

Case study

This is a case study provided to us by Aroma Care People Ltd, a domiciliary care provider whose staff completed our training in 2022. Please see staff talking about the training [here](#). This is their account of how their approach to care changed due to the training, and the human impact it had on one of their patients, Margaret:

Margaret was a 77 year old female who became our service user in January of 2023, referred from the Local authority. She was diagnosed with multiple health conditions such as Ankylosing Spondylitis, COPD, Lung cancer, Osteoarthritis and anxiety. She lived at home alone with her 2 dogs Skipper and Milo. Margaret had one daughter who she did not have contact with and a brother who lived locally but again no contact. Aroma care became her emergency contacts.

In March of 2023, Margaret was diagnosed as becoming a palliative care patient by the Marie curie team and her GP. Steps taken by Aroma care when the diagnosis was given to amend her care plan to end of life planning, following her wishes. We completed a review of the care package at the home with her main carer and Margaret present. Margaret had an increase to her care package and it became a 24 hour package with a single carer call 4 times a day also.

We planned a meeting at the house with Margaret and talked about the changes to her care and her wishes for us to follow. We discussed all aspects of how she would like her care to be delivered moving forward and if she was to become incapacitated through becoming more unwell we had a clear plan for all staff to follow. Margaret had no Lasting Power of Attorney in place and was able to make all decisions herself.

This started with Margaret choosing to have a DNACPR in place, she had this discussion with her GP and this was stored for all staff to see, this was also placed in her documents section and clearly stated on the front page of her care plan.

We discussed if she had thought about what would happen to the dogs as we knew this was so very important to her when she became poorer, Firstly we helped with planning a dog walker to come in daily so the dogs were still able to get their exercise and helped put a plan in place for them to be transferred to the dogs rehoming shelter when the time came with the telephone numbers being added to her profile. We continued to provide pet care for the dogs as Margaret was doing so they remained settled and continued to sleep with Margaret as she wanted them too.

Margaret discussed with us where she would like to be moved to sleep in her home, when the new equipment was delivered we were able to support with moving her furniture to best accommodate her. Margaret gave her views on meals, drinks and her nutritional intake. All her preferences were listed and updated as the package continued on her activities section- as her health decreased her choices changed and she was able to communicate to us what it was that she wanted at each visit.

We had to change how Margaret's personal care was delivered and she gave us full preferences on equipment she would like to use, where this would be stored and the care plan updated for the carers.

She had previously met with the undertakers of her choice and she provided us with the telephone numbers and they also met us at the property so she could discuss with them her final wishes and for all contact details to be shared with Aroma care. She also stored a folder in the property for easy access.

After a meeting with the district nurses and palliative care team we put in place time specific calls for repositioning so we decreased her chances of getting pressure sores, we then tracked her skin integrity with checks at each visit and throughout the night.

We planned times with the Palliative care team to ensure she was delivered her medications on time via her syringe driver, the care staff were able to give a hand over to the nurses on how she had been in between visits.

We ensured that Margaret's wishes to remain at home were followed at all times. Clearly documented in the care plan Margaret requested for no paramedics to be called and only the Marie Curie team.

Towards the end Margaret was still able to communicate with the carers, she did approach her daughter and we arranged a meeting between them, this allowed them to hold discussions in private after being apart for some time. We were able to introduce staff to her daughter and help to explain Margarets end of life wishes and what the care team were going to be implementing to keep her as comfortable as possible. With Margarets permission we shared our contact details and we kept in contact with her, Margaret did not wish to see her again after the day they met. We also supported her daughter with being able to contact Marie Curie for further bereavement support she could access.

When Margarets care package was increased to having one carer for 24 hours a day we came up with a plan of a small team of carers who were trained with end of life support and manual handling so they would be able to support Margaret. We held conversations with them on her wishes and kept in daily contact to ensure that the staff were also able to cope well with the package. They worked collaboratively with Marie Curie who provided support and further training.

All staff showed compassion while being with Margaret, she requested certain music to be played to her during the day and also her favourite TV programs even if she was not engaging any longer. They continued to do this for her. The staff would still talk to her, sing songs, say prayers to her, complete hourly checks throughout the day and night detailing her condition at all times.

She also requested that when she died, she was placed into a dress of her choice with a necklace she had shown to staff, we made sure this was completed before she left the property.