

**Carers Emergency Plan**

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| **EMERGENCY CARE PLAN FOR:** |
| Carers Full Name: |  |
| Carers Full Address: |  |

The information provided in this document must only be used in case of an emergency and must be used in accordance with UKGDPR Regulations.

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| **Contents:** |
| Introduction  | 3 |
| General Details | 5 |
| Dependent Children  | 5 |
| Emergency Contacts | 6 |
| Other Documents | 6 |
| Care Options | 7 |
| About the person you care for | 9 |
| Behaviours | 10 |
| Communication  | 10 |
| What you do for the person you care for | 11 |
| Moving Around | 11 |
| GP Details | 12 |
| Medical Details | 12 |
| Health Tasks | 13 |
| Medication List | 13 |

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| **Introduction** |
| **About Emergency Planning** |
| As carers, we like to think that we will always be there when needed but this is not always possible. This could be for many reasons such as:* You may become very unwell or be injured and be unable to carry out your usual caring role.
* Unplanned admission to hospital following an accident or a medical emergency.
* You may have a household emergency which must be dealt with (e.g. fire, flooding)
* Family emergency, such as relative or other dependent being taken ill or a death.
* Breakdown of care arrangements.

Being prepared for an unplanned event is always a good idea. An Emergency Plan is a useful document where you put all the details about your caring role together in case so that there’s something in place if you cannot provide the care for your loved one. It helps to make sure that your emergency contacts can be notified quickly and make any arrangements needed for your loved one. |
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| **Guidance to Help you Complete your Emergency Plan:** |
| Before you complete your plan, have a good think about the people who you can rely on for support. It’s important they understand that they will be called in an emergency and that they agree for their information to be included on this form. **Don’t forget to give them a copy of your Emergency Plan.** Make sure that you have the phone number of all relevant contacts and organisations on your mobile phone, in case you need to contact them.  *It would be useful to add these numbers in the Contact List in your Emergency Plan too.*It may be helpful to have a relative, friend or trusted person to help you complete your plan. Local organisations may also be support you to complete it if you already access services with them. If you are unsure of what local services are available Bexley Council could offer information or you could find organisations using the Bexley Care Hub online.**Don’t forget**: If you have a pet, make sure that the emergency contacts have details about how to look after them. You may want to make a separate list about this.  |
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| **Emergency Contacts:** |
| There’s room for you to list three emergency contacts in your plan, although you can have as many as you wish. Please make sure that you have their permission to add their details to your plan and agree to what level of support they are willing to provide. * Will they organise replacement care?
* Will they contact family?
* Will they go shopping?
* Will they sit with the person you care for?

If you feel there are no family or friends who are able to act as a contact for you, we suggest you put the phone number of **Bexley Adult Social Care 020 8303 7777**. When you begin to fill out your plan, make sure that any organisations that provide support (*such as a care agency*) have the correct details for you, for example your mobile phone number.**Store at least one emergency contact in your mobile phone. Check your phone instructions for how to do this so that emergency staff will know where to look for this. You can also list this under ICE. This stands for ‘In Case of Emergency’ and emergency staff will know where to look for this, but cannot do this if your phone is locked.**Decide where you want to keep your emergency plan and let your emergency contacts know where to find it. It would be beneficial to give them a copy of this plan.If there’s a young person providing care in your family, or who is one of your emergency contacts make sure that their school knows about this.  |
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| **Making the Emergency Plan Known** |
| It is important that people know about your plan and that it is easy to access. If you have family or friends who you would like to include in this plan you need to discuss that with them first before including them and then let them know where the plan is kept.You should:* Complete this Carers Emergency Planning Form. Once its completed, give a copy to a trusted person; this could be someone you have identified as an emergency contact.
* Carry a card on you, which states that you’re a carer. The Carers Emergency Card is available from Carer organisations or Bexley Council.
* Inform your GP that you are a carer and ask them to flag you as a carer on their system. Depending on the system that’s used; this may show up when your medical records are accessed.
* Keep the plan updated, keep it somewhere safe and do tell people you trust where it’s located. The plan contains some personal and sensitive information, so it is important to keep it somewhere safe.

Other people may need to get involved and this document is a useful tool to gather important information about your life, so that should anything unforeseen happen your loved one is looked after in the best possible way. |
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| **What Happens Next?** |
| In the case where an emergency service (fire, police or ambulance) is involved, your Carers Emergency Card will alert them of the fact that you’re a carer and they will call one of your emergency contacts. As emergency services may also attend your home which may disturb the person you care for; it’s important that any information which is needed is available. This is so any upset or disturbance is minimised. We hope that you will never find yourself in a situation where you need to use your Emergency Plan. However, we know that having made these arrangements; it will help to give you peace of mind.  |

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| **Section 1: General Details** |
| My Name Is: |  |
| The name of the person I care for is: |  |
| Their address is: |  |
| Their date of birth is: |  |
| They can be contacted by: |  |
| If you need to gain access to the property where the person I care for lives, a key is held by: |
| Name: |  |
| Address:  |  |
| Telephone: |  |
| Mobile: |  |

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| **Section 2- Details of any Dependent Children or Young Carers in the Household** |
| First Name: | Surname: | DOB: |
| Please Tick the Relevant Boxes:Is a Dependent Helps out with Caring |
| First Name: | Surname: | DOB: |
| Please Tick the Relevant Boxes:Is a Dependent Helps out with Caring |
| First Name: | Surname: | DOB: |
| Please Tick the Relevant Boxes:Is a Dependent Helps out with Caring |
| Will the needs of the children also be met by the emergency contact in this plan?  | Yes/No |
| If not, is there anyone else we should contact, **give details below** |
| Name: |  |
| Contact telephone numbers: |  |
| Email: |  |
| Relationship to you: |  |

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| **Section 3- Emergency Contacts** |
| If I am not able to provide care, because of an emergency. Please contact one of the following, ***who are listed in order preference.*** |
| **Contact 1:** |
| First name and Surname: |  |
| Address: | Postal Code: |
| Home Phone Number: |  |
| Mobile Phone Number: |  |
| Work Phone Number: |  |
| Email: |  |
| Relationship to the Cared for Person: |  |
| Is this a person a key holder? YES/NO  |  |
| **Contact 2:** |
| First name and Surname: |  |
| Address: | Postal Code: |
| Home Tel. Contact Number: |  |
| Mobile Phone Number: |  |
| Work Tel. Contact Number: |  |
| Email: |  |
| Relationship to the Cared for Person: |  |
| Is this person a key holder? | Yes/No |

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| **Section 4: Other Documents** |
| I have an advance directive. This can be found/is held by: |  |
| The person I care for has an advance directive. This can be found/is held by: |  |
| The person I care for has a crisis plan. This can be found/is held by: |  |

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| **Section 5- Care Options** |
| Friends, family or neighbours your relative could stay with in an emergency: |
| In an emergency how long could your relative stay at home for? | Not at all 1-4 hours All dayOvernight A few days  |
| How long could they stay at home for with low level support?  | Not at all 1-4 hours All dayOvernight A few days |
| What support would they need? (phone call, short visit etc) |  |
| Please give details below: |
| **For 1-4 hours**, name and contact number: |  |
| What support would they need? |  |
| **For all day**, name and contact number: |  |
| What support would they need? |  |
| **For overnight**, name and contact number: |  |
| What support would they need? |  |
| **For a few days or longer**, name and contact number: |  |
| What support would they need? |  |

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| If there is a support worker paid through a personal budget who may be able to help in an emergency please give details below: |
| Name  |  |
| Phone Number: |  |
| What support might they give in an emergency?  |  |
| Name and contact number of organisation that employs them (if you do not employ them directly): |  |

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| Services/support organisations that may help in an emergency (e.g. short breaks/respite, community support, domiciliary care organisation): |
| **Organisation 1** |
| Name of organisation |  |
| Contact number |  |
| What support do they give now? |  |
| What support could they give in an emergency? |  |
| **Organisation 2** |
| Name of organisation |  |
| Contact number |  |
| What support do they give now? |  |
| What support could they give in an emergency? |  |

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| **Section 6- About the Person You Care For** |
| Please say more about the person you care for to help if emergency care needs to be provided |
| Their daily routine and if they can manage changes to it: |
| The activities they enjoy: |
| The activities they don’t like: |
| The food they like, mealtimes and what support they need: |
| Things that scare them: |
| If they can’t be contacted by phone or found at home, they might be found at the following places: |
| Mental health support (coping strategies/distress tolerance/safe place): |
| Anything else you think it is important that somebody knows: |
| **Safety During the Day & Night:** |
| During the DAY, how long (if at all) can the person you care for be left on their own? |  |
| During the NIGHT, how long (if at all) can the person you care for to be left on their own? |  |

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| **Section 7- Behaviour Difficulties** |
| The person I care for has the following behaviour difficulties:The best way to:* Reassure them is……
* Calm them down is…
* Break bad news to them is…
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| **Section 8- Communication:** |
| Often people with support needs maintain they can care for themselves and everything is fine.If they are asked questions, can their replies generally be relied on? Yes/No |
| Is there anything else to know about how the person you care for communicates *e.g. language they use, interpretation, repeat words, speak slowly, write things down, needs easy read, signing (BSL, Makaton) etc.* |

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| **Section 9- What do you do for the person you care for?** |
| **Please tick to the relevant boxes below.** |
|  | **DAY** | **NIGHT** | **NO SUPPORT NEEDED** |
| Personal Care (e.g. dress, wash, toilet, eat/drink) |  |  |  |
| Eating and drinking (including shopping or preparation) |  |  |  |
| Health needs (e.g. dressings and injections) |  |  |  |
| Moving and Handling (e.g. helping with getting in/out of chair/bed, walking) |  |  |  |
| Safety during the day and/or night |  |  |  |
| Emotional Support (e.g. providing company and dealing with crisis) |  |  |  |
| Life Planning/Management (e.g. dealing with letters/services/managing finances) |  |  |  |
| Day-to-Day Activities (e.g. laundry/leisure/transport outside the home) |  |  |  |
| **Please use this space below to give more details about the care and support you provide; or details of anything else which isn’t included above.**  |

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| **Section 10- Moving Around:** |
| Does the person you care for require assistance with **moving around the home?**  | Yes/No |
| Does the person you care for require assistance with **transfers?** | Yes/No |
| Does the person you care for require assistance with **getting out and about?** | Yes/No |
| Does the person use mobility aids? (E.g. hoist, frame, commode etc.) | Yes/No |
| If answer is **yes to any questions above**, please give more details: |
| **Section 11- GP Details** |
| My GP Name: |  |
| The Practice name: |  |
| Practice Address and Postcode: |  |
| Telephone No. of Practice: |  |
| If the person you care for has a different GP or Practice please give their details: |  |

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| **Section 12- Medical Details** |
| Does the person you care for experience any of the following? *(Please circle all that apply)* |
| Alzheimer’s  | Deaf or hard of Hearing  | Diabetes |
| Dementia  | Swallowing Difficulties  | Stroke / TIA |
| Confusion  | Parkinson’s Disease | Multiple Sclerosis  |
| Mental Health Problems | Visual Impairment  | Renal Problems |
| Learning Disability  | High Blood Pressure | Arthritis |
| Autistic Spectrum | Low Blood Pressure | Poor Mobility |
| Epilepsy  | Breathing Difficulties | Prone to Falls  |
| Behaviour that challenges | Requires Oxygen | Wheelchair User |
| Other (Please Specify): *e.g. other medical condition, allergies, or any other medical information you think is important.* |

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| **Section 13- Health Tasks:** |
| Does the person you care for need support with nursing tasks? ***E.g. wound care, injections etc. Please describe the type of task, frequency and who carries the task out.***  |

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| **Section 14- Medication:** |
| Does the person you care for take regular medication?  | Yes/No |
| Is a dosette box prepared? \* |  |
| *\*A dosette box is a disposal plastic system for arranging your weekly medicines.**At a glance you can see which pills to take, and when to take them. The use of a dosette reduces the risk of mistakes.* |
| Where is the dosette box located? |  |
| The pharmacy who usually dispense the medication for the person I care for is: |  |
| Their phone number is: |  |

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| **Medication name:** | **Where it’s kept:** | **Time to be taken:** | **How to be taken:** |
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| **Continued on a separate sheet?** | **YES** | **NO** |

Thank you for completing this care plan, please remember to keep it somewhere safe and to let trusted people know where it is.

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| **Carers Name (IN BLOCK CAPITALS):** | **Signature:** | **Date Completed:** |