CASE STUDY Palliative Care

The Service User

Lilly* was a ninety-nine year old lady who suffered from short term memory loss and poor mobility. Lilly's health was quickly deteriorating, and as she lived alone, a serious fall resulted in Lilly being admitted to hospital.

The Requirement

Whilst in hospital, Lilly was given a prognosis of only weeks to live. She was discharged by the hospital and the local PCT contacted Interserve Healthcare to implement a twenty-four hour care package in Lilly's home.

Interserve Healthcare worked closely with Lilly's local District Nursing team to ensure that she received the care necessary to improve her current situation and that she was prepared for the future. Lilly' care package would assist with personal care, ensuring that she had a nutritionally balanced diet and maintained an adequate fluid intake.

Individual care plans were written for each need identified, including: a detailed assessment of her needs and any problems, the aims and objectives of the PCT, and an intervention plan to achieve these objectives. At each visit Interserve documented relevant information in each section of the care plan enabling a clear view of progress made.

Continuity of care was crucial, and due to Lilly's short term memory loss a Care Worker with extensive palliative care experience was arranged to visit Lilly five days per week, with four others visiting her nights and weekends.

The Outcome

Interserve Healthcare provided care to Lilly for eleven months, continually reviewing and adapting the care plans in place as her needs changed. She passed away peacefully in her own home as was her wish. Her main Care Worker was with her and her family were informed immediately, which was their wish.

For the local PCT it was a more cost effective to provide Lilly with care at home rather than the cost of frequent emergency hospital admissions, and it also allowed Lilly the choice of where she wanted to live.

**Service Users name has been changed for data protection.*