CABINET MEMBER FOR HEALTH AND WELLBEING

Venue: **Town Hall, Moorgate Street, Rotherham. S60 2RB**

Date: **Monday, 3rd December, 2012**

Time: **11.30 a.m.**

A G E N D A

1. To determine if the following matters are to be considered under the categories suggested in accordance with the Local Government Act 1972

2. To determine any item which the Chairman is of the opinion should be considered later in the agenda as a matter of urgency.

3. Minutes of meeting held on 8th October, 2012 (Pages 1 - 4)

4. Health and Wellbeing Board

5. Woodlands Trust
   - Nick Sandford, Regional and Local Government Officer

6. CQC Review of Health Care in Care Homes (Pages 5 - 9)
   - report referred from Contracting for Care Forum for information

7. Rotherham Tobacco Control Alliance Annual Report (Pages 10 - 23)

8. Medication Policy - Independent Sector Home Care and In-House Enabling Services (Pages 24 - 39)

9. Date and time of the next meeting: -

   - Monday 14th January, 2013, to start at 11.30 am in the Rotherham Town Hall.

CABINET MEMBER FOR HEALTH AND WELLBEING
8th October, 2012

Present:- Councillor Wyatt (in the Chair); Councillors Buckley, Pitchley and Dalton.

K22. MINUTES OF THE PREVIOUS MEETING HELD ON 17TH SEPTEMBER, 2012

Resolved:- That the minutes of the meeting held on 17th September, 2012, be approved as a correct record.

Arising from Minute No. 21 (Rotherham Warmer Homes Strategy 2012-2015), it was noted that a bid had been submitted to the Warm Homes Healthy People Fund. The outcome of the bid would be known on 31st October, 2012.

K23. HEALTH AND WELLBEING BOARD

The Chairman reported that a workshop session to undertake a self-assessment of the Board had been held earlier that morning.

It had been a very worthwhile exercise with additional information to be built into the work programme. Different Theme Leads would be invited to regular Board meetings to enable performance management of the Strategy.

A representative from the Pharmaceutical Committee would be attending the next Board meeting together with the Chief Executive of the Rotherham Hospice to talk about End of Life issues and Dying Well.

K24. SEASONAL FLU VACCINATION PROGRAMME

Dr. Radford, Director of Public Health, reported that the groups to be included in the Seasonal Flu Vaccination Programme, issued by the Chief Medical Officer, remained unchanged i.e.:-

- People over the age of 65 years
- People 6 months to 65 years with chronic or long term conditions
- People living in long stay care facilities e.g. care homes
- Carers of "at risk" groups
- Pregnant women (any stage of pregnancy)
- Frontline health and social care staff

Responsibility for delivering and performance managing the Programme sat locally with NHS Rotherham and the Public Health Department in partnership with the Rotherham Foundation Trust and the Local Authority. The Programme would be delivered primarily through general practices but the RFT had been commissioned in a supportive capacity providing opportunistic vaccination to all groups predominantly through Ante-natal Clinics, Planned Investigation Unit, Medical Nurse Practitioners and Outpatients Departments (Fracture and Orthopaedic Clinic, Medical and Elderly Medicine). GPs remained responsible for the vaccination of housebound patients (including care homes) who were not on a District Nurse caseload.

The Council had secured 500 vaccines to be delivered to front line Social Care staff free of charge under the Service Level Agreement by Rotherham Workplace, Health and Wellbeing. Sessions were planned at various sites across Rotherham to facilitate attendance and access.

From April, 2013, the Programme would be commissioned by the NHS Commissioning Board on behalf of Public Health England. It would be the responsibility of the Director of Public Health to hold this system to account for vaccination levels in the Borough.

A comprehensive local media campaign had been developed in conjunction with the Council, RFT and NHSR focussing on all the eligible groups using the 'Flu Safe' banner and on Health and Social Care staff using the 'Flu Fighter' banner. The campaign would be rolled out across Rotherham using as many public facing sites/premises as possible.

It was also noted that the Whooping Cough vaccination was been offered through GP practices for those between 28-38 weeks pregnant.

Resolved:- (1) That the report be noted and the campaign to achieve the required uptake across all groups endorsed.

(2) That all health and social care providers and staff take every opportunity to promote and encourage vaccination among patients, clients/Service users and other staff in addition to taking up the offer of free vaccination for themselves. It was noted that for healthcare professionals this was endorsed by their professional registration bodies.

(3) That the lessons identified from the 2011/12 Programme be acted upon and embedded in the 2012/13 Programme.

(4) That the delivery and uptake within Social Care be monitored and addressed in conjunction with the Council Contracts Managers.

(5) That the importance of front line Care staff being vaccinated be raised at the forthcoming RMBC/Trades Unions Joint Consultative Committee meeting.

(THE CHAIRMAN AUTHORISED CONSIDERATION OF THE FOLLOWING 2 ITEMS TO ENABLE THE APPROPRIATE ACTION TO BE TAKEN.)

K25. CONFERENCE

The Chairman reported details of a free conference to be held on 13th November, 2012, in London organised by the Local Government Association entitled "Health and Wellbeing Simulator: Engaging and Representing Children and Young People".

Resolved:- That the Cabinet Member (or substitute) and an Advisor be authorised to attend the above free conference.

K26. HEALTH AND WELLBEING MEMBERS GROUP

The notes of the Health and Wellbeing Members' Group held on 1st October, 2012, in Wakefield, were circulated for information.

Discussion at the meeting had taken place on:-

Membership of the Board
Development
Governance
Scrutiny
Going Forward
What the LGA could offer on Board development

Resolved:- (1) That the report be noted.

(2) That the report be submitted to the Health and Wellbeing Board for information.

K27. EXCLUSION OF THE PRESS AND PUBLIC

Resolved:- That, under Section 100A(4) of the Local Government Act 1972, the press and public be excluded from the meeting for the following item of business on the grounds that it involves the likely disclosure of exempt information as defined in Paragraph 3 of Part 1 of Schedule 12A to the Local Government Act 1972 (as amended March 2006) (information relating to the financial or business affairs of any person (including the Council)).

K28. ROTHERHAM HEALTHWATCH SERVICE SPECIFICATION FOR CONSULTATION

Clare Burton, Commissioning, Policy and Procurement, provided a verbal update on the commissioning of Healthwatch Rotherham.

The commissioning and procurement activity was on track as planned. Commissioning activity such as consultation, service mapping and service design had been completed.

The Specification had been drafted and was based upon the statutory Legislation within the Health and Social Care Act 2012 for each local authority to commission a local Healthwatch that would include a NHS Complaints Advocacy Service.

It would form part of the tender document to be issued to enable potential providers to bid for the Healthwatch Rotherham 3 year contract.

The closing date for the pre-qualification questionnaire was the 11th October and it was proposed that the invitation to tender documents would be issued on 22nd October with a closing date of 29th November. The contract would be awarded to the successful tenderer on 11th January, 2013 with contract commencing on 1st April, 2013.

Consideration was being given to a regional simulation event being held in the New Year. Support was available from the LGA for such an event.

Resolved:- (1) That the progress on the commissioning of Healthwatch Rotherham be noted.

(2) That the re-drafted Service specification be circulated via email to Cabinet Member and Advisors for Health and Wellbeing for consultation.

(3) That further reports be submitted on the outcome of the tendering and evaluation processes and the recommended provider.

(4) That arrangements for a simulation event being held in the New Year be supported.

ROTHERHAM BOROUGH COUNCIL – REPORT TO MEMBERS

1	**Meeting:**	**Cabinet Member for Health and Well Being**
2	**Date:**	**3rd December, 2012**
3	**Title:**	**CQC Review of Health Care in Care Homes**
	Directorate :	**Commissioning Policy and Performance – Resources Directorate**

4 Summary

The Care Quality Commission (CQC) carried out a national review in 2011 to identify how well the health care needs of people living in care homes are met

This report summarises the findings from the review conducted by the Joint Commissioning Team and identifies areas that have seen significant improvement or developments over the last 12 months as follows:

- The risk assessment provided by CQC has highlighted that Rotherham is performing well overall and delivering high quality community health services into care homes.
- Commissioned dedicated community health services that are delivering better outcomes for residents by providing training, education, advice and support in the management of residents with complex needs.
- Additional investment has enabled commissioning of a GP local enhanced service to drive up quality of care to residents within care homes.
- The Adult Partnership Board has prioritised a partnership approach between NHS Rotherham and the Local Authority to contract monitoring arrangements within the residential and nursing care sector.

5 Recommendations

That the report is received which illustrates the key findings from the CQC review of health care in care homes.

6. Proposals and Details

6.1 CQC have carried out a national review to identify how well the health care needs of people living in care homes is met.

6.2 The main purpose of the review was to identify whether people in care homes have equal access to NHS services, have choice and control over their healthcare and receive healthcare that is safe and respects their dignity.

6.3 The review covered the needs of adults of all ages living in residential and nursing homes, including older people and younger adults of working age with mental health and physical and learning disabilities.

Rotherham rated as performing well in the following areas:

- Training and support to promote health and well-being (including promotion of healthy eating) is available to all care home staff. This is delivered through information via bulletins, newsletters, handouts and providing training sessions in Active in Age, Yesterday Today Tomorrow, dementia, life story, mental health first aid, reminiscence, alcohol in later life and tackling social isolation.

- Annual health checks carried out by GPs, assesses the health care needs of people with learning disabilities. In 2010/11, when the checks were first introduced, there were 202 people with learning disabilities in care homes, 10(5%) received a health check and 52(26%) received a health action plan. This has now significantly improved in 2012/13, with 59% receiving a health check and 86% receiving a health action plan.

- The RDaSH Mental Health Liaison Service provides psychiatric support to people living in care homes, thus promoting access to appropriate mental health assessment/screening and reducing avoidable admissions to mental health wards. 90% of referrals from care homes are seen within 10 working days.

- The TRFT Care Home Support Service originally established as a pilot to provide training, education and support to targeted care homes to promote health and well-being of residents, screening and identification of physical and mental health conditions and support a case management approach for those residents at high risk of hospital admission. The service provided occupational therapy and physiotherapy input within an average waiting time for assessment within 5 working days.

- The TRFT Podiatry Service provides treatment, prevention and advice for lower limb pathology and the average waiting time is around 16 days for an assessment. Urgent case is seen within 7 days within care homes.

- The TRFT Tissue Viability Service responds to 90% of cases within one working day in the assessment and treatment of pressure ulcers in care homes, with a response rate of around 10 days for leg ulcers. This ensures

that effective wound management is in place and risks to pressure areas are minimised by the use of appropriate equipment.

- The TRFT Continence Service provides an emergency response rate within one working day with an average waiting time of 15 working days in care homes.

- The TRFT Falls and Fracture Service and the new Community Otago programme are reducing the number of falls resulting in hospital admission, serious physical injuries and reducing the number of fractured neck of femurs following a fall. In 2011-2012, admission for fractures saw a 9.6% reduction. 85% of residents are seen within 5 working days.

- There is a Community Geriatrician in Rotherham who provides medical cover for Fast Response and intermediate care beds to case manage residents with complex long-term conditions. An assessment and medicine reviews is provided within 24 hours from admission into the service.

- There is strong evidence of multi-agency working co-ordinated by NHS Rotherham to improve the healthcare residents living in care homes. This is evident through performance meetings with Care Home Support Service and Mental Health Liaison Service, Palliative Care strategy groups, Gold Standard Framework project groups, Continuing Healthcare Panels and RMBC Residential and Nursing Care forums.

- Monitoring contracts for care home placements is carried out by the Local Authority's Contract Quality Assurance Officers (CQAO's) who carry out contract monitoring visits that covers initial care planning by the care home, review of service user plan, involvement of person and/or family carer and support for access to primary health care services. There is a robust mechanism in place to raise contracting concerns regarding the standard of healthcare provided in care homes.

7. Areas for Development

Since the review, areas for development or improvement are now in place as follows:

- RMBC have made significant changes to residential care contracts, with streamlining into one single contract for older people, learning disabilities, physical disabilities and mental health.

- Further work within the next 12 months are planned for NHS Rotherham to work closely with the Local Authority on developing contracts monitoring arrangements for health elements of the residential and nursing care contract.

- A care home assurance framework for end-of-life have been developed which includes communication, preferred priorities for care, working with GP's and other professionals, review of practice and bereavement.

- Commissioning of GP Local Enhanced Service (LES) to support targeted care homes, offering a pro-active weekly surgery. The GP practice provides a

dedicated weekly surgery in each targeted care home, produces a medical care plan, annual review and medication reviews for each resident registered.

- NHS Rotherham are working on incorporating a designated medical care plan for care homes which will be shared between designated GP and care homes via a mixture of paper and electronic methods. Several GP practices have opted to pilot this and working with NHS Rotherham to evaluate this.

- Reconfiguration of the TRFT Care Home Support Service to improve health care, target those with high-level needs and at risk of admission to hospital. The dedicated team provide training, education, advice and support in the management of residents with complex needs, undertaking screening and identification of physical and mental health needs, provide assessment, training and rehabilitation to help improve independence and function in all activities of daily living.

- Extension of the TRFT Advanced Nurse Practitioner service to assess, diagnose and treat minor illnesses and injuries and prescribe medication. Cover is available between 8.00 am to 8.00 pm Monday to Friday and 8.00 am to 4.00 pm at weekends and Bank Holidays.

- An additional Community Physician is now in post who works collaboratively with GPs and other primary care health practitioners to provide consultant input to help case manage residents for those with complex long-term conditions.

- Accredited training have been provided to Activity Co-ordinators and care staff in care homes around improved strength and balance that will improve independence and quality of life of residents.

8. Finance

8.1 Continued recurrent funding of around £750,000 been secured in the provision and extension of the TRFT Care Home Support Service and Advanced Nurse Practitioner Service. Both services are commissioned by NHS Rotherham and cover all care homes in Rotherham including older people and adults with physical/learning disabilities and mental health.

8.2 An investment of £93,600 for a one-year period has been provided for the GP Local Enhanced Service (LES) that is delivered by 7 GP practices in 8 care homes which is commissioned by NHS Rotherham.

8.3 Both of these services are regularly monitored through bi-monthly performance meetings which are led by NHS Rotherham

9. Risks and Uncertainties

9.1 Additional investment have been provided by NHS Rotherham to provide a GP Local Enhanced Service (LES) in targeted care homes for a one-year pilot to reduce the number of hospital admissions. An evaluation of the project

towards the end of 2012/13 will be carried out which will measure the success of the project.

10. Policy and Performance Agenda Implications

10.1 The information provided in this report is able to support the **"Improved Health and Emotional Well-Being"** and **"Exercise Choice and Control"** outcome set out in the Social Care Outcomes Framework.

11. Background Papers and Consultation

11.1 CQC Review of Health Care in Care Homes published on 7th March, 2012. Available on CQC website: **http://www.cqc.org.uk/public/news/review-health-care-care-homes-published**

11.2 A summary of findings and full data set collected from the inspections of 81 care homes and 9 PCTs identified as "poorly performing" are available on CQC website: **http://www.cqc.org.uk/public/reports-surveys-and-reviews/reviews-and-studies/meeting-health-care-needs-people-care-homes**

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ROTHERHAM BOROUGH COUNCIL – REPORT TO HEALTH AND WELLBEING BOARD

1.	**Meeting:**	**Cabinet Member for Health and Wellbeing**
2.	**Date:**	**3rd December 2012**
3.	**Title:**	**Annual report of the Rotherham Tobacco Control Alliance 2011/2012**
4.	**Directorate:**	**Public Health**

5. Summary:

Rotherham Tobacco Control Alliance is the strategic partnership group that leads on

- prevention of smoking uptake
- smoking cessation
- protection of the community from secondhand smoke
- regulation of tobacco products

The accompanying annual report outlines the activity undertaken by the Alliance and its constituent partners during 2011/2012.

6. Recommendations:

That the Cabinet Member note the content of the report.

7. Proposals and Details:

Rotherham Tobacco Control Alliance would like to highlight the following key messages to the Board:

- The number of 4-week quitters through NHS services was the highest ever achieved in the borough. Smoking prevalence, however, remains at 24%
- Smoking at delivery rates reduced to under 20% for the first time, and the service helped 194 women stop smoking during pregnancy
- Smoking rates among young people (11-15 year olds) are higher than the national average
- The availability of cheap and illicit tobacco remains an issue and undermines other work to reduce tobacco use
- Performance measures will change in 13/14 from 4-week quitters to smoking prevalence reduction
- Almost all tobacco-related funding is currently invested in stop smoking services

8. Finance:

N/A

9. Risks and Uncertainties:

Despite the good performance of our stop smoking services for a number of years, smoking prevalence has remained static at around 24%, a problem common across the region. As a result, a comprehensive review of tobacco control investment and commissioning priorities is underway across South Yorkshire, supported by the University of Sheffield, to identify how we should be directing the available resources to best achieve a reduction in prevalence. This work is expected to report in early 2013.

10. Policy and Performance Agenda Implications:

There are three smoking-related indicators in the Public Health Outcomes Framework:

- Smoking prevalence among 15 year-olds
- Smoking prevalence at the time of delivery (smoking in pregnancy rate)
- Smoking prevalence among adults

11. Background Papers and Consultation:

N/A

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Rotherham Tobacco Control Alliance Report of activity 2011-2012

Contents

Introduction

Smoking remains the main cause of preventable morbidity and premature death in England, leading to an estimated annual average of 86,500 deaths between 1998 and 2002[i] .

A wide range of diseases and conditions are caused by cigarette smoking, including cancers, respiratory diseases, coronary heart and other circulatory diseases, stomach and duodenal ulcers, erectile dysfunction and infertility, osteoporosis, cataracts, age-related macular degeneration and periodontitis. Following surgery, smoking contributes to lower survival rates, delayed wound healing and post-operative respiratory complications [ii].

Research commissioned by Action on Smoking and Health (ASH) has shown the cost to the NHS of treating diseases caused by smoking is approximately £2.7 billion each year.[iii] A report by the Policy Exchange[iv] estimated the total cost to society of smoking as being £13.74 billion, including the cost to the NHS as well as lost productivity from smoking breaks, increased absenteeism, cleaning smoking litter, cost of cigarette-related fires and the loss of economic output from the death of smokers and passive smokers.

Smoking is costly to the individual, with tobacco products being 33% less affordable in 2010 than they were in 1980[i]. People from routine and manual working groups will have lower incomes than the general population this increasing unaffordability is more likely to increase their use of illicit tobacco, including unregulated products with higher levels of contaminants.

In Rotherham, the oversight of tobacco control activities is the responsibility of the multi-agency Rotherham Tobacco Control Alliance.

Smoking behaviour in Rotherham

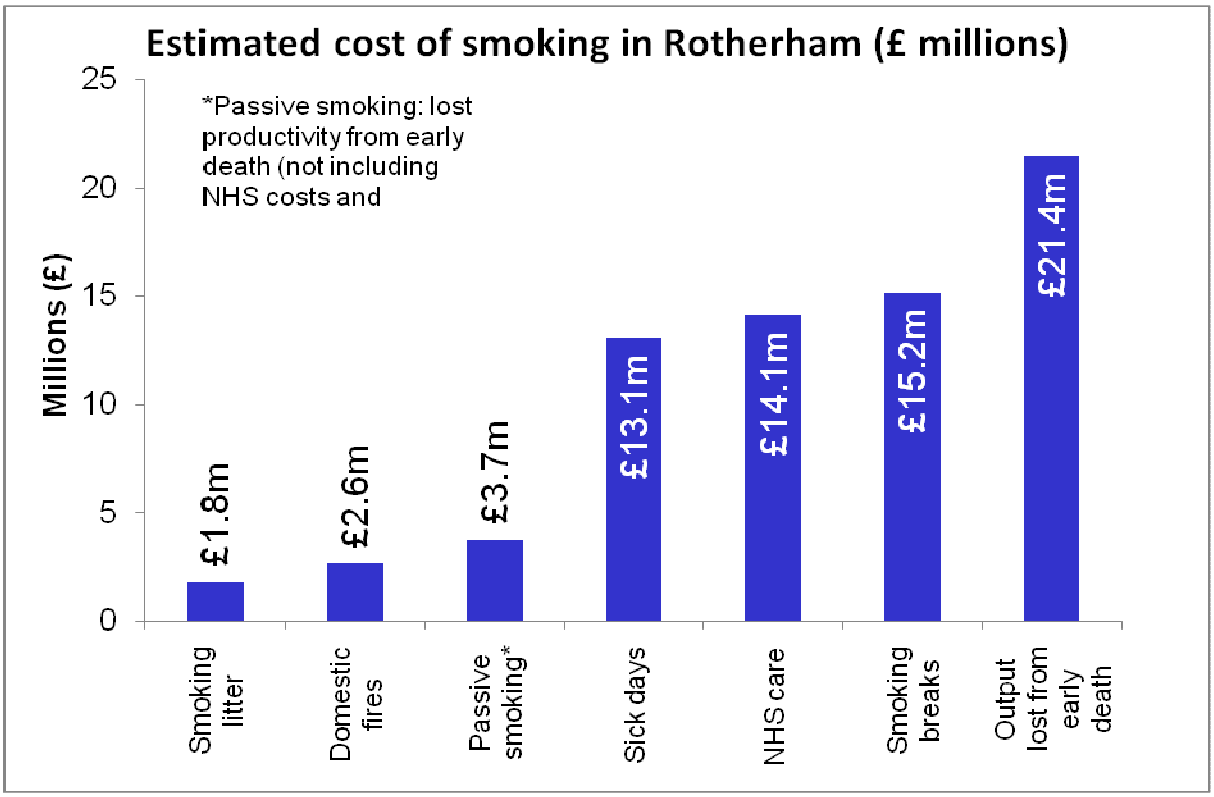
In Rotherham, more people than average for England are regular smokers. The local smoking rate, at around 24%, has been static for a number of years, and the drop seen in national smoking prevalence following the introduction of smokefree legislation in 2007 was not reflected locally. However, smoking rates vary widely across the borough, from a low of 9% up to a high of 45%.

Historically Rotherham has always had a high number of women who continue to smoke during pregnancy. This hit a high during 2009-10 of 27% - seventh highest rate in England. A new approach to managing smoking during pregnancy was introduced in February 2010 and this has shown a significant impact, with fewer than 20% of women still smoking at the time of delivery during 11/12.

The cost of smoking locally has been estimated as £71.9 million each year. Rotherham smokers spend around £81.5m on tobacco products, which contributes £62.1m to the Exchequer[v]. Pro-smoking groups often argue that the taxes they pay on tobacco more than covers the cost of NHS treatment, but these arguments are flawed in two key respects:

- The cost to the NHS is not the only societal cost of smoking (see figure 1)

- Not all tobacco is duty paid, therefore the shortfall in funding is almost certainly greater than suggested by the £9.8m from the above figures.



Such data, however, often mask a vital message regarding smoking and one we should more often celebrate: **most people in Rotherham do not smoke.**

Stop smoking services

Rotherham provides a range of support for people wishing to stop smoking. Rotherham NHS Stop Smoking Service (RSSS), which is part of Rotherham NHS Foundation Trust, runs stop smoking groups across the borough, and provides one-to-one and telephone support 6 days a week. It also runs Quit Stop, the stop smoking shop in the town centre, and a stop smoking centre at Rotherham Hospital. Most people who quit smoking with NHS support do so with RSSS.

In 2011/2012 the service had its most successful year in terms of 4-week quitters, supporting 1805 people to stop smoking.

Some GP practices, pharmacies and dentists also provide support to their patients to quit, and a further 999 achieved a 4-week quit through these enhanced services.

Before 2011/2012 any GP practice, pharmacy or dental practice who wanted to offer stop smoking support was able to do so. This had resulted in some parts of the borough having so many providers

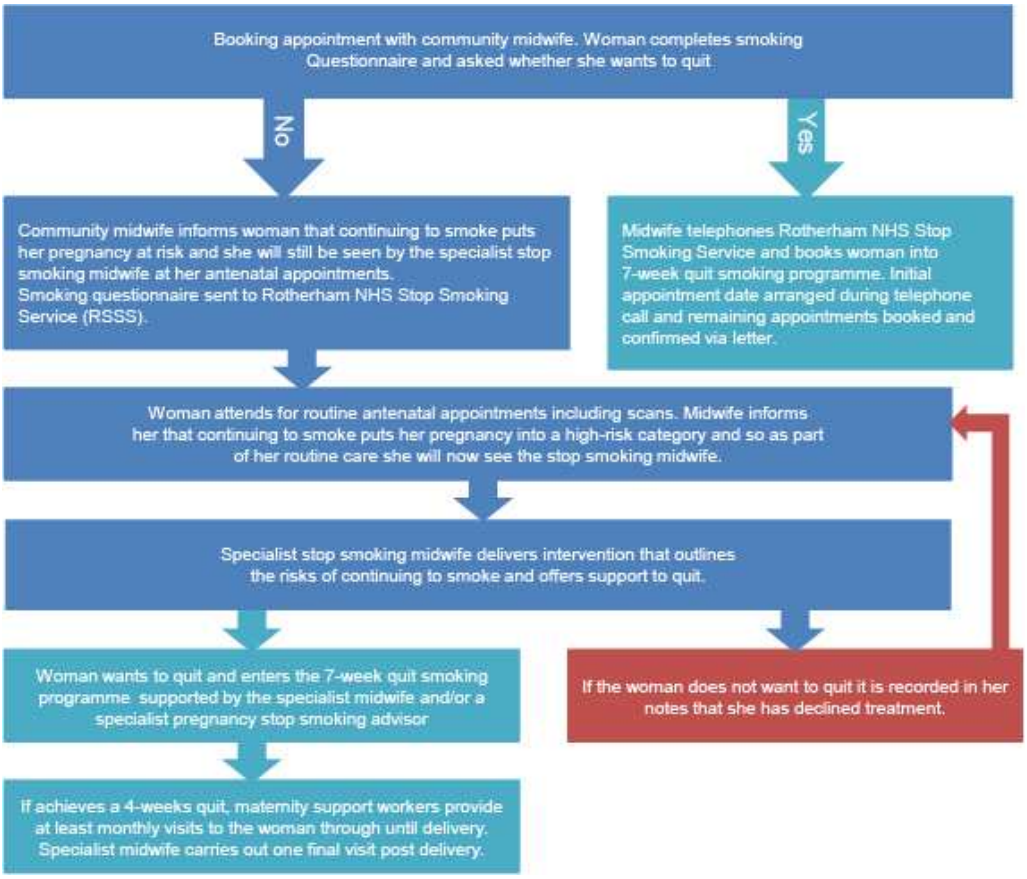
of support that the advisors were unable to support the minimum numbers required to maintain competency. We also found that there were some gaps in coverage. We therefore invited all GP practices, dental practices and pharmacies who wished to offer stop smoking support to submit an expression of interest and awarded agreements based on need in the area and capacity to meet minimum contract requirements. We also introduced a more robust performance review process for these enhanced providers to ensure that people wishing to stop smoking could be assured of the quality of the service they received.

Smoking in pregnancy

The new approach to tackling smoking in pregnancy, embedding smoking cessation advice into routine antenatal care, really began to demonstrate impact during 11/12, despite a reduced capacity within the pregnancy team due to staff movements. Pregnancy support is delivered by two stop smoking specialist midwives and one pregnancy advisor within RSSS. The team is supported by maternity health workers in maintaining contact with women following a successful quit attempt through until delivery.

Since February 2010 all pregnant women who smoke see the stop smoking midwives as part of their routine antenatal care, even if they have previously declined support to stop (figure 2). These women receive a candid explanation of the additional risks to their health and that of their unborn baby as a result of their smoking, following which they are informed that the stop smoking programme is part of their recommended treatment for this risk factor. If they still do not want support to stop this is recorded in their notes as declining recommended treatment.

Figure 2



In 2011/2012 the smoking in pregnancy team supported 194 pregnant women to achieve a 4-week quit. The smoking at delivery rate during 11/12 had dropped to 19.8%, the lowest rate ever achieved in the borough and another large drop on the previous year (10/11 rate: 22.4%).

The Rotherham approach to managing smoking in pregnancy continued to create interest across the country, with one of the specialist midwives appearing in a BBC3 programme *Misbehaving Mums to Be* in May 2011, and securing coverage in local and national media. In addition, an academic article describing the work was published in a peer reviewed journal, the *British Journal of Midwifery,* in early April 2012[vi].

Prevention of uptake

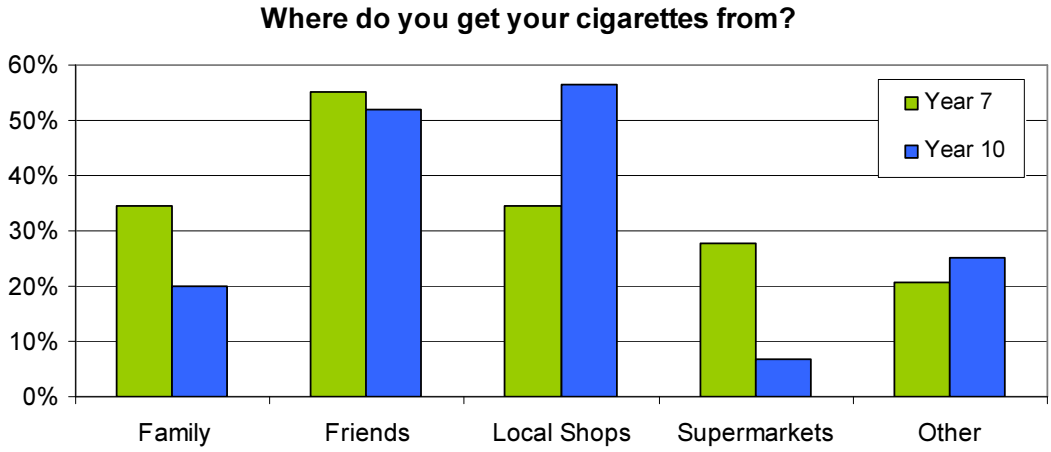
Each year Rotherham pupils in years 7 and 10 complete a lifestyle survey. This provides us with data on smoking behaviour that we can compare with national trends. In the 2011 survey when asked if they smoked cigarettes, 84% of Year 7 and 52% of Year 10 pupils had never tried cigarettes. Seven per cent of Year 7 pupils had tried smoking once and not done it again, compared with 26% of Year 10 pupils. Currently, only 2% of Year 7 pupils smoke regularly compared with 14% of Year 10.

Figures for England in 2011 were lower; only 5% of the 11-15 year olds who completed the national survey were regular smokers (smoked every day or every week) compared to 8% of Rotherham

pupils. As in Rotherham, the proportion who smoked increased with age from less than 0.5% of 11 year olds to 11% of 15 year olds[vii].

Rotherham pupils who identified themselves as smokers were then asked where they got their cigarettes from (figure 3).

Figure 3



Most Year 7 and Year 10 pupils get their cigarettes from their friends, however a large number also get their cigarettes from the local shops which raises issues around the selling of cigarettes to underage young people (see *protection of our community* below). This also seems to be the case for supermarkets, particularly with Year 7 pupils. A high proportion of Year 7 pupils are also getting cigarettes from family members. Of those that smoke, only 6% of Year 7 and 23% of Year 10 pupils want help to stop smoking.

The Smokefree Class activity pack was again promoted in secondary schools in the borough. Ten schools requested packs. The activities focus on the benefits of being a non-smoker and use a social norms approach to promote a smokefree lifestyle. Whilst aimed at year 7 pupils, many schools have chosen to run the activities across multiple year groups.

A Masters in Public Health student on placement at NHS Rotherham carried out a project to develop a smokefree class resource for primary school use. Following academic research into appropriate approaches with this age group, a series of 10 classroom activities has been developed and will be rolled out to all primary schools in the borough to use. Each of the activities can be carried out as a stand-alone lesson, or form part of a themed series of lessons.

At the end of the year the Department of Health launched a consultation on the introduction of standardised packaging. There is research evidence that by removing all brand marketing from packets tobacco products become less attractive, particularly to young people, and that this may reduce the number of young smokers. Standardised packaging also increases the impact of health warnings and reduces misleading beliefs about certain cigarettes being less harmful as a result of the colours of packaging used (colours previously associated with 'low tar' or 'lite' products). Rotherham Tobacco Control Alliance(along with the Health and Wellbeing Board and the RMBC Health Select Commission) submitted a response to the consultation supporting the proposals.

Protection of our community

Secondhand smoke contains the same substances as the smoke inhaled by active smokers. Passive smoking has been shown to cause lung cancer and heart disease, and probably to cause COPD, asthma and stroke in adults. It is harmful to children, causing sudden infant death, pneumonia and bronchitis, asthma, respiratory symptoms and middle ear disease.Smokefree homes and cars schemes are intended to reduce the exposure of children and non-smokers to secondhand smoke.

The RotherhamSmokefree Homes initiative continued during 11/12 and at the end of the year there were around 4,500 households signed up to the scheme. By making a smokefree homes pledge a household commits to not allowing smoking anywhere in their home or car. National figures suggest that increasing numbers of people do not allow smoking anywhere in their home. The Omnibus Survey found in 2008/2009 that 69% of people did not allow smoking in the home. Whilst those who have never smoked (81%) or given up smoking (78%) were more likely to ban smoking in the home, current smokers also impose restrictions, with 33% banning smoking anywhere in the home and 43% only allowing smoking in some rooms or at some times[viii].

Rotherham is participating in a Yorkshire and Humber-wide pilot project using a social norms approach to increasing smokefree areas. 'Social norms' is an environmental approach aimed at not just the individual but the entire community context in which individuals live. It is a highly cost effective way of reaching large numbers of people, correcting misperceptions of the prevalence of a problem behaviour (e.g. smoking), and promoting the healthier ones instead (e.g. being Smokefree).

The social norm theory states that much of people's behaviour is influenced by their perception of how other members of their social group behave and their tendency to over-estimate the level of 'bad' behaviours. If people think harmful behaviour is the norm, e.g. everyone smokes; they are as individuals more likely themselves to engage in that behaviour. By educating a community that in fact the usual practice among their peers is the healthy version, e.g. three out of four people do not smoke, the behaviour of all can be affected in a positive manner.

Each PCT area was asked to identify one discrete community, with good existing social networks where the approach could be tested. In Rotherham we selected Treeton as our pilot site as it differed demographically from many of the communities identified elsewhere. A community survey to ask about smoking behaviours and beliefs, and what the respondent considered the community's smoking behaviours and beliefs were, was carried out in March 2011. A marketing campaign to correct misperceptions and celebrate smokefree spaces is scheduled for September 2012.

A key strand in any tobacco control strategy is the tackling of cheap and illicit tobacco. Within England it is illegal to:

- sell all forms of tobacco and tobacco related products to a person under 18 years of age - Children and Young Persons (Sales of Tobacco) Order 2007[ix]
- sell illicit tobacco. (Tobacco that is either counterfeit or has evaded UK taxation)

Locally, the Trading Standards team with Rotherham Metropolitan Borough Council lead the work to reduce the availability of cheap and illicit tobacco by carrying out test purchases to identify retailers selling to under 18s, and seizures of counterfeit products. Their interventions, however, depend on

intelligence from the local community of sources of such products, and obtaining this intelligence is always a challenge when many residents see it as a victimless crime, with the only loss being to the Treasury. As an Alliance we need to continue to raise the awareness of the links between illicit tobacco and organised crime, and of the increased risks in smoking unregulated tobacco products, often with far higher levels of contaminants than standard cigarettes.

The future

There are significant changes ahead with the implementation of the Health and Social Care Act and the move of public health to a local authority responsibility. Alongside this reorganisation there are changes to the targets, with a move away from 4-week quitters towards prevalence measures among adults, pregnant women and 15-year olds.

Across South Yorkshire overall smoking prevalence has remained static over recent years, despite Stop Smoking Services that have delivered high numbers of 4-week quitters. We recognise that the approach taken to achieve 4-week quitter targets is therefore not appropriate for a prevalence reduction programme, and that we need to focus investment and expertise in a wider range of tobacco control activity. With colleagues from public health teams in Barnsley, Doncaster and Sheffield, and supported by the School of Health and Related Research at the University of Sheffield, Rotherham Public Health has been participating in a review of tobacco control investment priorities to identify where increasingly scarce funding is best directed to deliver a reduction in smoking rates. The group is scheduled to report key recommendations to Directors of Public Health in late 2012/early 2013.

Performance tables

Number of people setting a quit date and successful quitters by ethnic category and gender

Ethnic category and gender	Males setting a quit date	Females setting a quit date	Total persons setting a quit date	Males successfully quit	Females successfully quit	Total persons successfully quit
White						
British	2,117	2,977	**5,094**	1,130	1,473	**2,603**
Irish	16	12	**28**	8	5	**13**
Any other White background	58	85	**143**	25	43	**68**
Sub-total	**2,191**	**3,074**	**5,265**	**1,163**	**1,521**	**2,684**
Mixed						
White and Black	7	3	**10**	3	1	**4**

Caribbean						
White and Black African	2	1	**3**	2	0	**2**
White and Asian	4	5	**9**	2	4	**6**
Any other mixed background	2	5	**7**	1	2	**3**
Sub-total	**15**	**14**	**29**	**8**	**7**	**15**

Asian or Asian British

Indian	11	5	**16**	5	3	**8**
Pakistani	59	13	**72**	29	5	**34**
Bangladeshi	0	0	**0**	0	0	**0**
Any other Asian background	13	5	**18**	7	3	**10**
Sub-total	**83**	**23**	**106**	**41**	**11**	**52**

Black or Black British

Caribbean	1	4	**5**	1	0	**1**
African	9	1	**10**	6	0	**6**
Any other Black background	0	1	**1**	0	0	**0**
Sub-total	10	6	**16**	7	0	**7**
Other ethnic groups						
Chinese	2	0	**2**	1	0	**1**
Any other ethnic group	16	10	**26**	9	4	**13**
Sub-total	18	10	**28**	10	4	**14**
Not Stated						
Not Stated	21	50	**71**	10	22	**32**
Total	2,338	3,177	**5,515**	1,239	1,565	**2,804**

Number of pregnant women setting a quit date and outcome at 4 week follow-up	**Number**

Total number setting a quit date in the quarter	**399**

Number who had successfully quit (self-report)	194
Number who had not quit (self-report)	157
Number not known/lost to follow-up	48

Number who had successfully quit (self-report), where non-smoking status **confirmed** by CO validation	135

Rotherham Tobacco Control Alliance members

During 2011/2012 the following people were members of the Rotherham Tobacco Control Alliance

- Cllr Ken Wyatt (Chair – from May 2011)
- Cllr John Doyle (Chair – until May 2011)
- Cllr Jo Burton
- Cllr Judy Dalton
- Dr John Radford, Director of Public Health
- Joanna Saunders, Head of Health Improvement
- Alison Iliff, Public Health Specialist
- Simon Lister, Manager, Rotherham NHS Stop Smoking Service
- Alan Pogorzelec, Trading Standards Manager, RMBC
- Kay Denton Tarn, Healthy Schools Consultant, RMBC
- Amanda Thomson, South Yorkshire Fire and Rescue
- Fiona Middleton, Rotherham NHS Foundation Trust

The following people attended meetings as guests/alternates:

- Peter Jones, South Yorkshire Fire and Rescue
- Dennis Ager, Regional Tobacco Control Coordinator, West Yorkshire Trading Standards
- Lauren Ellis, Student
- VibhavariKhadam, Student

[i]Twigg L, Moon G, Walker S (2004) The smoking epidemic in England. London: Health Development Agency.

[ii] US Department of Health and Human Services (2004) The health consequences of smoking: a report of the Surgeon General. Washington DC: USA.

[iii]Callum C, Boyle A, Sandford A (2010) Estimating the cost of smoking to the NHS in England and the impact of declining prevalence. Health Economics Policy and Law.doi: 10.1017/S174413310000241

[iv] Nash R, Featherstone H (2010) Cough Up: Balancing tobacco income and costs in society. Policy Exchange

[v] 'Reckoner' spreadsheet for calculated estimated local costs (ASH, 2011)

[vi]Fendall L, Griffith W, Iliff A, Lee A, Radford J. (2012) Integrating a clinical model of smoking cessation into antenatal care. *British Journal of Midwifery*, Vol. 20, Iss. 4**,** 06 Apr 2012, pp 236 - 243

[vii] NHS Information Centre (2012) Smoking, drinking and drug use among young people in England 2011. London: NatCen Social Research

[viii] NHS Information Centre (2012) Statistics on Smoking: England 2012.

[ix] HM Government (2007) *The Children and Young Persons (Sales of Tobacco etc.) Order 2007.* Available from http://www.legislation.gov.uk/uksi/2007/767/contents/made

ROTHERHAM BOROUGH COUNCIL – REPORT TO MEMBERS

1.	**Meeting:**	**Cabinet Member for Health and Wellbeing**
2.	**Date:**	**3rd December, 2012**
3.	**Title:**	**Rotherham MBC Medication Policy – Independent Sector Home Care and In House Enabling Services**
4.	**Programme Area:**	**Resource Directorate**

5. Summary:

The Rotherham Metropolitan Borough Council (RMBC) Medication Policy as applies to home care services, including Enabling and Independent Sector services, has been updated.

The 2003 policy has been revised into two separate documents for contracted Community and Home Care Services (Domiciliary Care) (Appendix 1) and RMBC Enabling Services (Appendix 2).

Both policies outline a 'verbal prompt or administer from a pharmacy dispensed monitored dosage system only' approach.

The policy has been updated to bring it into line with changes in legislation, policy and practice and is a step towards a further revision of the policy to move towards 'administration' of medication. For RMBC to move to a position of adopting a safe 'administration' policy, full engagement is required from NHSR/CCG to implement relevant procedures across all partner agencies. A full risk and impact assessment will be completed.

6. Recommendations:

- **Endorse the implementation of the 2012 revised versions of the 2003 policy.**

- **Agree to receive a further report outlining the revised policy including the administration of medication.**

7. Proposals and Details

7.1 The 2012 revised versions of the 2003 policy contain updated procedures pathways and references necessary as a result of the transformation of services, such as; the in house domiciliary care service becoming enablement service and to differentiate the independent sector provision under a separate policy.

Medication policies take a stepped approach to the provision of medication support. Assessment of customers results in the following outcomes:

- They are independent and can take medication without support
- They require a prompt to take medication (verbal reminder)
- They require assistance to take medication (bottle opened, etc)
- They require their medication to be administered (given directly to them by the staff member)

Background

7.2 A draft medication policy was set to replace one agreed in 2003. In respect of home care, the former policy advocated prompt and dispense from a monitored dosage system (pre filled by a pharmacist).

The later policy proposed the move to administer directly from bottles/tubs. This meant a radical change was required in the management of medicines in the home setting. This new policy has not been adopted due to concerns regarding safety and practicality arising from the pilot undertaken in residential homes. Further work with health partners will be undertaken to reach agreement on how the administration element of the policy will be fulfilled as this is an NHS responsibility.

7.3 The policy has been revised as an interim measure to ensure that it meets current requirements. This work is now complete (see Appendix 1 and 2).

The Residential and Intermediate Care policy is currently under review. Both these locations already operate a policy where medications are administered and will form a separate report.

8. Risk and Uncertainties

8.1 The current RMBC policy is different from some other local authorities who have adopted a full administration policy for home care services.

8.2 A move towards a safe administer medication policy requires a change in approach in respect of assessment and requires agreement from, all

care provider organisations, NHSR Medication Management Services, GP's, Pharmacists and Learning and Development Teams.

9. Financial Implications

9.1 There are no financial implications in adopting the revised version of the policy (Appendix 1 and 2).

9.2 Adoption of a medication administration policy could result in an increase in the unit cost of care. This would be as a result of providers employing additional supervisory and management staff with enhanced skills to monitor compliance and competency.

9.3 Costs of RMBC resources required to move to an administration policy would need to be estimated (i.e. project and training costs and potential of increased service delivery time).

10. Policy and Performance Agenda Implications

- The absence of robust practice guidelines on medication management may result in non compliance against:
  - Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010
  - The Royal Pharmaceutical Society (of Great Britain) The Handling of Medicines in Social Care
  - Outcome 9, Care Quality Commission, Essential Standards of Health and Safety
- Monitoring of compliance of independent sector providers against standards and regulations is undertaken by the contracts team.

11. Background Papers and Consultation

1. Consultation on the revised 2003 RMBC Medication Policy has been undertaken with A&CM Social Work Teams, Care Providers, Contracting and Commissioning Staff, SMT (H&WB).

2. Consultation on the development of a new policy to move to administration of medication has taken place previously but will require repeating. A large amount of the preparatory work has already been undertaken reducing the requirement for a large amount of project time.

3. Minutes documenting the meetings/work undertaken previously and more recently are available in Adult Contracting.

4. 2009 Medication Policy and associated documents (draft).

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Appendix 1

Rotherham Metropolitan Borough Council

Neighbourhoods and Adult Services Directorate

Health and Wellbeing

Contracted Community and Home Care Services (Domiciliary Care) Policy on Medication

August 2012
(revised version
Final Report)

Contents

Introduction

1. This Medication Policy was first published in June 2003. It was last reviewed and revised in May 2012. This policy applies to situations where carers employed by contracted Community and Home Care Services are providing care and support to service users in their own home. There is a medication policy for the Rotherham MBC Enabling Service, Residential Care, Intermediate Care and other settings for Service Users already in place.

   The Medication Policy for Community and Home Care Services complies with Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and The Care Quality Commission's regulations Outcome 9.

   Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 states that:

   The registered person must protect service users against the risks associated with the unsafe use and management of medicines, by means of the making of appropriate arrangements for the obtaining, recording, handling, using, safe keeping, dispensing, safe administration and disposal of medicines used for the purposes of the regulated activity.

   The Care Quality Commission regulations Outcome 9 states that:

   The registered person must protect service users against the risks associated with the unsafe use and management of medicines, by means of the making of appropriate arrangements for the obtaining, recording, handling, using, safe keeping, dispensing, safe administration and disposal of medicines used for the purposes of the regulated activity.

   People who use services:

   Will have their medicines at the times they need them, and in a safe way. Wherever possible will have information about the medicine being prescribed made available to them or others acting on their behalf.

   This is because providers who comply with the regulations will:

   - *Handle medicines safely, securely and appropriately.*
   - *Ensure that medicines are prescribed and given by people safely.*
   - *Follow published guidance about how to use medicines safely.*

   This Policy should be read in conjunction with the Mental Capacity act 2005 and Mental Capacity Act Code of Practice 2007 and with The Royal Pharmaceutical Society (of Great Britain) document; The Handling of Medicines in Social Care.

2. Definitions

2.1 **Medication** in this document refers to any substance that is given to prevent or treat illness or disease.

2.2 **Medicines** are given a **legal category** to control how they can be supplied to the public.

There are 3 types:-

a) Prescription only medicines (POM)

These can only be obtained with a health professional's prescription.

b) Pharmacy medicines (P)

These may be sold only in a pharmacy and the sale must be supervised by the pharmacist, e.g. antihistamines for the relief of hay fever symptoms

c) General sales listed medicines (GSL)

These are sold in stores, such as supermarkets, as well as pharmacies.

2.3 **Controlled drugs/medicines** are those that are controlled under the Misuse of Drugs legislation. Examples include, benzodiazepine, morphine and methadone

Home Carers will not have any involvement in the administration of controlled drugs/medicines.

2.4 **Home Carers are authorised under the terms of this Policy to Prompt or Administer medication ONLY as defined below and directed by this Policy.**

Prompt, for the purpose of this policy, is giving a verbal signal to remind a Service User to take their **prescription only medicines (POM)**. i.e. enquire if they have taken their medication.

Administer, for the purpose of this policy, is defined as aiding a service user to take medication from a monitored dosage system/compliance aid, e.g. Nomad and ONLY where the medicines have been placed in the dosage system/compliance aid by the supplying pharmacist. Aiding can include handing the medication to the service user.

3. General Principles

3.1 Wherever possible, Service Users should be enabled to manage and administer their own medicines. It is the role of the Rotherham MBC

Assessing Officer, to identify in the Individual Social Care Assessment (ISCA) the need for a Home Carer to support the Service User to maintain their independence to manage their medication. Assessments and any services arranged must take into account the Service User's age, gender, ethnic group, religion, culture, disability, personal relationships or living and caring arrangements.

3.2 The Home Carers involvement will be specified on the Support Plan, which is signed and dated by the Service User. **This however should not contain any activity that is not commensurate with the definition of 'Prompt' or 'Administer' as defined in Section 1 of this Policy.**

3.3 Home Carers are only allowed to assist with medication when the medication is in a monitored dosage system/compliance aid, e.g. Nomad and where the medicines have been placed in the dosage system/compliance aid by the supplying pharmacist.

3.4 Administering of medication cannot be undertaken if the dosage system has been filled by family, friends, etc. In these cases, the Home Carers may only prompt the Service User to take their medication. No physical assistance may be offered.

3.5 Home Carers may only administer medication if the scheduled visit coincides with the administration times of the medication. A Home Carers may not attend solely to assist with medication.

3.6 Where physical assistance (administering) is provided, medicines should be handled as little as possible. This is best achieved by tipping the dosage box over a plate from which the Service User may then pick up and self-administer. The Home Carers should then wash their hands and any utensils used. The medication should be taken immediately by the Service User, whilst the Home Carers is present, in order that the daily notes can be completed.

3.7 Missed doses – If a dose of medicine was missed or omitted during the previous visit a double dose must not be given. The Home Carers will record on the daily notes that a dose has been missed and report it to their Home Care Supervisor (or equivalent responsible person) who should then initiate Safeguarding Procedures.

3.8 Under no circumstances should

a Service User be forced to take medication;

any member of staff purchase or administer, on behalf of a Service User, non-prescription medicines; or

any member of staff offer advice on non-prescribed medicines and remedies. It is dangerous to do so. The Service User may be allergic to the treatment or be taking other medicine which may cause a reaction.

3.9 Home Carers are NOT authorised to be involved with any other action not commensurate with the definition of Prompt or Administer in Section 2.4 of this Policy.

In particular, but not exhaustively:

(a) Handing to or opening labelled containers for a Service User in order for them to administer their own medication
(b) Preparing prescribed drinks
(c) Dressings
(d) Suppositories
(e) Management or treatment of wounds, skin ulcers or sores
(f) Enemas
(g) Manual evacuation of the bowel
(h) Changing colostomy bags
(i) Diabetic or other injections
(j) Rectal or vaginal creams
(k) Creams which are a steroid, hydrocortisone, for pain relief, inflammatory conditions, etc.
(l) Artificial feeding, e.g. naso-gastric tube, peg feed
(m) Application of eye drops other than for dry eye condition
(n) Application of ear drops for treatment of an infection or other medical condition other than a wax softener
(o) Nebulisers, inhalers and volumatic spacers

4. Authorised Duties of Home Carers

4.1 Where;

written authorisation from a Rotherham MBC Assessing Officer has been received, training where appropriate has been undertaken, and Home Carers feel competent to undertake the task;

Home Carers are authorised to give assistance with the following tasks:

(a) Collection of prescribed medication from the pharmacy.

(b) Ordering of repeat prescriptions.

(c) Reminding or prompting a Service User to take their prescribed medication.

(d) Administration of medication from a monitored dosage system, dispensed by a pharmacist provided that the dosage system has not been tampered with by any other person.

(e) Application of external creams which are emollients, i.e. skin soothers/softeners and barrier creams only. Disposable gloves must be worn. (*See Appendix 1*)

(f) Assistance to use a compliance aid to allow a Service User to self administer eye drops to treat a dry eye condition. e.g. Hypromellose or Visco tears.

In Exceptional circumstances, where an assessment indicates a person is unable to use compliance aids because of physical or mental disability, and there is no other person able to assist (informal carer), the Rotherham MBC Assessing Officer should consult with the G.P. or nurse who will make a decision as to whether the Community and Home Care Services Care Worker should be allowed to administer the drops.

If permission is given, training should be provided by the District Nurse. Advice should always be sought from the District Nurse especially if the service user has a high-risk eye condition or following eye surgery.

This should be arranged with the Community and Home Care Services Branch Manager The decision to assist with the administration of eye drops will be subjected to regular review and will take into account the need to maximise independence as far as possible. As with all medication, people will be encouraged to self medicate and it is expected that the family or non-paid carer will assist wherever this is practical.

(g) Application of ear drops, or olive oil, for treatment to soften wax.

(h) Application of nose drops, for sinusitis or hay fever.

The date of opening of eye, ear and nose drops should be written onto the label of the dispensing container. Drops must not be used later than 28 days from the date of opening.

(i) Emptying catheter bags. A Home Carer may **empty** the bag by opening the valve at the base of the bag but must not change the bag. A night overflow bag may be attached to, or disconnected from the main bag.

Home Carers may also fit/apply convene catheters.

(j) Assistance with use of Tens equipment, for pain relief, where use of the equipment has been advised or recommended by a health care professional. (*See Appendix 2*)

(k) Assistance with the use of Hypostop gel for diabetics. (*See Appendix 3*)

(l) Application, if suitable trained, of compression hosiery or leg braces.

(m) Disposal of colostomy bags.

A Home Carer may assist with the disposal of bags and all items used by the Service User during cleansing and changing. A Home Carer should not attempt to change a bag or deal with any other problems relating to the management of the stoma. If a Service User has a problem, it should be reported to the G.P. or Stoma Nurse.

4.2 Product instructions for usage, storage and expiry should be adhered to and the date of opening written onto any dispensing containers.

5. Role of the Pharmacist

5.1 Pharmacists supply medicines and appliances as specified on N.H.S. or private prescriptions and should give advice to patients and Home Carer on the proper use, storage and disposal of medicines.

Most pharmacists keep computerised records of the medication that patients receive on prescription. These records provide useful information and can indicate potential drug interactions.

Many pharmacists offer a collection and delivery service for medicines. This may include advising Service Users on their medicines.

Community and Home Care Services and Adult Services staff should be encouraged to make full use of the professional advice with regard to a Service User's medication.

6. Consent

6.1 Legislation requires that no medical treatment may be given to any person without written and valid consent.

6.2 Written consent for the administration of the medication and application of creams should be obtained from the Service User, including the date, and recorded on the Support Plan and kept on the Service User's file.

6.3 Where consent can not be given, a judgment will have to be taken by the Rotherham MBC Assessing Officer about the risk and the Service User's **ability** to consent. Where a Service User is unable to give consent because of the severe nature of their condition, consent should be obtained from an authorised person acting on behalf of the Service User, i.e. those with Lasting Power of Attorney.

The provider must verify that **ability** to consent has been determined by the Rotherham MBC Assessing Officer.

The Rotherham MBC Assessing Officer and the Community and Home Care Services responsible Assessing Officer will be responsible for **obtaining** written consent.

If there is any doubt that the above has been undertaken then the Carer and/or Home Care Supervisor (or equivalent responsible person) must refer the Service User for review.

6.4 In situations where consent is refused, medication must not be administered. The refusal should be reported by the Home Carer to their Home Care Supervisor (or equivalent responsible person) who will report this to the G.P.

6.5 Where it is felt by the Community and Home Care Services Supervisor (or equivalent responsible person) that refusal of consent is not made of their own free will, it may be appropriate to refer to the South Yorkshire Safeguarding Adults Procedures and the Safeguarding practice guidance for Rotherham.

6.6 It is an individual's choice not to take medication. They cannot be coerced or forced in any way but some degree of encouragement can be given. Under no circumstances should any member of staff attempt to administer any medicine against the Service User's will, or without their knowledge.

6.7 Unacceptable practices include:

- Disguising liquid medicine in drinks
- Dissolving tablets in drinks
- Crushing tablets and mixing in food
- Breaking open capsules and dispersing contents into drinks or food

6.8 All refusals must be recorded by Carers in the daily notes and reported to their Home Care Supervisor (or equivalent responsible person).

7. Storage

7.1 Where assistance has been assessed, medicines must be stored where they are readily accessible to all Home Carers. They should be kept out of the reach of children and away from heat and light sources. Should they need to be stored out of the reach of the Service User, information on their location must be available to all Home Carers.

7.2 Medicines will only be hidden where there is a need in order to protect the health and safety of the Service User.

7.3 Occasions may also arise where a Home Carer identifies a problem relating to a particular Service User. The Home Carer will raise the problem with their Home Care Supervisor (or equivalent responsible person) who will consult with the Rotherham MBC Assessing Officer and agree any appropriate action.

8. Disposal

8.1 Where the Rotherham MBC Assessing Officer has requested, unused, out of date or no longer needed medication may be returned to the

pharmacist by the Home Carers, with the Service User's consent. A receipt should be obtained from the pharmacist.

9. Care Recording

9.1 As with all other authorised duties, the Home Carers will record that a task has been undertaken by recording this on the Service User's daily notes which is retained in the Service User's home. The Home Carers will sign the daily notes to confirm that the task has been completed on the date stated.

9.2 If the Service User refuses, or does not take their medication, this should be recorded on the daily notes. It should be reported immediately to their Home Care Supervisor (or equivalent responsible person), who in turn should report to Rothercare Direct and advice should be sought from the G.P. or District Nurse. Any action taken should also be recorded by the Home Carer on the daily notes.

10. Training

10.1 Home Carers will be given training on their involvement regarding medication and other health related tasks as part of their Induction training and in accordance with contractual requirements.

11. Guidance Notes on Medical Issues

11.1 It is the responsibility of the General Practitioner or Consultant to explain the reason, for the treatment and the likely effects, including side effects, of any medication prescribed to their patient.

11.2 The medical practitioner makes a judgment on whether to explain to a patient the nature of an illness and the implications of any treatment. The judgment will be respected by Home Care staff.

11.3 Home Carers must not discuss or disclose a Service User's medical history or treatment to a relative or to another person. Any questions from others must be re-directed to the Service User or their G.P.

APPENDIX 1

APPLICATION OF SKIN CREAMS BY HOME CARERS

The creams listed below may be applied to Service Users by Home Carers. They are all either emollients i.e. softening/soothing or barrier creams. This is not an exhaustive list.

Disposable gloves must be worn when applying creams.

E 45 Cream

Unguentum Merck

Aqueous Cream

Dermamist Spray

Diprobase Cream

Diprobase Ointment

Sudocream

White Soft Parafin

Vaseline

Metanium Ointment

Aveeno

Calmurid

Univate Cream

Salcaplic Acid

Siopel Cream

APPENDIX 2

ASSISTANCE WITH THE USE OF TENS EQUIPMENT FOR PAIN RELIEF

Transcutaneous Electrical Nerve Stimulation or TENS is the application of low level pulsed electrical current through surface electrodes placed on the skin. It activates a pain suppression system, which restricts the amount of pain signals reaching the brain. It also encourages the body to increase its production of Endorphins, which again reduce the number of pain signals from reaching the brain.

Examples of conditions treatable by TENS-
Low back pain, lumbago, sciatica, rheumatoid arthritis, osteoarthritis, muscle spasm, musculoskeletal disorders, metastic bone pain, neuralgia, amputation pain, acute trauma, post operative pain, obstetric (labour pain)

Traditional placement of electrodes involves locating the painful or tender points and applying the electrodes on or around these areas.

Home Carers may assist by thoroughly washing and drying the unbroken skin where the electrodes are to be positioned, and then applying the electrodes to the prepared skin, at least a few centimetres apart.

The Service User will control the output and frequency of the treatment.

The equipment is supplied with full instructions for use.

APPENDIX 3

GUIDELINES ON THE USE OF HYPOSTOP GEL FOR DIABETICS

Product Description

Hypostop Gel is a fast-acting dextrose (glucose) gel for energy.
It is composed of 80 gms of 40% Dextrose concentration (32 gms glucose)
It is readily absorbed.
Total calories in the dispenser are 128 cals.
Not recommended for children under 2 years.

It can be administered by Home Carers if a diabetic Service User appears to be very drowsy, incoherent, confused, disorientated, very slow or unrousable.

Directions for use

- Turn the white tip counter clockwise to open.
- Place the dispenser tip in the mouth and slowly squeeze in one third of the contents (10 gms glucose)
- Turn clockwise to close.

If the Service User is unable to swallow, the gel will still be absorbed into the mouth.

It takes effect after approximately one minute.

- Inform the District Nurse immediately following use.