the bungalow, and things that we needed to buy which could help Mum on a daily basis.

The **decision making agreement** was vital, as at times Mum felt that I made too many decisions which worried her from several points of view. She understood that I felt I knew what was best and although she trusts me she wanted to be more actively involved in making important decisions. She was also worried about me having to cope with all the decision making on my own, which in turn caused her to become stressed.

Following our discussion, there were some big changes.

We re-arranged Mum's bedroom so she can move about easier. We made sure she can reach the mattress variator controls to help her get in and out of bed, and extended the pull cords for the curtains that she previously couldn't reach.

Mum was feeling very stressed and worried (which affected her physically) about being left in the house without any food. Previously I had done the shopping for her, but Mum told me she wanted to go to the supermarket herself and pick her own food. Her diet had changed dramatically since her Diabetes so she wanted to be more creative with her diet. We also bought a freezer so she can stock up on the basics and relieve her anxiety about having no food in the house.

To give Mum a break from her own house, she now regularly comes and stays with me. In the past I had been reluctant to arrange this because I thought Mum would find the stairs difficult. However, she loves coming to stay and feels that the risk is

worthwhile. Sleepovers are now a regular arrangement: Mum brings her medications, and I respect her decision to take that risk.

To increase Mum's independence we bought a storage cover and had a lock fitted to her scooter so it can be kept at the front of her house. Previously it had been stored in the outhouse at the back of her property as Mum was worried about it being stolen or weather damaged. With her confidence growing it is now easier for Mum to ride to the local shops, visit the hairdresser post office and her doctors. She's much more involved with the community now – there isn't much that goes on without her knowing about it these days!

Finally we agreed that Mum will go to all her medical appointments on her own, as she is very informed and realistic about her conditions. Previously, I had always accompanied her but Mum was confident about going on her own and actually enjoyed organising her own transport to and fro. I also found out that when Mum was talking, which can take a long time due to her getting breathless, I would end up speaking for her. Mum now has a memory board where she writes any questions down that she would like to ask, a diary of her appointments, a list of her medications and feels much more in control of her medical care.

Mum's emotional and physical wellbeing has improved dramatically since these changes. She is now more independent and has more control over her health, and the life that she leads.

We're now using another person centred planning tool - **Hopes and Dreams.**
Here are her top five.

- *To stay as healthy as I can*
- *Have the best quality of life as I can, given my medical conditions*
- *Spend as much time as I can with and seeing my granddaughter grow up*
- *Sit on the beach, in the sun, at least once a year*
- *Have a ride on a Harley Davidson Motorcycle for my 70th birthday* (psst don't tell her, but already arranged!)

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Doris's Story - Enfield

Mrs Doris Carpenter is 84 years old and lives alone in a one bedroom maisonette in Enfield.

Doris has arthritis and often gets very low and anxious. Her husband used to manage all their finances and since he died, a few years ago, things have got on top of her. She found she struggled with the bills and correspondence, and got into debt, which made her feel worse. She was referred to the Older Peoples Team at Enfield Council for help with resolving these problems, and to move to another property under the Enfield Home Scheme.

Using Person Centred Thinking to Help Doris Get on Top of Her Life

Doris does not like to be rushed and like all of us does not like being forced into agreeing into anything she does not understand. So the older people's team in Enfield used person centred thinking to ensure all their assessments take account of what's really important to Doris about their support and having a good life.

For Doris it was really important to feel that she was the centre of all conversations, and that the pace of decision making is her own.

Doris told us:

> *'I am always rushed to make a decision and people don't listen to me'*
>
> *'Sometimes I am not treated like a person because of my age.'*

One of the first changes made in helping Doris get back her sense of control was to change the times when people visited her to talk through her arrangements and assessments for support. Previously her social workers visits had visited in the morning, but this was really difficult for Doris, whose medication can make her sleepy at these times. By re-organising her visits to the afternoon and making them shorter, Doris found she was much calmer and both understood and contributed more to the conversations. She also remembered more things that helped staff work with her to develop a **person centred support plan**.

Doris has no family locally and does not like other people being involved in her affairs. Using a **Relationships Map** her social worker discovered that Doris has a good relationship with her Community Liaison Officer. Involving this person in making arrangements for Doris' move proved invaluable.

By sorting what was **important to and for** Doris, staff were able to ensure that she has more control of key decisions (like moving to her new flat), and together they were able to identify which tasks she would prefer to complete herself. As a result, Doris made all the arrangements to get her correspondence re-directed; she opened a new bank account with direct debit facilities; and drew up a plan to improve her new flat and make it feel like her own home.

Doris told her social worker:

> *'I'd like someone to come every few weeks to help me with my paperwork (and post) and help me get on top of the paying of bills''*.

Funding was agreed for a floating support worker to work with Doris for 6 months, and together they have identified a bank account and savings Doris had forgotten about. Doris has a better understanding of her affairs, and is less anxious as most of her bills are now paid by direct debit.

Doris loved dancing when she was younger and has fond memories of these earlier days, so her social worker looked into dance classes held at a local resource centre, Ruth Winston House. They are going to go together to once Doris has settled into her new home.

Staff working with Doris told us:

> *"Although I feel I have always completed my assessment / review in a person centred way, I have paid particular attention to capturing on paper what Doris wanted in her life and how these changes were to happen. Feedback from Doris is she feels more in control, understood and listened to"*

Doris sums up the difference in her life compared to other support she had experienced in the past:

“I needed alot of help to get back to my normal self ”

“They (previous care staff) *rushed things far too much… I don’t feel rushed with you”*

“You understand me better and I feel you are listening to me”

“The way you worked with me has given me power and I feel in control”

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