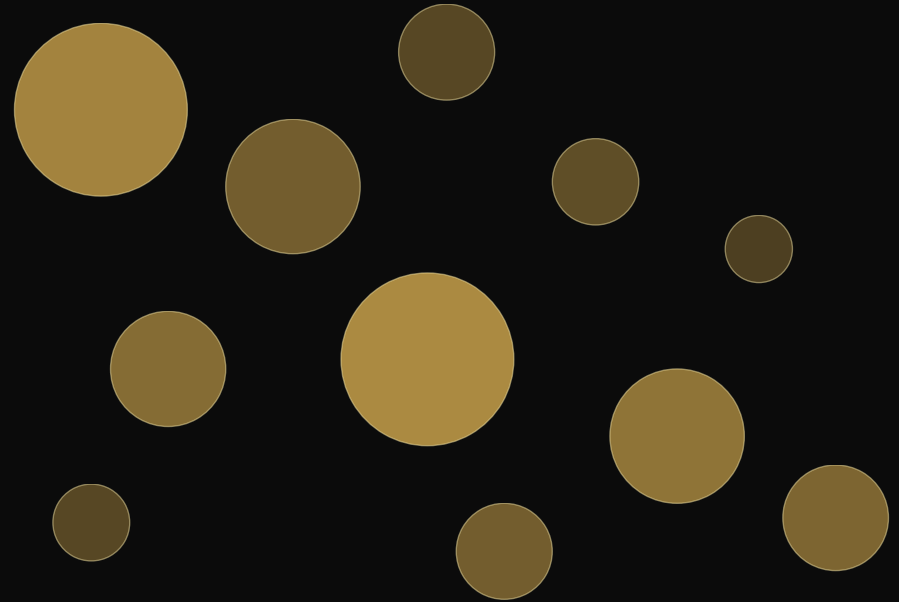


System Breakdown at 8:30 PM

When the primary caregiver suddenly drops out – and nobody knows who stays with the wife who has dementia.

20 : 3

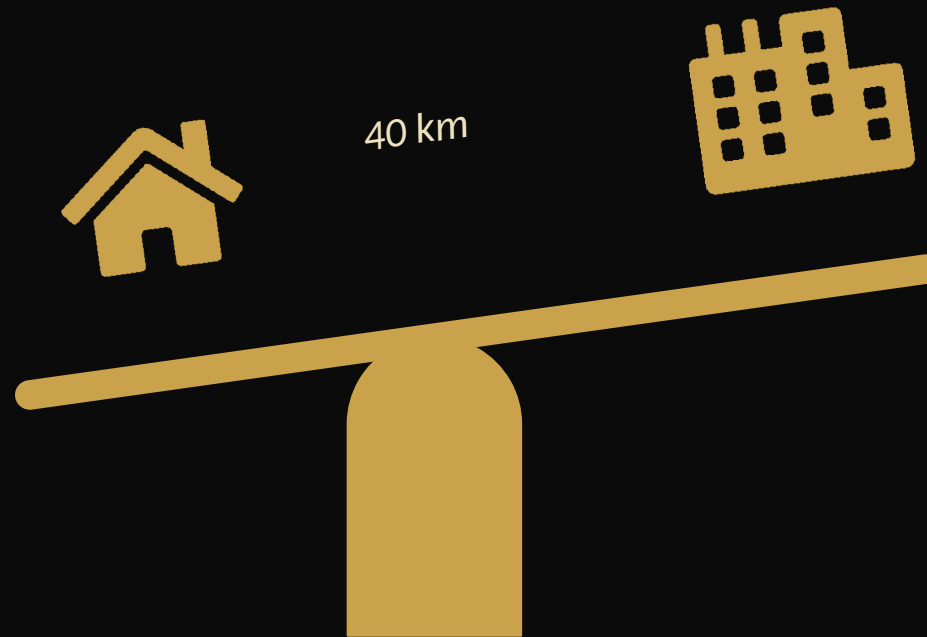


The Invisible Balance

Rural area.

Wife with early-stage dementia.

Husband compensates for all her limitations in daily life.



No outpatient care service.

No reliable support network.

No binding emergency provision.

The **situation** is stable – **until** the **moment** the **only pillar** gives way.

Two Emergencies at the Same Time



The visible emergency: The heart attack. Immediately visible, medically unambiguous and treatable without delay by the ambulance service.

The core question is not just “Who is responsible?”, but: Who recognises that, alongside the medical emergency, a social-care emergency has arisen?



The invisible emergency: The care failure. The collapse of the home care system becomes apparent only at second glance.

The Psychological Inner Perspective



Fear of death & guilt

“What will happen to my wife if I go with them?”
(Danger: he might delay his own life-saving treatment.)



Loss of control & disorientation

Strangers enter the house; her most important anchor is taken away.

Fear, restlessness or refusing help are not “challenging behaviour” this night – they are an understandable panic reaction that calls for dementia-sensitive support.

“She cannot stay alone” is not yet a diagnosis

Dementia



Legal capacity to contract

Concerns the valid conclusion of contracts.
(Wholly secondary in the acute situation.)



Capacity to consent

The ability to understand the meaning,
consequences and risks of a decision. (Can
she accept help voluntarily?)



Practical risk

The nursing-professional ability to stay
physically safe alone for a few hours.

Acute screening questions: Does she understand the situation? Can she call for help? Are there concrete risks of falls or fire?

The Four Levels of Emergency

Type of need (Social/care → Medical)

Need for support.
(Everyday assistance. No acute danger.)

Concrete danger.
The care emergency escalates. Imminent
considerable risk through sudden
solitude.

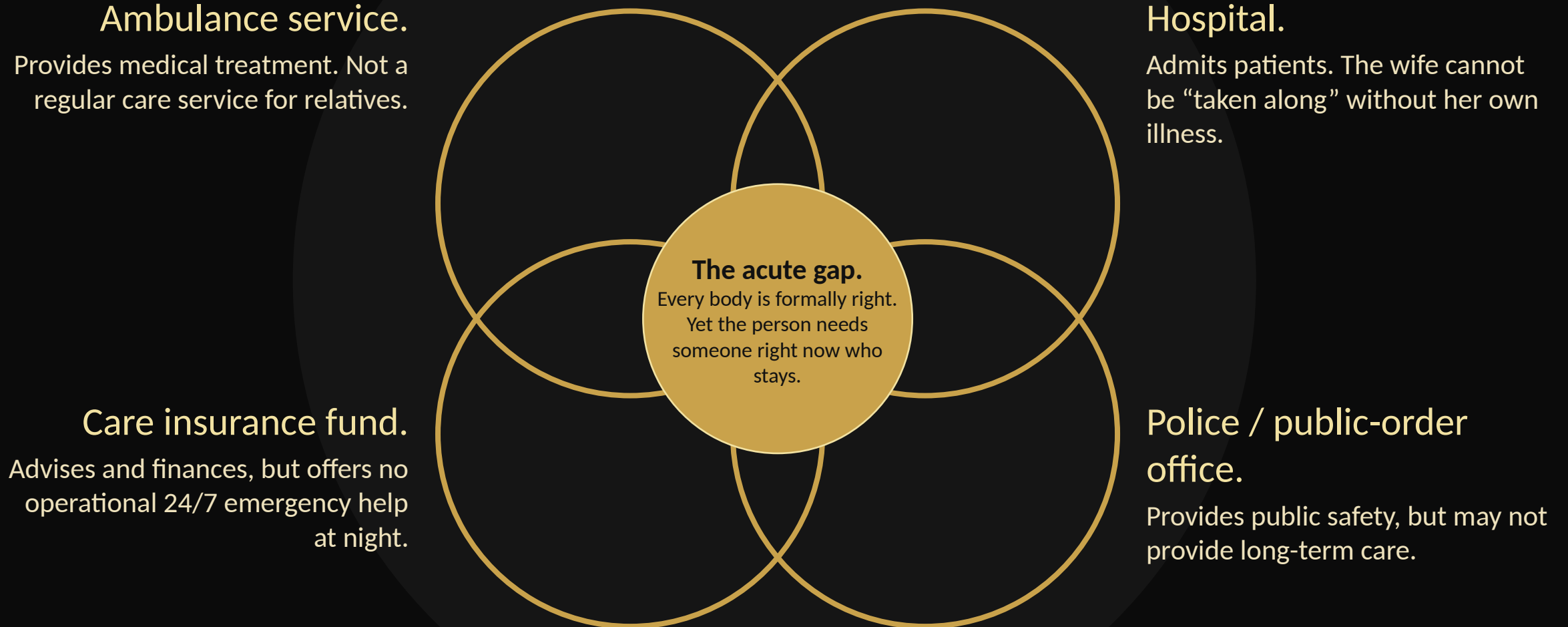
Illness / care.
(Chronic conditions without immediate
danger to life.)

Medical emergency.
(Acute danger to life, e.g. heart attack.)

Acuteness of the threat (Everyday → Acute danger to life)

This night the wife slips from a compensated need for support directly into the official “Concrete danger”.

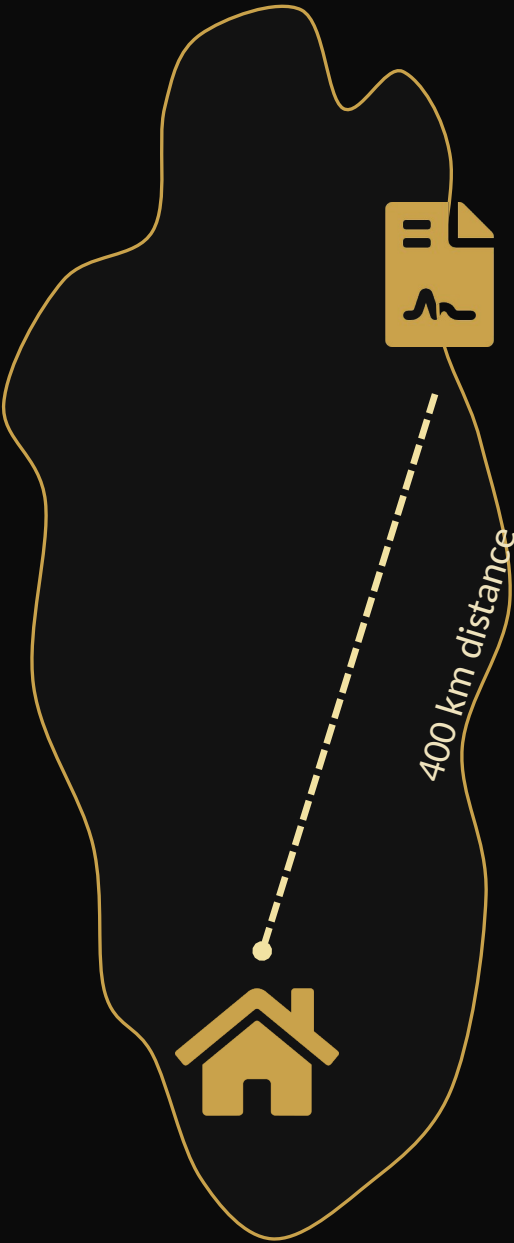
The System of Organised Non-Responsibility



Case variant: The legal guardian lives 400 km away

The ambulance service reaches the appointed guardian by telephone at 8:45 pm.

The illusion	The reality
The problem is now solved, since a “responsible person” with power of representation was found.	A signature creates no physical presence at the bedside and, at 8:45 pm, generates no care places that do not exist.



Delimitation: What the legal guardian really does

✓ Organisation (Within his scope of duties)

- ✓ Share information about the illness.
- ✓ Consent to decisions legally.
- ✓ Contact authorities and services.
- ✓ Initiate social-law care from a distance.

✗ Practical implementation (What he does NOT do)

- ✗ Not care personally or travel as a night watch.
- ✗ Not create a free short-term care place.
- ✗ Not replace missing staff.
- ✗ Not take over the tasks of public safety authorities.

The guardian organises – the local service providers must deliver care.

Course of action over time: The acute phase (8:30 pm until deep into the night)

Phase 1: 8:30 pm

Initial assessment (8:30 – 9:00 pm)

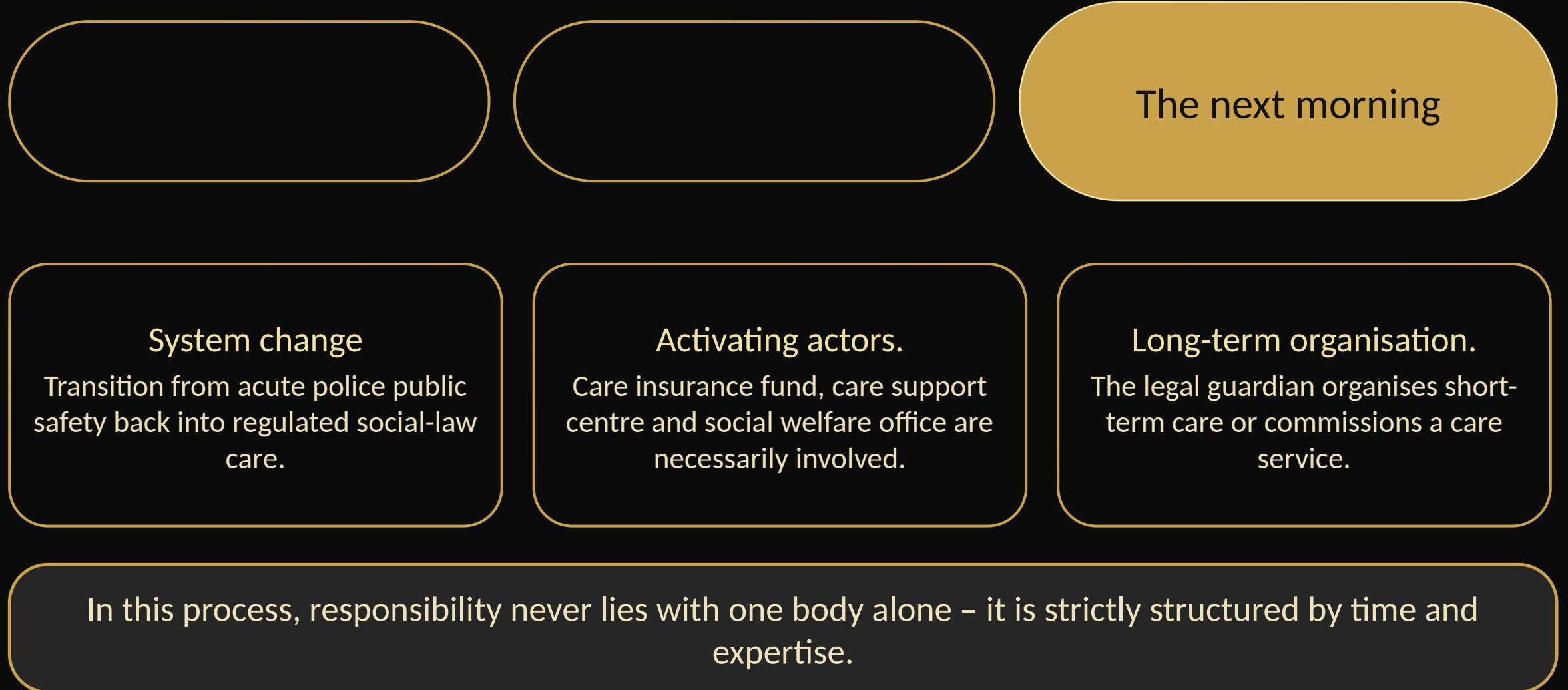
- Medical focus on the husband.
- Duty to report the second emergency to the dispatch centre.
- Activating the network (guardian, neighbours).

Phase 2: The night

Public safety (The night)

- If the private network fails, responsibility passes to the state.
- Police/public-order office secures the scene physically (aim: provisional safety, not care).

Course of action over time: Phase 3 – The social-law handover



The Limits of Social Law at 8:30 pm

§ 7a SGB XI (Care counselling)

Draws up care plans by day,
but is not an overnight
response service.

§ 42 SGB XI (Short-term care)

Finances accommodation,
but physically helps only if a
bed in the region is actually
free.

§ 39c SGB V (Without care level)

Does not apply! The law
requires that the person to
be admitted is herself
seriously ill – here,
however, the husband
suffers the heart attack.

A legal entitlement to a benefit guarantees no available bed and no physical professional at 8:30 pm.

Real solution model: The resilient crisis plan

A guardian at a distance needs instruments that work locally, ***before*** the crisis occurs:

- ✓ **Key arrangement:** Deposited key or code safe.
- ✓ **Local contacts:** At least two reachable people close to her, living nearby.
- ✓ **Advance agreements:** Binding contact with care services for emergency call-outs.
- ✓ **Residential backup:** List of short-term care facilities contacted in advance.
- ✓ **Medical data:** Immediately available list of diagnoses, medication and orientation aids.

Concrete demands on a functioning system

Regional security of care

24/7 dementia emergency help.

Integrated municipal crisis services (following the Hamburg model) that close the night-time gap between medicine and police.

Guaranteed emergency places.

Designated short-term care beds strictly reserved for unforeseeable failures of family carers.

Binding protocols.

Clear alert routes between dispatch centre, state public safety and guardianship authorities, so that no one falls through the net.

The net must be woven before 8:30 pm

Care counselling, medical care, legal representation and public safety are entirely different tasks. None of these bodies can spontaneously replace the others in a night-time crisis. Only when these isolated systems are foresightedly woven into a binding regional network does real security arise for those who can no longer help themselves.

#CareEmergency #LegalGuardianship #SecureCare #Dementia