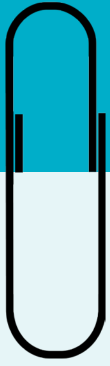
4



Case study four: Vignette

Name: Anne Woolsey

Gender: Female

Age: 92

Ethnicity: White British

First language: English

Religion: Christian faith (Anglican Church)

Anne is married to Arthur, 94. They have been married for over 70 years and live in their own bungalow in a village. Anne and Arthur have two daughters, five grandchildren and eight great grandchildren. The family are quite dispersed across the country. Their nearest daughter Carol, who lives 40 miles away, visits twice a month. Daughter Jean visits every other month. Both daughters phone regularly. Their neighbour Betty calls in most days.

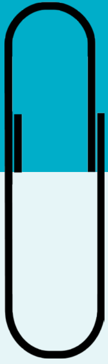
Arthur has end stage Chronic Pulmonary Disease (COPD) and is nearing the end of his life. Arthur is currently housebound, using oxygen at home. He has support from a Community COPD nurse. Anne has provided care for Arthur for eight years, and the support that he needs is increasing. The COPD affects Arthur's mobility and he is unable to get to the toilet in time at night. Most mornings he awakens with soiled sheets which distresses him. Anne continues to look after the home and has started to manage the finances, which previously Arthur did. Anne and Arthur find it difficult to talk with each other about Arthur's death. They would both like Arthur to die at home, with his wife and daughters.

Anne's health is generally good, though she has mild arthritis and takes tablets for stable angina. However, she is becoming less strong and more tired. Anne has some hearing impairment and finds it difficult to read small print. Anne devotes her time to caring for Arthur and no longer goes to church. Both were previously active in the community and attended a local lunch club. Anne is determined to be there for Arthur and does not like to leave him, even with someone else. Her main concern is that she will not be able to support Arthur till the end. Anne is beginning to find it difficult to look after the home and garden, and to feel quite isolated. She is not confident in managing the family finances and is not sure how she will manage when Arthur is gone.

Carol is concerned about her mother not sleeping well and looking tired. She rings the local authority. You go out and complete the initial assessment and support plan with Anne. As part of this you talk to Arthur, Carol, Jean and Betty.

©Research in Practice for Adults 2016

4



Case study four: Chronology

Personal details

Name	Anne Woolsey		
Address	12, Oak Tree Close, Hawton ZZ2 Z22		
Telephone	01654 654321		
Email	N/A		
Gender	Female		
Date of birth	28.06.23	**Age**	92
Ethnicity	White British		
First language	English		
Religion	Baptised C of E		
GP	Dr Philps, Oak Tree Surgery		

Chronology completed by

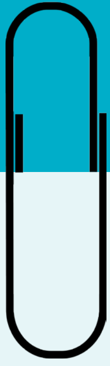
Name...

Role..

Organisation...

Date chronology completed: 15 February 2016
Date shared with person: 15 February 2016

©Research in Practice for Adults 2016

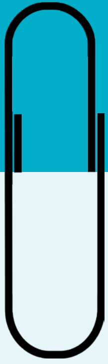


Case study four:
Chronology continued

Date	Life event	Outcome and/ or response
08.08.45	Anne Mary Marshall married Arthur Eric Woolsey (dob 18.11.21), a local builder	Married name Mrs Anne Mary Woolsey
25.11.53	Birth of first child	First daughter, Carol Anne Woolsey
12.04.55	Birth of second child	Second daughter, Jean Lesley Woolsey
31.01.82	Husband Arthur retired from the building trade. He had carefully planned for his retirement, having always managed the family finances.	Arthur and Anne enjoyed good health in their early retirement, and were active within the local community, particularly with their local church.
17.09.88	Arthur has been a smoker most of his life and his breathing begins to affect his mobility. Anne and Arthur decide to move to a bungalow.	Anne and Arthur moved home. They bought a bungalow so that Arthur did not have to worry about stairs as his breathing worsened. They continued to enjoy an active retirement following the arrival of five grandchildren during the last decade.
22.03.08	Arthur attends his local GP surgery with chronic breathing difficulties and is referred to the local hospital for investigation.	Diagnosis of Chronic Obstructive Pulmonary Disease (COPD. It is thought that his work in the building trade may have been a contributory factor, along with his smoking habit. Arthur did give up smoking at some point in the ten years before being diagnosed.
03.07.15	Arthur admitted to hospital with chronic chest infection and difficulties breathing.	Arthur diagnosed with end stage COPD. Anne now provides all personal care for Arthur. Anne is starting to become more isolated as she does not feel happy leaving Arthur.
17.07.15	Referral to Community COPD nurse service as part of hospital discharge plan. Arthur now has oxygen at home.	COPD Nurse begins to visit every few weeks to check on Arthur and bring medication.
03.01.16	Daughter Carol is concerned about her mother not sleeping well and looking tired. Referral to social services.	Social worker phones to arrange an assessment visit.
15.01.16	Initial SW assessment visit to Arthur and Anne.	SW arranges to visit again when Carol is next visiting her parents to continue the assessment. Arthur agrees to have his own assessment as part of this visit.
11.02.16	Second assessment visit with Carol, Jean and Betty (neighbour) present.	Carer’s assessment and support plan completed.
15.02.16	Paperwork completed.	Sent to Anne.

©Research in Practice for Adults 2016

4



Case study four:
One page profile

What others like and admire about me

> My marriage to Arthur – we've loved each other for seventy years

> I'm very fit for my age

> I've always helped out in the parish and I used to run the Mother's Union

> My big family – we are fortunate to have eight great-grandchildren

What is important to me

> Looking after Arthur

> Staying on top of the house work

> Having a bit of a sit together with Arthur

> Someone to help with the finances

> My faith and my parish

> Looking after myself

Anne Woolsey

How best to support me

> Talk to me about what is happening to Arthur

> Be honest about what you can do

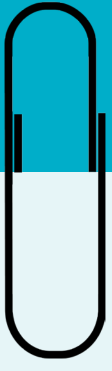
> Let me know who to contact if the worst happens

> Don't expect me to use a computer

> Help me with the finances

> Let my family know that I need help now

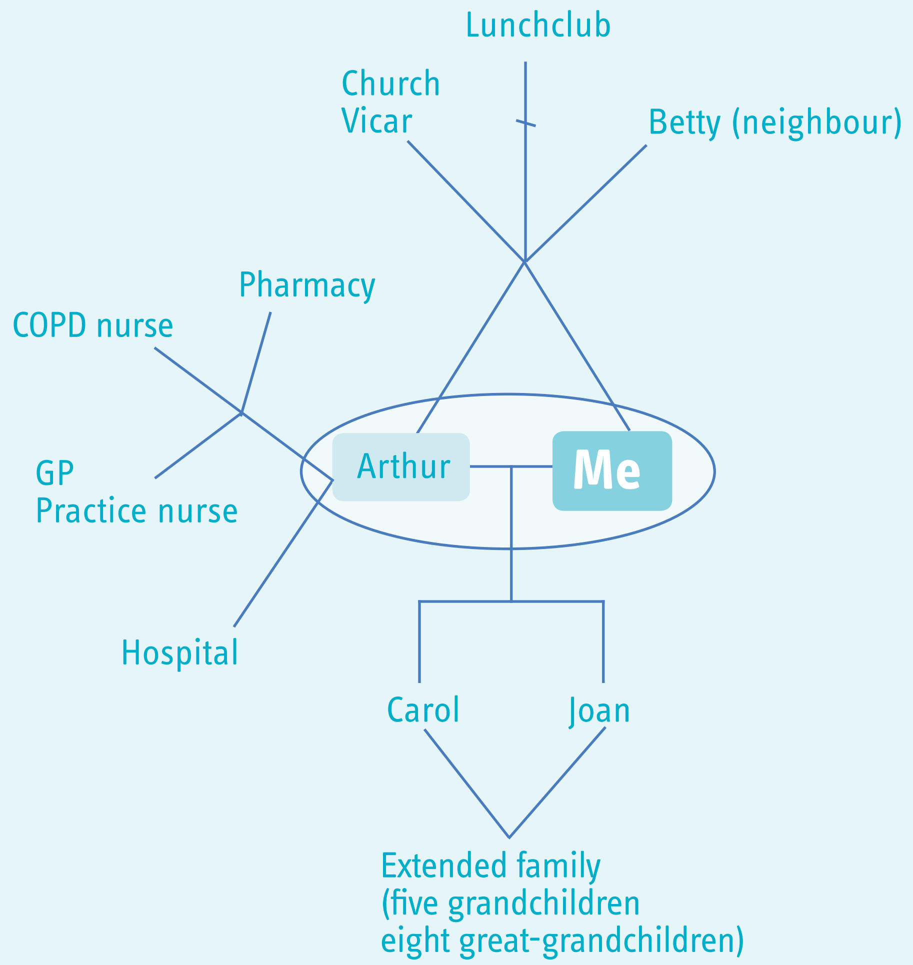
©Research in Practice for Adults 2016



Case study four: Ecogram

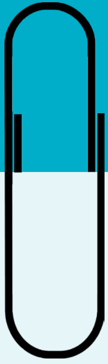
Name: Anne Woolsey

Date completed: 12 February 2016



©Research in Practice for Adults 2016

4



Case study four:
Carers Assessment

About me

Name	Anne Woolsey		
Address	12, Oak Tree Close, Hawton ZZ2 Z22		
Telephone	01654 654321		
Email	N/A		
Gender	Female		
Date of birth	28.06.23	**Age**	92
Ethnicity	White British		
First language	English		
Religion	Baptised C of E		
GP	Dr Philps, Oak Tree Surgery		

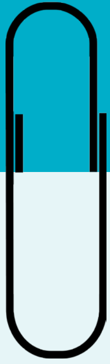
How would you like us to contact you?

By telephone or letter

Do you need any support with communication?

I need written information to be in large print

©Research in Practice for Adults 2016



Case study four:
Carers Assessment continued

About the person/ people I care for

My relationship to this person	Wife		
Name	Arthur Woolsey		
Address	12, Oak Tree Close, Hawton ZZ2 Z22		
Telephone	01654 654321		
Email	N/A		
Gender	Male		
Date of birth	18.11.21	**Age**	94
Ethnicity	White British		
First language	English		
Religion	Baptised C of E		
GP	Dr Philps, Oak Tree Surgery		

Please tell us about any existing support the person you care for already has in place. This could be home care, visits or support from a community, district or community psychiatric nurse, attending any community groups or day centres, attending any training or adult learning courses, or support from friends and neighbours.

Our two daughters help out when they can - Carol is nearest, 40 miles away. She visits a couple of times a month and our other daughter, Jean, tries to come as often but it's more like every 2 months or so. Jean and Carol each phone every week to see how we are.

Our neighbour, Betty – she pops in nearly every day now to see if we need anything. We've been friends for many years and she's not young herself.

The GP and nurse at the surgery are very good though we don't like to bother them, they are very busy.

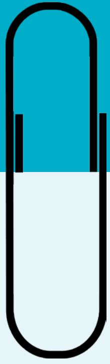
The COPD Nurse stops by every few weeks to check on Arthur and bring his medication.

Vicar – we don't get to church much now a days but the vicar comes round now and then.

We used to go up to a lunch club at the church but we've stopped going lately.

Carol does the heavy shopping and helps with the housework when she comes. Jean and Carol both look things up for their parents and advise them as best they can. Both take Anne and Arthur out for short drives when they visit.

©Research in Practice for Adults 2016



Case study four:
Carers Assessment continued

The things I do as a carer to give support

Please use the space below to tell us about the things you do as a carer (including the emotional and practical support you provide such as personal care, preparing meals, supporting the person you care for to stay safe, motivating and re-assuring them, dealing with their medication and / or their finances).

Arthur has Chronic Obstructive Pulmonary Disease (COPD) - Arthur did give up smoking about ten years ago. He was in the building trade all his life which the hospital said may have been a contributory factor, along with his smoking. We've been told he probably won't make it to next Christmas, but that is what we hope for all being well.

This is what I do for Arthur and me:

> *Get my husband out of bed and get him washed and dressed.*

> *The bed clothes are usually soiled so I get the bed stripped and into the wash.*

> *Make him breakfast and help him eat it.*

> *Give him his tablets.*

> *Do the housework – I try to do a few jobs each day, rather than doing one big clean - looking after Arthur takes up so much of my time.*

> *Deal with the visitors to the house - social worker, COPD nurse, GP - I try to have them come in the morning.*

> *Pop out to get some shopping- just to the local shops, little and often as I can't carry a heavy shop any more.*

> *Do us a bit of dinner, though Arthur doesn't eat so much these days*

> *In the afternoon, I might look at trying to pay some bills. I'm trying to find out about power of attorney.*

> *Make our tea*

> *Tidy up and get us ready for bed*

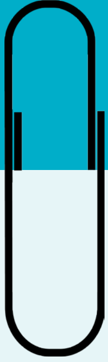
> *Make Arthur a drink and give him his tablets*

> *Sort out the oxygen*

> *Lock up for the night.*

©Research in Practice for Adults 2016

4



Case study four:
Carers Assessment continued

How my caring role impacts on my life

Please use the space below to tell us about the impact your caring role has on your life.

Arthur and I have been married for over 70 years – he's my world. He's always sorted out the finances, paid our bills and made sure we have enough to go round. I'm trying to do the paperwork now but I'm very worried about how I'll cope, I've never had to do this before. I've never written a cheque and I'm worried I'll get it wrong.

I wake up in the morning still tired, it's usually a disturbed night's sleep, but I have to get on with it as Arthur needs washing and dressing. He's often in a mess poor thing.

I make sure we have time to sit together and relax, I try to do things little and often - I'm very lucky to still have my health.

When Arthur nods off I try to do the bills but I end up nodding off too then I get very worried that things will fall behind. I don't know how I will manage when Arthur is gone.

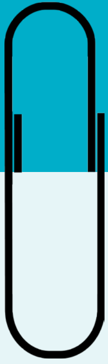
The girls are very good and the grandchildren ring now and then. I try not to make a fuss, they're all so busy. The girls know I'm very worried about losing Arthur. I can't bear to talk about it, I just want to make the most of the time we have left.

This year I've not been able to do my planting and keep the bungalow up as I'm used to. I am feeling more tired and I suppose the main fear I have is that I won't be able to keep caring for Arthur to the end. I know I need to look after myself but I'm sometimes too tired to eat and I'm not sleeping well.

I have lost touch with the church and the people we used to see. Sometimes I feel quite alone.

©Research in Practice for Adults 2016

4



Case study four:
Carers Assessment continued

What supports me as a carer?

Please use the space below to tell us about what helps you in your caring role.

Betty next door is such a good friend, she does her best but she is not young herself.

The doctor is understanding but there's not much he can do now.

The nurse up at the surgery has known us a long time and I can ring her if I'm worried.

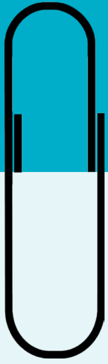
The Community COPD nurse comes once a month and checks how Arthur is.

Carol and Jean help with the shopping and try to help me with the bills and letters but Arthur and I have always managed these things ourselves, I don't want to let him down.

Carol does the heavy shopping for me once a month.

We see the Vicar now and then. The church has always been a comfort to me.

©Research in Practice for Adults 2016



4

Case study four:
Carers Assessment continued

My feelings and choices about caring

Please use the space below to tell us about how you are feeling and if you would like to change anything about your caring role and your life.

I am determined to look after Arthur until the very end. I need to stay well enough to do that.

Arthur and I both want me to help him with personal care, not a stranger.

I want to be able to manage and do my best for him.

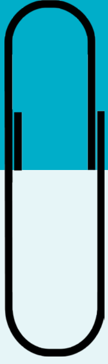
I would like to have more sleep so I don't nod off when I should be sorting things out.

I wish the girls were closer so that they could come more often.

When the time comes I would like Arthur to die at home with me and his girls. This is what he wants too though he doesn't like to talk about it.

I need to make sure that I can take care of the bungalow and the garden, and that the bills are sorted out.

©Research in Practice for Adults 2016



Case study four:
Carers Assessment continued

Information, advice and support

Let us know what advice or information you feel would help you and what sort of support you think would be beneficial to you in your caring role.

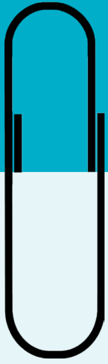
Some help with sorting out the bills and keeping on top of the paperwork like Arthur would want me to.

I would like the garden to look better so Arthur could sit outside sometimes.

Some back up in the mornings with changing the bed and getting the laundry done.

Someone to talk to about how to manage all of this. I don't like to talk about it in front of Arthur. He finds it very difficult to talk about leaving me and he doesn't want to talk about what he would like to happen at the end or after he's gone. I don't want to think about it. We have always said we would stay together till the very end. That is all I want, to be together in our own home. We never made our wills and I don't have power of attorney or anything like that.

©Research in Practice for Adults 2016



4

Case study four:
Carers Assessment continued

Conclusion

To be used by social care assessors to consider and record measures which can be taken to assist the carer with their caring role to reduce the significant impact of any needs. This should include networks of support, community services and the persons own strengths. To be eligible the carer must have significant difficulty achieving 1 or more outcomes without support; it is the assessors' professional judgement that unless this need is met there will be a significant impact on the carer's wellbeing. Social care funding will only be made available to meet eligible outcomes that cannot be met in any other way, i.e. social care funding is only available to meet unmet eligible needs

Date assessment completed 15 February 2016

Social care assessor conclusion

Anne is providing significant daily support to her husband aged 94 who has COPD and is reaching the end of his life. At 92 years of age herself, Anne's health is generally good though she is increasingly frail and says she tires more easily these days. The couple live together in the matrimonial home. Her husband has monthly visits from the COPD nurse. Their nearest daughter visits once a month and does the heavy shopping. They have one other daughter who visits when she can, about every other month, and phones regularly. Their neighbour, Betty, a pensioner herself, pops in most days to check they are ok. Anne is very organised and has supported Arthur for many years while looking after the home. However, Anne's caring role is starting to impact on her health. She says that she is starting to feel increasingly tired and has disturbed nights. Anne does not feel confident in managing the family finances and is beginning to find it difficult to manage the home and garden. Anne would like to continue looking after Arthur at home "until the end". Both want to be together and for Arthur to die at home with his family. Anne would benefit from support to enable her to manage the demands on her, and to have some more time to relax and just be with Arthur. They each find it hard to talk about Arthur's death in front of the other. Arthur finds it difficult to say what he would like to happen at the end and to plan for this. Anne has previously found comfort in the church but has become more isolated recently. Anne would benefit from some emotional support for herself and for her family, as well as practical help, advice, and support to manage finances. This will enable her to continue as Arthur's main carer, which is what both of them want, and to maintain her own health and wellbeing.

Eligibility decision *Eligible for support*

What's happening next *Create support plan*

Parallel assessment for Arthur Woolsey

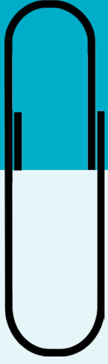
Completed by

Name...

Role...

Organisation...

©Research in Practice for Adults 2016



Case study four:
Carers Assessment continued

Signing this form (for carer)

Please ensure you read the statement below in bold, then sign and date the form.

I understand that completing this form will lead to a computer record being made which will be treated confidentially. The council will hold this information for the purpose of providing information, advice and support to meet my needs. To be able to do this the information may be shared with relevant NHS Agencies and providers of carers' services. This will also help reduce the number of times I am asked for the same information.

If I have given details about someone else, I will make sure that they know about this.

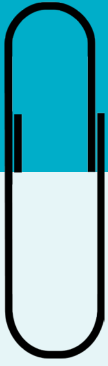
I understand that the information I provide on this form will only be shared as allowed by the Data Protection Act.

Name...

Signature...

©Research in Practice for Adults 2016

4

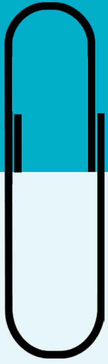


Case study four: Support Plan

About me

Name	Anne Woolsey
Address	12, Oak Tree Close, Hawton ZZ2 Z22
Telephone	01654 654321
Email	N/A
Gender	Female
Date of birth	28.06.23 Age 92
Ethnicity	White British
First language	English
Religion	Baptised C of E
GP	Dr Philps, Oak Tree Surgery

©Research in Practice for Adults 2016



Case study four:
Support Plan continued

About the person/ people I care for

My relationship to this person	Wife
Name	Arthur Woolsey
Address	12, Oak Tree Close, Hawton ZZ2 Z22
Telephone	01654 654321
Email	N/A
Gender	Male
Date of birth	18.11.21 Age 94
Ethnicity	White British
First language	English
Religion	Baptised C of E
GP	Dr Philps, Oak Tree Surgery

Support plan completed by

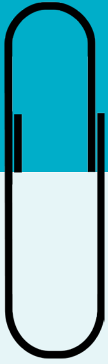
Name...

Role...

Organisation...

©Research in Practice for Adults 2016

4

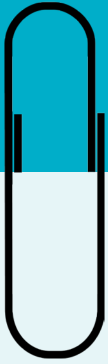


Case study four:
Support Plan continued

Support plan

Needs	Outcomes	Actions
To stay well and active	*Anne is able to continue to provide personal care.* *Anne sleeps better and is less tired during the day.*	*Social Worker to ensure Anne is on the carers' register at the GP surgery and ask for a carer's health check.* *As part of Arthur's care and support plan, social worker to refer to the equipment service to assess for minor aids and adaptations.* *Someone to help with cleaning and shopping. Direct payment for Anne to arrange this (parish community to advise on possible Personal Assistants).* *As part of Arthur's care and support plan, social worker to refer him to continence nurse for advice on options, particularly at night.* *Carol to continue to do the heavy shopping once a month.* *Carol to arrange a gardener.*
Help to navigate through health and social care services	*A clear plan and a named person to co-ordinate services including direct payments.*	*Social worker to complete spider diagram with Anne to show services and important contact details.* *Social worker remains as care coordinator and Anne can contact with any concerns.* *Refer to user-led organisation to help Anne manage direct payment and co-ordinate service for as long as needed.*
To have people to talk to and be less isolated	*Family visits are agreed, regular and co-ordinated. Daughters and wider family members who Anne feels confident to leave Arthur with are all involved.* *Anne and Betty have more time as friends.* *Anne occasionally goes to church or takes part in parish activities as she feels confident enough to leave Arthur for a short while.*	*With Arthur's agreement, visiting plan drawn up with Carol, Jean and Betty for three afternoons a week and a weekend each month so that Anne can take a break.* *With Anne's agreement, Betty to phone Jean and Carol each week to let them know how things are. Jean and Carol to continue to call Anne at least once a week.* *Sitting service arranged for Sunday mornings so that Anne can attend church. Betty to give Anne a lift.* *Betty and Anne to find out about how Anne could be more a part of the parish community.*

©Research in Practice for Adults 2016



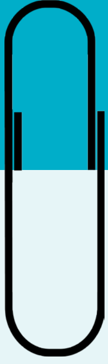
Case study four:
Support Plan continued

Needs	Outcomes	Actions
To have advice about how to manage bills and finances, and support to achieve this, including someone to help with arranging power of attorney and wills.	*Anne less anxious about her ability to manage the finances. Has support to arrange payments and obtain Lasting Power of Attorney.* *Confident in writing cheques.* *Wills completed.*	*Social worker to make referral for Citizens Advice Bureau to visit and do a benefits check for Anne and Arthur.* *Social worker to make referral for legal advice re LPA and wills.* *Befriending service via carers' centre to visit Anne and help with financial matters, direct debits, advice on managing their bank account and how to write a cheque.*
To have support plans in place to enable Arthur to die at home with his wife and daughters present	*Everyone to know what to do as Arthur reaches the final stages of life.*	*Social worker to arrange a family meeting involving Anne, Arthur, the COPD nurse, Carol and Jean, to talk about dying at home and make plans to enable this. Social worker to contact hospice social worker about support available from local hospice as part of this.* *Social worker to provide emergency numbers as part of spidergram.* *Social worker to refer for 'lifeline' call system. Betty to hold a key and keysafe to be installed.* *Agree contingency plans for care and any advance directives. Agree contingency plans for managing finances.*
To have a plan for Arthur and Anne's deaths.	*Family all aware of Arthur and Anne's wishes.* *Funeral plans in place.*	*Social worker to ask hospice social worker for advice and support for family to plan for Arthur's dying and his funeral wishes, and also for Anne to think about this for herself.* *Anne to ask Vicar to visit to talk about this.*

Date of support plan: 15 February 2016

This plan will be reviewed on: 15 April 2016

©Research in Practice for Adults 2016



Case study four:
Support Plan continued

Signing this form

Please ensure you read the statement below in bold, then sign and date the form.

I understand that completing this form will lead to a computer record being made which will be treated confidentially. The council will hold this information for the purpose of providing information, advice and support to meet my needs. To be able to do this the information may be shared with relevant NHS Agencies and providers of carers' services. This will also help reduce the number of times I am asked for the same information.

If I have given details about someone else, I will make sure that they know about this.

I understand that the information I provide on this form will only be shared as allowed by the Data Protection Act.

Name...

Signature..

Anne has asked for her assessment and support plan to be considered as part of Arthur's assessment. Arthur is happy for his assessment and support plan to be considered as part of Anne's assessment and support plan.

©Research in Practice for Adults 2016