EMERGENCY
CARE PLAN

McCormick Dementia Services

Advancing community outreach and support

McCormick Dementia Services
Advancing community outreach and support

EMERGENCY CARE PLAN

TABLE OF CONTENTS

McCormick Dementia Services
Advancing community outreach and support

EMERGENCY CARE PLAN

Emergencies can happen anytime. If you are a caregiver, planning for emergencies can help you to cope, even when things go wrong.

Having a plan in place means that if something goes wrong, the person you care for will still be looked after.

Instructions

1. Fill out Emergency Care Plan
   - Take time to go through this document and complete it to the best of your abilities.
   - It should have all the information someone else would need to know, in order to be able to look after the person you care for.
   - If you need to add more information, you can write it on extra pages and keep them with your plan.
   - Consider including copies of documents such as POA, DNR, and medication lists.

2. Share your plan
   - Make copies of the plan.
   - Keep a copy of the plan somewhere safe and easy to access in your home.
   - Take a copy with you when you leave home or travel with the person you care for.

3. Keep it current
   - A person's needs can change over time. Review the care plan frequently (approximately every three months) to ensure all of the information is current.
   - Make sure to cross out any information that is no longer accurate.
   - Consider packing a "go bag" with essential items for your person should they need to stay overnight somewhere other than your home.

This Emergency Care Plan has all of the information on how to care for this person in the event their primary caregiver is unable to. Call 911 immediately if you believe they are experiencing a medical emergency. Do not rely on communication in this care plan for urgent medical needs.

EMERGENCY CARE PLAN

Caregiver who created this care plan: _____

Person this care plan was created for: _____

PERSONAL INFORMATION

Full Name :

Health Card Number : **Version Code** :

Date of Birth : _____ **Gender** : ☐ Male ☐ Female ☐ Other:

Address : _____

Phone Number : _____

Medical Diagnoses :

Allergies :

Does this person have a DNR (Do Not Resuscitate)? ☐ YES ☐ NO

★ **Please include a copy or the location of the DNR.**

Does this person have a Cool - Aid card? ☐ YES ☐ NO

★ **Card will be located on the fridge**

MEDICAL CONTACT INFORMATION

Family Doctor _____ **Family Doctor Number** _____

Specialist _____ **Specialist Number** _____

Specialist _____ **Specialist Number** _____

Pharmacy _____ **Pharmacy Number and Location** _____

Closest Hospital/Emergency Room

Name:

Location:

LEGAL DOCUMENTATION

Does this person have a POA? (Power of Attorney)

POA for Finance : ☐ YES ☐ NO

POA for Personal Care : ☐ YES ☐ NO

Power of Attorney Information (name, phone number) :

EMERGENCY CONTACT	
Name :	Relation :
Landline number :	
Mobile number :	

EMERGENCY CONTACT	
Name :	Relation :
Landline number :	
Mobile number :	

MEDICATION LIST

Medications are located :

Consider asking your pharmacy for a printed medication list to include in this package.

Pharmacy _____ **Pharmacy Number** _____

Medication Name	Dose	Route	Frequency
Example: Ibuprofen	325 mg, 2 tablets	By mouth	Once a day

Consider outlining what a typical day looks like.

MORNING

AFTERNOON

NIGHT

SCHEDULE AND ROUTINES

Consider outlining what a typical week looks like.

MONDAY	**TUESDAY**
WEDNESDAY	**THURSDAY**
FRIDAY	**SATURDAY**
SUNDAY	**NOTES**

CARE NEEDS

We understand that a person's needs may change over time, which is why we have provided a secondary box for each activity of daily living for you to record and update care needs. Please remember to cross off the old information.

AID INFORMATION

Consider: Where they are located? When to use them. How to use them. Add any other relevant information.

Glasses	
Hearing Aids	
Walker	
Cane	
Wheelchair	
Mechanical Lift	
Other	
Other	
Other	

ACTIVITIES OF DAILY LIVING

The person I care for needs help with:

☐ Managing Medications

Consider: How much support does the person require to take their medications? Do they require cueing? Do they use blister packs? Are they fully dependent on the caregiver to manage medications? Are there tips or tricks you use to encourage the person to take their medications?

Please use this box to record the most accurate information should the person's needs change over time.

CARE NEEDS

We understand that a person's needs may change over time, which is why we have provided a secondary box for each activity of daily living for you to record and update care needs. Please remember to cross off the old information.

ACTIVITIES OF DAILY LIVING

The person I care for needs help with:

☐ Toileting and continence

Consider: Does the person require assistance when using the washroom? How much and what type of assistance is needed? Do they follow a toileting schedule? Do they wear incontinence products? What cueing phrases work well to support this person?

Please use this box to record the most accurate information should the person's needs change over time.

☐ Personal Hygiene

Consider: How does the person manage their personal hygiene (combing hair, brushing teeth, shaving, applying make up, washing/drying face and hands)? Do they require cueing, set up, or total care? Are there tips or tricks to completing these tasks with the person?

Please use this box to record the most accurate information should the person's needs change over time.

CARE NEEDS

We understand that a person's needs may change over time, which is why we have provided a secondary box for each activity of daily living for you to record and update care needs. Please remember to cross off the old information.

ACTIVITIES OF DAILY LIVING

The person I care for needs help with:

☐ Mobility

Consider: Does the person need help with standing, transferring, or walking? How much support is needed? Do they have a history of falls?

Please use this box to record the most accurate information should the person's needs change over time.

☐ Meals

Consider: When does the person typically eat? What does the person typically eat? Does the person requires reminders to eat? Does the person require cueing? Does the person use adaptive equipment? Does the person have allergies or texture requirements?

Please use this box to record the most accurate information should the person's needs change over time.

CARE NEEDS

We understand that a person's needs may change over time, which is why we have provided a secondary box for each activity of daily living for you to record and update care needs. Please remember to cross off the old information.

ACTIVITIES OF DAILY LIVING

The person I care for needs help with:

☐ Sleep

Consider: Does the person have a night-time routine? What are the typical sleep and wake times for this person? Do they wake throughout the night? Do they use any incontinence products at night?

Please use this box to record the most accurate information should the person's needs change over time.

☐ Bathing

Consider: Does the person take a shower, bath or sponge bath? How often does the person bathe? What is their typical bathing routine? What type of and how much support does the person require to accomplish this task? Are there tips or tricks to completing this task successfully?

Please use this box to record the most accurate information should the person's needs change over time.

CARE NEEDS

We understand that a person's needs may change over time, which is why we have provided a secondary box for each activity of daily living for you to record and update care needs. Please remember to cross off the old information.

ACTIVITIES OF DAILY LIVING

The person I care for needs help with:

☐ Transportation

Consider: Does the person drive? Are there any safety concerns regarding access to car keys? How much support does the person require getting in and out of a vehicle? Do they require any mobility aids when leaving the house?

Please use this box to record the most accurate information should the person's needs change over time.

☐ Housework

Consider: Are there certain chores that are a part of the person's daily routine? How much support does the person need to accomplish tasks? Where are housekeeping supplies located? What day of the week is garbage and recycling pick up?

Please use this box to record the most accurate information should the person's needs change over time.

SAFETY AND TECHNOLOGY

Does this person have a history of wandering or elopement? ☐ YES ☐ NO

Consider: Does the person wear an ID bracelet? What safety measures are put in place? Is the person registered with a wandering registry?

Is there any technology used for safety in the home? ☐ YES ☐ NO

Consider: Alarms, locks, camera systems, personal fall-alert systems

SUPPORT SERVICES

Does this person have any in-home supports? (private pay, community support services, volunteer services) ☐ YES ☐ NO

Does this person receive services from Home and Community Care Support Services (e.g., personal support workers, respite care)? ☐ YES ☐ NO

Care Coordinator: NAME _____ PHONE _____

NAME _____ PHONE _____

*Consider: What services ? When do they come? Where do they come from? **Provide con**tact information.*

SUPPORT SERVICES

*Consider: What services ? When do they come? Where do they come from? **Provide** contact information.*

COMMUNITY SUPPORTS

Does this person attend any day programs, groups or treatments in the community on a regular basis?

☐ YES ☐ NO

Provide details (day, time, location, contact information):

RESPONSIVE BEHAVIOURS AND MOOD

Responsive behaviours are a response to a trigger or cue in the person's surroundings. All behaviours have meaning and often result from an unmet need. Common types of responsive behaviours are: anxiety, sundowning, verbal behaviours, delusions, wandering, paranoia, etc.

Does this person's mood fluctuate throughout the day? ☐ YES ☐ NO

Tips for supporting this person:

Does this person experience responsive behaviours? ☐ YES ☐ NO

If yes, please explain:

BEHAVIOUR	POSSIBLE TRIGGERS	WAYS TO HELP

MEANINGFUL ACTIVITY ENGAGEMENT

This person enjoys:

☐	**Colouring:**
☐	**Gardening:**
☐	**Music:**
☐	**Reading:**
☐	**Puzzles:**
☐	**Physical activity:**
☐	**Using the computer/tablet:**

☐	**Watching TV/movies:**
☐	**Talking on the phone:**
☐	**Looking through photo albums:**
☐	**Helping tasks:**
☐	**Sorting tasks:**
☐	**Other:**
☐	**Other:**

This person likes talking about:

Try to avoid talking about:

Additional information about what this person likes to do: