



## Emergency Care Plan



This booklet is for family carers to think about who could offer support, and what that person would need to know, in the event the primary family carer is unable to provide care due to an emergency.



### EMERGENCY CARE PLAN FOR

\_\_\_\_\_

Insert cared for person's name here

Developed by: \_\_\_\_\_ (primary family carer)

Date: \_\_\_\_\_

Personal details of person being cared for:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Eircode: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Email: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

GP Name: \_\_\_\_\_

GP Address: \_\_\_\_\_

\_\_\_\_\_

GP Phone Number: \_\_\_\_\_

**What difficulties/disabilities does this person that you care for have?**

- |                               |                          |                           |                          |
|-------------------------------|--------------------------|---------------------------|--------------------------|
| Arthritis                     | <input type="checkbox"/> | Illness: Life-Threatening | <input type="checkbox"/> |
| Autistic Spectrum Disorder    | <input type="checkbox"/> | Intellectual Disability   | <input type="checkbox"/> |
| Cancer                        | <input type="checkbox"/> | Mental Health             | <input type="checkbox"/> |
| Cerebral Palsy                | <input type="checkbox"/> | Multiple Sclerosis        | <input type="checkbox"/> |
| Dementia/Alzheimer's          | <input type="checkbox"/> | Parkinson's               | <input type="checkbox"/> |
| Behaviour/Development Issues  | <input type="checkbox"/> | Physical Disability       | <input type="checkbox"/> |
| Diabetes Elderly/Frail        | <input type="checkbox"/> | Stroke                    | <input type="checkbox"/> |
| Epilepsy                      | <input type="checkbox"/> | Substance Misuse          | <input type="checkbox"/> |
| Hearing Loss                  | <input type="checkbox"/> | Palliative Condition      | <input type="checkbox"/> |
| Heart Condition               | <input type="checkbox"/> | Visual Loss               | <input type="checkbox"/> |
| Illness: Non-Life-Threatening | <input type="checkbox"/> | Spina Bifida              | <input type="checkbox"/> |
| Hydrocephalus                 | <input type="checkbox"/> |                           |                          |

Other (please specify):

**The person I care for can:**

- |                            |                          |  |                          |
|----------------------------|--------------------------|--|--------------------------|
| Communicate verbally       | <input type="checkbox"/> | Get themselves something to eat/drink                                | <input type="checkbox"/> |
| Manage their own medicines | <input type="checkbox"/> | Stay safely on their own independently in the house for a short time | <input type="checkbox"/> |
| Wash/dress themselves      | <input type="checkbox"/> | None of the above  | <input type="checkbox"/> |
| Answer the door            | <input type="checkbox"/> |  |                          |
| Answer the phone           | <input type="checkbox"/> |  |                          |
| Go to the toilet alone     | <input type="checkbox"/> |  |                          |

**List of Medications:**

Name of Medicine	Dose	How many times a day	Special Instructions

Where in the person's house is their medication kept?

Do they need support to take their medication?

*If yes, what support is needed?*

Pharmacy Name:

Pharmacy Phone Number:

**Does the person receive any care or support services?**

Main HSE<sup>1</sup> Contact (as required): \_\_\_\_\_

Phone Number: \_\_\_\_\_

Day Service (if applicable): \_\_\_\_\_

Name of Service: \_\_\_\_\_

Name of Main Contact: \_\_\_\_\_

Phone Number: \_\_\_\_\_

**Home Support / Personal Assistant Support (if applicable):**

Name of Service: \_\_\_\_\_

Name of Main Contact: \_\_\_\_\_

Phone Number: \_\_\_\_\_

**Respite Service (if applicable):**

Name of Service: \_\_\_\_\_

Name of Main Contact: \_\_\_\_\_

Phone Number: \_\_\_\_\_

**Other issues that may impact on the person's health and wellbeing:**

Does the person have epilepsy?                      Yes                       No

Does the person have any allergies?                      Yes                       No

*If yes, please list allergies and record if the person takes Buccal or has an EpiPen.*

<sup>1</sup> This could be a Public Health Nurse, Social Worker, Disability Manager, etc.

Does the person have behaviours others need to be aware of?

Does the person need assistance to eat or drink? Yes  No

*If yes, describe what help is required.*

Does the person have a PEG or NG tube or require fluids to be thickened?

Yes  No

*Where are the products and parts stored and who supplies them?*

Does the person use any continence products? Yes  No

*If yes, outline the type continence products needed and who supplies them.*

Does the person require the use of a mobility aid e.g. hoist, wheelchair, walking stick, etc.? Yes  No

Does the person have any sensory issues? Yes  No

*If yes, describe them here.*

### Emergency Contacts:

If there was an emergency and you were no longer able to provide care, do you have a family member or friend who would be able to provide the full care the person requires? Yes  No

*If yes include their details*

Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Eircode: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Relationship to you, the carer? \_\_\_\_\_

Relationship to the person you care for? \_\_\_\_\_

Does this person have a key to the cared for person's house? Yes  No

### Other Emergency Contact:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Eircode: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Relationship to you, the carer? \_\_\_\_\_

Does this person have a key to the cared for person's house? Yes  No

**Have you discussed this plan with your contacts and do they agree to be contacted in the event that you are not able to provide care?**

Yes  No

### Other Information:

Use this space to consider what other information a person would need to know if they were required to provide care in the event of an emergency.



## What now?

- Talk about the plan with the person you care for.
- Talk about the plan with the emergency contacts named in this document.
- Talk about the plan with other family members, healthcare professionals and people you trust.
- Give people a copy of the plan – or let them know where they can find it.
- Make sure the information is regularly updated.
- Find out your Eircode and make sure it is available close to the phone or the front door of the house in case of an emergency.
- Make sure you have enough medication for the person for a month – please don't stockpile medication as others who need it may not have access to it.
- Members of Family Carers Ireland have a membership card with contact details of a person to be contacted in case of emergency – carry it with you.
- In the event of an emergency, please contact 999.
- Try to relax and know that you have a plan in the event of an emergency situation.

This document was developed by **Family Carers Ireland** in response to the Covid-19 outbreak, at the request of our members, but it can be used for any emergency.

If you would like to share your experience of completing this document or using this plan, we would love to hear from you. If there is additional information you would like to see included in future versions please contact us by email at [kmcloughlin@familycarers.ie](mailto:kmcloughlin@familycarers.ie).

**Family Carers Ireland** provide services and supports to carers of all ages across Ireland. This includes a National Freephone Careline - 1800 240724, a carer's emergency card, support groups, information about rights and entitlements, home care, respite, education and training and activities for carers designed to give them a break.

See [www.familycarers.ie](http://www.familycarers.ie) to become a member and get access to a range of supports and membership benefits including discounts for a large number of services and products.



Family Carers Ireland  
No one should have to care alone

Freephone National Careline  
1800 24 07 24



[www.familycarers.ie](http://www.familycarers.ie)

