- **Pharmacist**

  They can offer valuable advice on medication, such as what to do if a dose is missed, what potential side effects might arise from particular medication and how to help the person you care for to take their medication if they have swallowing difficulties. They can also provide aids to help you remember when medicines should be taken.

- **Occupational Therapist (Community)**

  They can also carry out Community Care Assessments. They have specialist knowledge about equipment and adaptations to help the person you care for be as independent as possible in every day tasks such as bathing, dressing, confidence building and linking with the community.

- **Mental Health Officers**

  They are Social Workers with experience and training in the area of Mental Health. They have statutory responsibilities under the current legislation.

Section 4

Services in your community

As outlined in section 1, the person you care for and you, as their carer, should be involved in the planning of services and support. To be involved you need to know what services may be available.

This section provides you with basic information about these services and who provides them.

Community Care

The key to receiving community care services is a Community Care Assessment. A member of the social work department normally carries this out. If the assessment is carried out in hospital, it will form a central part of the discharge plan.

The assessment looks at what is required to enable the person to live as independently as possible at home. Here are some of the services that may be provided.

- help with meals, housework and/or shopping
- day support/short breaks/community alarms
- help with personal care such as bathing and dressing
- equipment, adaptations and transport
- residential and supported accommodation.

This list is not exhaustive but provides a starting point for you, and the person you care for, to think about what you might need. There may be charges for these services *(see section 5 for more detail)*.

Who's who in Community Care

Now you know what services can be provided through Community Care, the next step is knowing who does what. The key people involved are listed below.

❖ **Social work staff**

Someone from social work will normally carry out the Community Care Assessment and will talk to the person you care for about their needs. They should also involve you as the carer. However the assessment will focus on the needs of the person you care for rather than your needs. Your needs as a Carer can be assessed through a Carer Assessment *(see section 1)*.

When the Community Care Assessment is carried out as part of the discharge plan it will generally be carried out by a Social Worker based in the hospital. The Social Worker will normally review the services provided for up to four weeks after leaving hospital. After this time, responsibility for reviewing the care is handed over to the local Social Work Services. You should contact them if the situation at home changes and you need further advice and support.

❖ **Home Care** *(Home helps/Home Care Workers)*

They can offer support to the cared for person, with cooking, shopping and personal care. Advice can be obtained from Social Work.

❖ **Carer Support Team**

There is a Co-ordinator for Carers based within North Lanarkshire Carers Together and a Carer Development Officer employed full time by South Lanarkshire Carers Network. Both form part of the 'Carer Support Team' alongside the Co-ordinators for Carers based at the three acute hospitals in Lanarkshire. Much of their work in the community focuses upon working with general practitioners (GPs) to raise awareness of carer's issues and to ensure carers are identified and given the information and, where appropriate, the support they need to continue to care.

❖ **General Practitioner (GP)**

They will provide ongoing medical care and advice when the person has been discharged from hospital. They will receive information from the hospital consultant and nursing staff about the medical needs of the person you care for; this should include a copy of the discharge letter. They can refer the person you care for back to the hospital consultant if required. Contact your GP if you require further medical advice.

❖ **Community Nursing Team**

The community nursing team includes District Nurses, Public Health Nurses, Treatment Room Nurses, a range of Specialist Nurses can be contacted via the GP surgery.

What the **District Nursing** Service offers:

The District Nursing Team provide skilled nursing care for people 7 days a week, 365 days a year and offer a range of services provided in your home or clinic:

These include:

- ❖ Wound care management/complex clinical procedures, Post-operative Care
- ❖ Management and support for patients/carers with long term illnesses
- ❖ Support and nursing care for terminally ill patients/carers
- ❖ Catheter, stoma and continence care
- ❖ Health promotion/screening
- ❖ Flu Vaccination to housebound patient's

Practice Nurses are employed by the GP practice and provide care in the GP surgery which includes chronic disease clinics and travel vaccinations.

Public Health Nurses focus on health improvement and provide a range of screening services including child development programmes, childhood immunisations, advice, support and information on a whole range of health related issues across the age range. They offer home visits and a range of clinics in health centres and community centres. They also offer support to vulnerable families.

❖ **Community Psychiatric Nurse (CPN)**

They are trained to work with people with mental health problems. They offer support to patients, their families and carers and can be accessed via the GP.