Emergency Care Planning

New Intake Form-Has all the information that we need for CRM and will guide us for ER Planning

LSS MN CAREGIVER AND COMPANION SERVICES

MERGED INTAKE FORM (General intake, Emergency Care planning intake)

Referral Source: _____ Referral Date: _____

Phone Intake Date: _____ Home Assessment Date: _____

Completed By: _____

CAREGIVER INFORMATION

Caregiver Name: _____ Gender: _____

Caregiver Phone: _____ DOB: _____

Additional Phone Numbers: _____ Email Address: _____

Preferred Contact: ☐ Cell ☐ Alternate ☐ Email

Address: _____

Lives with Care Receiver: ☐ Yes ☐ No

Waiver Funding: ☐ EW ☐ AC ☐ CADI Case Manager: _____

Pay Source: _____ Occupation: _____

SSN: _____ Education: _____

Church Affiliation: _____

CARE RECEIVER INFORMATION

Care Receiver Name: _____ Gender: _____

Relationship to Caregiver: _____ DOB: _____

Cell Phone: _____ Alternate Phone: _____

Preferred Contact: ☐ Cell ☐ Alternate ☐ Email Email Address: _____

Address: _____

Waiver Funding: ☐ EW ☐ AC ☐ CADI Case Manager: _____

Insurance Plan: _____ Church Affiliation: _____

Pay Source: _____ Occupation: _____

SSN: _____ Education: _____

MILITARY SERVICE ☐ **Not Applicable**

Caregiver Military Service _____ (Branch of service and approx. years of service)

Care Receiver Military Service _____ (Branch of service and approx. years of service)

Other Family Member's Military Service _____ (Name and Relationship to Family)

_____ (Branch of service and approx. dates of service)

Branch of Service (SOT-Approved): ☐ Army ☐ Marine Corps ☐ Navy ☐ Air Fc

Branch of Service – Other: ☐ Reserves ☐ National Guard ☐ Coast Guard

Current Status: ☐ Active ☐ Inactive ☐ Retired Veteran Status: ☐ Yes ☐ No Years of Service:

CORE Resource

_____

RGENCY INFORMATION

gency Contact: _____ Phone: _____

onship to the Care Receiver: _____

ER SUPPORT PERSONS

e	Relationship	Address/Phone	Permission to Contact

Caregiver/Care Receiver: _____

Support for Respite Care: ☐ Need to Schedule

☐ Informal (Family/Friends)

_____

☐ Formal (Facility/Community Provider)

_____

Care Receiver's Primary Clinic/Physician_____

Preferred Hospital/Location _____

Cognitive Ability (Orientation/Memory/Judgment)

_____

Medical Conditions

☐ No Known Medical Conditions

☐ Cardiac/Plumonary: _____

☐ Diabetic: _____

☐ Neurological: _____

☐ Gastrointestinal: _____

☐ Musculoskeletal: _____

☐ Gynecology/Urinary: _____

☐ Infectious Disease: _____

☐ Immune Disorders: _____

☐ Chronic Pain: _____

☐ Wounds: _____

☐ Vision: _____

☐ Hearing: _____

☐ Dental: _____

☐ Allergies: _____

Behavioral/Spiritual Health

Any major changes/loss recently? _____

☐ Concerns with use of drugs/alcohol: _____

☐ Concerns with verbal/physical abuse: _____

☐ Current/Past therapy: _____

Special needs of the care recipient as described by caregiver/care receiver:

Mobility
_____Independent
_____Needs Assistance
_____Home Bound

Personal Care
_____ Independent
_____ Needs Assistance
_____ Total Assistance

Speech
_____ Good
_____ Impaired
_____ *Describe Impairment*:

Cognition/Memory
_____ Good
_____ Impaired
_____ *Describe Impairment*:

Special Equipment Used
_____ Walker
_____ Cane
_____ Wheelchair
_____ Crutches
_____ C-Pap machine
_____ Oxygen therapy
_____*Instructions:*

Favorite Pastimes
____Reading
____ TV
____ Puzzles
____ Outside Activities
____ *Other:*

Care Receiver's Recent Hospital Admissions:

Date: _____ # ED Visits in Last 6 Months: _____

Details: _____

Caregiver's Recent Hospital Admissions:

Date: _____ # ED Visits in Last 6 Months: _____

Details:_____

Personal Emergency Response System ☐ Yes ☐ No ☐ Need to Schedule_____

Support Services

Inter-County Nursing	☐ Need to Schedule	☐ Established Provider: _____
Occupational Therapy	☐ Need to Schedule	☐ Established Provider: _____
Physical Therapy	☐ Need to Schedule	☐ Established Provider: _____
Hospice	☐ Need to Schedule	☐ Established Provider: _____
SW/Case Manager	☐ Need to Schedule	☐ Established Provider: _____
Chore	☐ Need to Schedule	☐ Established Provider: _____
Transportation	☐ Need to Schedule	☐ Established Provider: _____
Senior Dining/Congregate dining	☐ Need to Schedule	☐ Established Provider: _____
Frozen Shipped Meals	☐ Need to Schedule	☐ Established Provider: _____
Home-Delivered Meals	☐ Need to Schedule	☐ Established Provider: _____
Home Care (HHA/HM)	☐ Need to Schedule	☐ Established Provider: _____

Caregiver/Care Receiver: _____

Adult Day Services	☐ Need to Schedule	☐ Established Provider: _____
County Social Services	☐ Need to Schedule	☐ Established Provider: _____
Companion Care	☐ Need to Schedule	☐ Established Provider: _____

Referrals Made to: (Include date referrals made)

☐ Senior Linkage Line
☐ Transportation
☐ Nutrition Services
☐ Public Health
☐ Adult Day Services
☐ Counseling Services
☐ Ombudsman
☐ Medical Supplies/Equipment
☐ County Social Services
☐ Lifeline
☐ Legal Services
☐ Hospice
☐ Deaf and Hard of Hearing Services
☐ MN Services for the Blind
☐ Prescription Drug Programs (Medicare Part D)
☐ Other: _____

Information Shared Regarding:

☐ Alzheimer's Disease
☐ Parkinson's Disease
☐ Cancer
☐ Stroke
☐ Long Term Care
☐ Other _____

GENERAL OBSERVATIONS

_____

Signature: _____ Date: _____

Tips on promoting the Emergency Care Plan

- Things to say?
- *Instead of asking "do you have an emergency plan?"*
- *Ask "what exactly would happen to your care receiver if something happened to you?"*

Tips on creating an Emergency Care Plan

- Initial intake takes roughly 1.5-2 hours
- Call the team members individually before the planning date and personally invite them to the meeting
- Ask the team members if there is anything you need to know about their availability to help, what they're seeing of the CG & CR. Utilize question list?
- Schedule planning meeting for 2 hours – ensure you have this time blocked off
- Prep time includes anywhere from 1-2 hours, maybe more depending on the care team
- Preparation includes calling the care team, researching resources, mailing handouts for resources if needed

Questions to ask care team members

- What are your biggest concerns regarding your parents?
- Is it feasible for you to step in and help as a family caregiver?
- What would it look like if you were needed to provide support and care for your father?
- How much time and for how long would you be able to help?
- Would you be comfortable with hands on intimate cares if that was a need?
- How do you communicate best? and How would you best communicate and work as a team with your siblings in a crisis (or in a difficult transition)?
- What do you want most for your parents? (ex. to honor their wishes, to make sure they are safe, etc.)

What is an example of a completed ER Plan?

Client's Emergency Care Plan Team

Team member's contact information

Client is an 84-year-old male who recently moved to Thief River Falls with his wife. Client was diagnosed with an unspecified type of dementia a few years ago. Client's dementia has advanced to the point where he is not safely able to be left alone for a long period of time. Client has not displayed wandering behavior. Client has fell one time during the last 90 days. He did not have any significant injuries as a result of the fall. He can follow verbal direction but may need many reminders.

In the event of an emergency, the following contacts need to be contacted:

Team members info-

Overview of Client's day- Client starts his day around 10 a.m. He can independently dress, toilet, and feed himself at this time. He does need reminders about showering. Hw fixes his own breakfast. He usually walks Bernie, the dog, at 10:30 a.m. until 11 a.m. He can walk the dog independently at this time. He takes Bernie for a walk three to four times a day for about ten minutes.

Client is sleeping more during the day. He likes to make phone calls to friends and family. He, at times, will call people at inappropriate times of the day. For example, he will call people at 10 p.m. Wife gently reminds him that people are sleeping at this time. He and his wife sit down and have their evening meal between 5:30 p.m. and 6 p.m. He takes two medications in the evening. He takes a baby aspirin and 25 mg of Losartan. He can take his medication independently at this time.

Client can independently get himself ready for bed. He does need someone to lay clean clothes out for him for the next day, as he tends to wear the same clothes multiple days in a row. He typically goes to bed around 10 p.m.

Client, recently, has displayed socially inappropriate behavior. There was an issue with the new neighbor. He tapped on the back of the neighbor's vehicle, while the person was in the vehicle. This caused the neighbor to be frightened. Wife has reminded him to stay away from the neighbor when he walks the dog. He will make noises, that are like "starting a trumpet". He displays these behaviors when he is happy or when there is silence. Wife feels this is a way for him to get attention. He is obsessed with food, specifically sweets.

Emergency Care Plan organized by: Julie Praska-Moser, CMC, Lutheran Social Service of MN

90-Day Review

- Invite all care team members
- Schedule every 90 days (count then as coaching units)
- 90-day evaluation tool:
- Review the plan with the whole team
- Make updates if needed

Questions to ask during 90-Day Review

- Have you had to implement the plan?
- If so, what adjustments would you make?
- Did creating an emergency care plan result in a decrease in stress and worry?
- Were you satisfied with the process of this planning?
- Do you have any suggestions on how we can improve our service?

Other resources/forms you can use…

Caregiver Care Plan

- **Client**
-
- **Caregiver Risk Factors**
-
-
- **Caregiver Concerns**
-
-
- **Caregiver Strengths**
-
-
- **Recommendations**
-
-

Client – Important Care Information

Updated 07-2020

General caregiving information here.

Activities/Interests

1.

Important Information when Caring for Client

1.

Medication Routine

•

Morning Wakeup Routine

•

Bus Pickup/Dropoff

•

Evening Bedtime Routine

•


FILE OF LIFE®
Lutheran
Social Service
of Minnesota
Caregiver Support & Respite Services
Crisis Respite Plan
1.800.488.4146
Address:
FILE
OF LIFE

Weekly Schedule:

	SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
5:30 AM							
6:00							
6:30							
7:00							
7:30							
8:00							
8:30							
9:00							
9:15							
9:30							
10:00							
10:30							
11:00							
11:30							
12:00 PM							
12:30							
1:00							
1:30							
2:00							
2:15							
2:30							
3:00							
3:30							
4:00							
4:30							
5:00							
5:30							
6:00							
6:30							
7:00							
7:30							
8:00							
8:15							
8:30							
9:00							
9:30							
10:00							

Emergency Care Planning: Client (Example)

Identified Emergency Plan Needs

- Identify 24/7 crisis contact who can speak to Client's immediate needs and make a connection to LSS.
- Develop an Emergency Care Plan that adequately provides 24/7 care coverage for Client, including informal and formal supports who can help during a crisis when Sarah is not able to provide care to Client.
- Establish a plan for home ownership that allows Client to stay in his home and receive care long-term.
- Establish a plan for long-term financial management of Client's assets.

Completed Items

- Conducted a Care Receiver Assessment to identify Client's emergency planning needs
- Identified informal supports who can provide short-term care for Client during a crisis
- Releases signed to facilitate care planning and to allow for engagement during crisis support
- Created an Organizational Support Questionnaire to be completed by Client's church community when it is appropriate to bring them into Client's care plan as a formal resource
- Created a list of Client's interests, activities, and important care information to share with those supporting Client during a crisis
- Created an electronic, modifiable list of Client's daily activities to be updated and shared with Client's care providers
- Conducted Caregiver Assessment to identify caregiver support needs that will help prevent burnout
  Completed an Emergency Plan that identifies existing resources for placement on fridge (with sticker for door to alert emergency personnel that there is a "File of Life" for Client
- Explored options for ongoing emergency planning under service lines for care coordination and persons with disabilities
- Identified need for and hired legal representation to pursue legal options that will keep Client living in his home

Next Steps

- ☐ Order medical alert bracelet that includes LSS contact information and refers to Client's emergency plan ***(Responsible Party Name)***
- ☐ Follow up with LSS Pooled Trust & Guardianship to explore options to protect Client's financial assets and options for Healthcare Agent and Supported Decision-Making ***(Responsible Party Name)***
- ☐ Continue discussions with church community to work towards inclusion within Client's support system ***(Responsible Party Name)***
- ☐ Create a digital photo album of Client's experiences and share with LSS emergency planning team ***(Responsible Party Name)***
- ☐ Determine what options exist to have conversations with school district leaders on supports needed to properly support children with disabilities in a distance and on-premise learning environment ***(Responsible Party Name)***
- ☐ Identify pathway to increase advocacy efforts that support individuals with disabilities and addresses housing and other issues crucial to a successful emergency plan ***(Responsible Party Name)***
- ☐ Confirm Sharon's role in helping Sarah transition Client's financial benefits after he turns 18 ***(Responsible Party Name)***
- ☐ Review Emergency Plan & send materials to Sarah. ***(Responsible Party Name)***

Caregiver Services

ORGANIZATIONAL SUPPORT QUESTIONNAIRE

Person needing support (optional): _____

List specific needs (optional): _____

Readiness and Experience

1. What experience does your organization have in providing occasional support to persons with disability and/or aging needs? Please include the types of support provided and when/how often it is available.
2. Are you willing to make modifications to activities and support available to allow the inclusion of persons with disability and/or aging needs? Please describe any modifications already made/available.

Policies and Procedures

1. Does your organization have a written policy that guides the providing of occasional support to persons with disability and/or aging needs? If no, are you willing to create a policy that would outline support that is available?
2. Are there any policies related to qualification for receiving occasional support? (i.e. membership at organization, proximity to your organization, etc.)
3. Are there any policies that may restrict or limit the nature of support?
4. Have there been instances when your organization was unable to provide support? (Please describe.)
5. Do you have policies regarding the provision of support under HIPAA or other privacy standards?

Potential Resources

1. Has your organization identified a team or individual(s) who are able and willing to provide support to persons with disability and/or aging needs?
2. Is there compensation for those providing support?
3. Has your organization identified a "point of contact" for occasional needs? Is this a staff member or a volunteer?
4. Does your organization provide ongoing training and support of individuals who may volunteer to support occasional needs?
5. Is there a cost to the person receiving occasional support?
6. Is there a time-limit to receiving occasional support? (i.e. total hours of service, timeframe, etc.)
7. Do you have access to other services, not provided by your organization, that would benefit the person being supported? Describe, including any associated costs.

Service Boundaries

1. Can volunteers perform additional contractual work?
2. Can your organization, staff, and/or volunteers become parties to legal agreements with persons receiving occasional support?
3. In what settings is the support available? (i.e. in the building, in community, in the individual's home?)
4. Are you willing to include the person needing support and appropriate family/friends in discussions about support that can be provided? Please describe any circumstances or scenarios where this is not allowed or recommended.

Remember…..if you have any questions, please reach out to Nicole, Tara, Julie, or Laura!!