MARGARET – CARE HOME

Margaret had a Learning disability and a diagnosis of Dementia prior to being admitted to the Care home in 2011, and was now in the late stages of Dementia. The staff described her as having a great personality and big sparkling eyes.

Despite being unable to communicate verbally Margaret was very good at making her feelings known through noise and body language which the staff had come to know. She would soon tell the staff if they had not done something right!

In November Margaret became unwell and was admitted to hospital where she continued to deteriorate; it was said that she was dying. A `Hospital Passport' went with Margaret with information about her likes and dislikes and the Home Staff felt that maybe the Ward staff were confusing her agitation with `Signs of Dying'. The Advance Care plan stated that Margaret wished to be cared for at the Home where she was known and who could communicate with her.

Following an MDT meeting Margaret was transferred back home on antibiotics. The Advance Care Plan was reviewed, the Coding was changed to `C', and anticipatory medications were prescribed in collaboration and communication with the GP and District Nurse.

Over a period of two months and regular review from the GP and district nurses, Margaret improved back to her old self. Following a Coding review meeting her coding was changed to an `A'.

In February Margaret enjoyed a holiday in Filey where she used to go as a child. Not long after this she developed a rash covering her body. The GP was reluctant to do blood tests as he said the results might suggest that Margaret be admitted to hospital. However, the Home insisted that she was still entitled to active treatment. The blood test was done and the home managed her care in the Home. As she continued to deteriorate, the Home managed her pain control with Patches rather than a syringe driver, as less invasive. The Coding was revised to a `C', anticipatory medications were prescribed and an out of hours handover form was completed and sent by the District Nurses. The Coding was changed to `D' when the Minimum protocol was completed with the support of the District Nurse. A member of staff remained with Margaret at all times, soft low volume music was played. Regular contact was kept with the niece and accommodation offered.

Margaret died comfortably and peacefully in the early hours of the morning with a member of staff with her. The niece was contacted and the Out of Hours Doctor came and certified death prior to Margaret being taken to the Chapel of Rest. The death certificate and funeral was arranged by the niece, the Staff choosing sentimental items to go into the coffin and a song to be played at the funeral.

The `Wake' was held back at the Home, which incorporated some of Margaret's favourite foods and a member of staff had put together a DVD of her life, using photo's from as far back as to when she was a baby, backed with her favourite music, "which was lovely to watch as we celebrated her life". A copy was given to the niece who continues to visit the home.

It can be said that Margaret's final days were comfortable and pain free, at Home where she chose to be. "The Gold Standards Framework enabled us to ensure that this happened" was the Care Home's comment.