**Peterborough Carers Wellbeing Service**

Carers Emergency Support Plan (ESP)

**As a carer you may worry about what would happen to the person you care for if you are involved in an emergency. This plan is designed to help you think about who could support you in such circumstances.**

**We encourage you to speak to family, friends and neighbours to help you put the plan together, however if you would like support from one of our Carer Support Workers this can be arranged.**

**Once completed the plan can either be kept in a safe place at home or it can be returned to us to store, and we can then provide support if you need to activate your plan. This support may include ringing emergency contacts on your behalf or helping to arrange small amounts of temporary professional care.**

**Below you will find some advice to help guide you through completing the plan.**

* Complete all sections of your Carers Emergency Support Plan as fully as you can.
* If you need support completing the plan, please contact Peterborough Carers Wellbeing Service:  
  Call: 01480 211006   
  Email: peterboroughcws@makingspace.co.uk
* Please ensure you include enough information to help someone else to take over your caring role in the event of an emergency
* It is important to keep a copy of the plan in a safe place and ensure that other people know where it is kept.
* If you become aware of any changes that need to be made to your plan, please either update your own plan or let us know as soon as possible so that we can make amendments for you.
* If you care for someone who doesn't live with you, ensure that a copy is kept at both addresses.
* Give copies of the plan to people who might need them, for example your emergency contacts or care agencies you currently use.

**Section 1: Personal Details**

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| **Your personal details *(unpaid carer)*** | | | | | | |
| Name: |  | | | | | |
| Address: |  | | | | | |
| Phone number: | Landline: |  | Mobile: |  | | |
| Email: |  | | | | | |
| Date of birth: |  | | | | | |
| Relationship to the person being cared for (e.g. child, parent, spouse): |  | | | | | |
| **Personal details of the person you care for** | | | | | | |
| Name: |  | | | | | |
| Health condition(s): |  | | | | | |
| Address: |  | | | | | |
| Type of property (House, Bungalow, Flat, Supported Living, Other): |  | | | | | |
| Phone number: | Landline: |  | Mobile: |  | | |
| Email: |  | | | | | |
| Date of birth: |  | | | | | |
| GP Practice: |  | | | | | |
| Does the person you care for live alone? | | | | YES | NO | |
| Can they answer the door to visitors? | | | | YES | NO | |
| Do they have a key safe? | | | | YES | NO | |
| If yes, please provide key safe number | | | |  | | |
| Have they agreed that their information can be shared | | | | YES | | NO |
| Health condition/diagnosis: | | | | | | |
| Please provide any other relevant details: | | | | | | |

**Section 2: Emergency contacts**

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| **Please record the contact details for up to three people who have agreed that they can be contacted in the event of emergency to take over care responsibilities.**  **These will usually be family or friends who you trust and who know you and  the person you care for.** |

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| **Name *(person 1)*:** |  | | | | | |
| Relationship to the person being cared for (e.g. family member, friend, neighbour): |  | | | | | |
| Phone number: | Landline: |  | Mobile: |  | | |
| Email: |  | | | | | |
| Have you spoken to them, and have they agreed to be an emergency contact? | | | | | YES | NO |
| Do they have a copy of this plan? | | | | | YES | NO |
| Do they have a key to the property? | | | | | YES | NO |
| What support are they able/willing to help with (e.g. personal care, giving medication, preparation of meals etc.) | | | | | | |

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| **Name *(person 2)*:** |  | | | | | |
| Relationship to the person being cared for (e.g. family member, friend, neighbour): |  | | | | | |
| Phone number: | Landline: |  | Mobile: |  | | |
| Email: |  | | | | | |
| Have you spoken to them, and have they agreed to be an emergency contact? | | | | | YES | NO |
| Do they have a copy of this plan? | | | | | YES | NO |
| Do they have a key to the property? | | | | | YES | NO |
| What support are they able/willing to help with (e.g. personal care, giving medication, preparation of meals etc.) | | | | | | |

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| **Name *(person 3)*:** |  | | | | | |
| Relationship to the person being cared for (e.g. family member, friend, neighbour): |  | | | | | |
| Phone number: | Landline: |  | Mobile: |  | | |
| Email: |  | | | | | |
| Have you spoken to them, and have they agreed to be an emergency contact? | | | | | YES | NO |
| Do they have a copy of this plan? | | | | | YES | NO |
| Do they have a key to the property? | | | | | YES | NO |
| What support are they able/willing to help with (e.g. personal care, giving medication, preparation of meals etc.) | | | | | | |

**Section 3: Information that will help someone else to takeover caring in an emergency**

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| **What does the person you care for need help with?** | | | | | | |
| **Description** | | **✓** | | **Description** | | **✓** |
| Getting up / going to bed | |  | | Getting washed and dressed | |  |
| Using the toilet and bathroom | |  | | Taking their medication | |  |
| Walking / mobility | |  | | Preparing food and drink | |  |
| Eating and drinking | |  | | Emotional support | |  |
| Sight and hearing | |  | | Going to work/college/training | |  |
| **Other (please provide details):** | | | | | | |
| **What is the best way to communicate with the person you care for?** | | | | | | |
| **Could you provide more details about their capacity to understand and make decisions on their own?** | | | | | | |
| **Can the person you care for be left alone during the day, and if so, how often and for how long?** | | | | | | |
| **Can the person you care for be left alone at night, if not please say why not?** | | | | | | |
| **If the person you care for cannot manage at home, it would be helpful to know if there is anyone they could stay with or any respite services they currently access:** | | | | | | |
| **Does the person you care for need support with medication?**  **If yes:** | | | | | | |
| Where is medication/prescription list kept? | | |  | | | |
| Which Pharmacy do you use? | | |  | | | |
| **Please provide details of any health and social care support services the person you care for receives and who provides them.** | | | | | | |
| **Organisation/Agency** | **Description** | | | | **Contact details** | |
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| **Please list any equipment or products that are used in your caring situation, and where they are kept (e.g. continence products, mobility aids, pill dispensers)** | | | | | | |
| **Description** | **Location** | | | | **Supplier** | |
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| **Please provide any other important information which you feel would be important to support the person you care for** | | | | | | |
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| **If you would like Peterborough Carers Wellbeing Service and Peterborough Council to register and store your plan, please complete all sections and send your completed plan to:** |
| **By email**: peterboroughcws@makingspace.co.uk  **By post**: Peterborough Carers Wellbeing Service, Suite 4, The Stables, Church Street, St Neots, Cambridgeshire, PE19 2BU |

**If you need to activate your plan, please contact the**

**team on 01480 211006. Please note if you ring outside of office hours your call will be transferred to a senior manager in Making Space for support. This support will involve using your plan to guide you through accessing support.**