

WISSENSRAUM NO. 5

SYSTEM BREAKDOWN AT 8:30 PM – WHEN THE PRIMARY CAREGIVER DROPS OUT

A case study from home care: heart attack and dementia

“Between legal representation, public safety and practical care, no one may be lost.”

AKADEMIE DER WEISHEIT — WISSENSRÄUME

◆ 1. Introduction — The Second Emergency Nobody Sees

A heart attack is visible at once. The collapse of a care system is not.

In many households, home care rests on a single person. That person balances, reminds, organises and holds everything together – so naturally that no one speaks of “care” any more. As long as this pillar holds, the situation looks stable. When it gives way, a situation arises within minutes for which no single party is responsible.

This Wissensraum examines such a moment as a case study: a husband suffers a heart attack in the evening, his wife with early-stage dementia cannot be left alone, and her legal guardian lives 400 kilometres away. The text combines the perspectives of guardianship law, social law, nursing practice and psychology. It does not first ask: Who is responsible? It asks: **Who recognises that, alongside the medical emergency, a second, social-care emergency has arisen – and who actually stays with the wife?**

“Between legal representation, public safety and practical care, no one may be lost.”

◆ 2. The Case at 8:30 pm — the Invisible Balance

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

An elderly couple lives in the countryside; the nearest larger town is about 40 kilometres away. The wife lives with early-stage dementia. Her husband accompanies her through daily life and compensates for what is becoming harder for her. No outpatient care service is involved, no reliable support network exists, and no binding provision was made for the husband dropping out.

At 8:30 pm the husband suffers a heart attack. The ambulance service arrives; he must be treated immediately and taken to hospital. **But the wife cannot be left alone.**

The example is deliberately ordinary. It needs no exceptional circumstances, only one person on whom everything depends. The federal state and district are not named in the case; local responsibilities must therefore be read as a matter of state law and municipal organisation.

♦ 3. Two Emergencies at Once — the Four Levels

The medical emergency is unmistakable. The care emergency becomes visible only at second glance.

The heart attack triggers an established rescue chain. For the wife who remains behind, there is no comparable process. She easily becomes a footnote to an operation that – understandably – focuses on the patient.

A classification in four levels helps. **Need for support:** everyday assistance, no acute danger. **Illness and care:** chronic conditions without immediate danger to life. **Concrete danger:** the care emergency escalates, and a considerable risk arises, for example through sudden solitude. **Medical emergency:** acute danger to life, as with the heart attack.

This evening the wife slips from a need for support – which her husband had invisibly compensated for – to the brink of the level “concrete danger”. Whether she truly reaches it is decided by the initial assessment (chapter 5).

♦ 4. The Inner Perspective — Security Gives Way on Both Sides

Fear is not a disorder here, but an understandable response.

The husband carries, besides fear of death and physical threat, a second burden: What will happen to my wife if I go with them? He might want to delay his own treatment, feel guilt although he is gravely ill himself, or try from within the ambulance to organise all her care. It relieves him when concern for his wife is explicitly taken over and said aloud: “We will take care of it.”

For the wife, the evening looks entirely different. Strangers enter the house, her husband is treated and taken away, and no one can reliably tell her when he will return. Fear, restlessness, repeated questions, refusal of help or an attempt to follow the ambulance should not be hastily classified as “challenging behaviour” in this situation. They can be an expression of an acute reaction of fear and of being overwhelmed by a situation the woman can no longer adequately make sense of.

Dementia-sensitive support this night means, first of all, that only one person speaks to her, as calmly as possible, in short, concrete sentences, repeated as needed. Her fear is neither belittled nor talked away. Familiar things stay with her – glasses, hearing aid, medication and familiar objects – and unnecessary changes of place and person are avoided. At the same time her basic

needs are checked: toilet, drinking, eating, warmth, pain and rest. And it takes a close look, because a sudden change in her condition must not be hastily attributed to dementia; delirium or an infection may lie behind it.

How behaviour in dementia can be understood is explored further in Wissensraum No. 1 — Navigation Atlas Dementia – Forms, Causes & Holistic Care.

◆ 5. “She Cannot Stay Alone” Is Not Yet a Diagnosis

Early-stage dementia does not automatically mean complete helplessness.

The diagnosis answers neither the question of decision-making capacity nor that of acute danger. Three terms must not be mixed up. **Legal capacity to contract** concerns the valid conclusion of legal transactions and is secondary in an acute situation. **Capacity to consent** describes the ability to understand the meaning, consequences and risks of a specific decision; it is situation-specific and can fluctuate. **Practical risk**, finally, is a question of nursing expertise: Can this woman safely stay alone for a few hours?

In the acute situation, a few concrete screening questions therefore help. Does she understand what is happening to her husband, and can she grasp what being left alone means? Can she use the telephone and call for help, and does she find her way around the home? Can she safely handle the stove, heating and front door, or are there risks of falls, fire or wandering? Does she need medication at particular times? And can she name a trusted person and agree to temporary support?

The ambulance service can make a first risk assessment. A dementia-diagnostic, nursing or guardianship-law examination, however, cannot be expected from anyone during a heart-attack call-out. The assessment must therefore be passed on rather than completed at the scene. How self-determination, protection and law fit together in dementia is set out in Wissensraum No. 1.

◆ 6. The System of Organised Non-Responsibility

Every body is formally right – yet the wife needs, at once, a person who stays.

All parties act correctly in this case and yet leave a gap open. The ambulance service is there for the patient, not for his relatives. It treats the husband, coordinates further help and receives the report about the wife left behind, but it is not a care service for relatives and takes on no long-term care. The hospital admits people who need treatment, not those who need care: the wife

cannot be “taken along” without needing treatment herself, and the hospital is no substitute for a care place.

The care insurance fund and care counselling advise, plan and finance defined benefits, but are regularly not an overnight response service – an entitlement does not create an immediately available place. Local public safety, depending on the state the police, the public-order office or a crisis service, assesses a concrete danger and secures the situation provisionally; its responsibility and means depend on state law, and it does not provide care. And the legal guardian, if one has been appointed, represents legally, organises and decides within the assigned scope of duties, but brings neither physical presence nor nursing nor a free place.

Each of these bodies fulfils its task – and yet, this night, the wife is left without a person who is with her. The gap lies not with a single body, but between them.

“The gap lies not with a single body, but between them.”

◆ 7. The Legal Guardian Lives 400 Kilometres Away

Appointing a guardian does not replace presence.

The case is extended: a legal guardian (rechtlicher Betreuer) has been appointed for the wife, and the ambulance service reaches him by telephone at 8:45 pm. The obvious hope is that the problem is now solved, since there is a “responsible person”. The reality is sobering: a guardian creates neither presence nor care places that do not exist. First it must be clarified which areas of responsibility the guardianship court has assigned – he may act legally only within these.

What he can do: share information about the illness and the wife’s wishes, name people close to her, communicate with authorities, services and facilities, conclude contracts within his scope of duties and organise follow-up care. **What he cannot do:** create a free care place, compel a service to take over at once, replace missing staff, take over the tasks of public safety authorities, travel 400 kilometres as a matter of course and spend the night with her – and decide against the wife’s will automatically.

Distance does not, however, release him from his duties: he must maintain personal contact and discuss matters with the person under guardianship (§ 1821 German Civil Code, BGB). If he knows that the entire home care depends on a spouse whose health is at risk, a contingency plan is part of careful guardianship, provided the scope of duties covers it. Whether a breach of duty exists in an individual case cannot be judged by distance alone. If it becomes evident over time that matters cannot be properly managed from afar, the guardianship authority and the

guardianship court can be involved; under certain conditions the court can appoint several guardians or a substitute guardian (§ 1817 BGB).

“The guardian organises – the service providers deliver care.”

♦ 8. Without a Legal Guardian — the Initial Variant

If any form of representation is missing, the wife initially remains entitled to decide for herself.

In the initial variant of the case there is neither a legal guardian nor – as assumed here – a valid power of attorney for care matters. Dementia deprives the wife neither automatically of her legal capacity nor of her right to self-determination. If she can grasp the situation and express her will, a voluntary solution may be organised only with her consent: care at home, being taken in by a trusted person, a support service or voluntary short-term residential care.

If, because of illness, she cannot manage necessary matters herself, this creates no automatic power of representation for relatives, ambulance service, police or nursing staff. The spouse’s emergency representation right (§ 1358 BGB) regularly does not help here either: it is limited to certain health-care matters and is time-limited, and the husband, because of his heart attack, is himself unable to act. If legal decisions are needed at once, the guardianship court is informed. In urgent cases it can appoint a provisional guardian, in case of imminent danger even before the personal hearing, which must then be held without delay (§§ 300, 301 Act on Proceedings in Family Matters, FamFG). This guardian can decide legally and organise help – but he does not produce a free place or an available carer.

Until that decision, the ambulance service treats the husband and reports the care gap to the dispatch centre. The wife is recorded as a case in her own right; her will, decision-making capacity and the concrete risk are assessed. In case of acute considerable danger, the local public safety authority is called in, and if she herself needs medical help, she is examined and, if necessary, taken to hospital. Without concrete danger and without her consent, however, compulsory placement solely because of missing care is not permissible.

How power of attorney, advance directive and spousal emergency representation interact is set out in Wissensraum No. 4 — Palliative Care 2026 – The Architectural Foundation.

◆ 9. The Course of Action in Three Phases

Responsibility never lies with one body alone – it is structured by time and expertise.

The first phase is the initial assessment (roughly 8:30 to 9:00 pm). The ambulance service treats the husband without delay. The crew reports the wife left behind to the dispatch centre as a second emergency; how this report is bindingly regulated follows from state law and local service instructions. On site, a rough assessment is made: is there a concrete danger? At the same time, the legal guardian is reached in order to activate the private network.

The second phase is public safety (the night). If the private network fails and a concrete danger exists, the dispatch centre calls in the locally responsible public safety authority – police, public-order office or crisis service, where reachable and responsible. The aim is a provisionally safe situation, not long-term care.

The third phase is social-law care (the next morning). Now the task is the transition from acute public safety back into regulated care: the care insurance fund, the care support centre and, where appropriate, the social welfare office are involved; the guardian organises short-term residential care or commissions an outpatient service.

Public safety does not mean that the police become carers. The responsible body assesses the danger and establishes a proportionate provisional solution; it does not owe permanent night-time care. The guardian contributes to the decisions from a distance.

◆ 10. What Social Law Provides — and What It Does Not

An entitlement to a benefit is not yet a guarantee that it is available the same night.

Care counselling (§ 7a Book XI of the Social Code, SGB XI) can assess needs, draw up an individual care plan and coordinate help. It is an essential part of preparation and follow-up planning, but regularly not an overnight response service.

Respite care and short-term residential care (§§ 39, 42 SGB XI) have been available since 1 July 2025 from a joint annual amount of up to €3,539 (§ 42a SGB XI), from care level 2 and for a maximum of eight weeks per calendar year for each benefit. If the caregiver drops out, respite care at home or short-term care in a facility comes into consideration. Both help, however, only if a replacement carer or a place is actually available. If the wife has no care level or only care level 1, it cannot be taken for granted that care insurance will immediately finance short-term care.

§ 39c Book V of the Social Code (SGB V) (short-term care in the absence of a need for care) is not a general safety net. The health insurance fund pays only if the person to be admitted is herself seriously ill or her illness has acutely worsened and home nursing is not sufficient. The husband's heart attack therefore establishes no entitlement for the wife. **Assistance with care** under SGB XII may also come into consideration, but requires a social-law assessment and does not provide a carer at 8:30 pm.

This text reflects the position at the beginning of October 2026. On 30 September 2026 the Federal Cabinet adopted the draft of the Care Reorganisation Act (Pflegeneuordnungsgesetz, PNOG). The legislative process has not yet been completed; the legal position described here therefore remains decisive. Current amounts are provided by the care insurance fund and the care support centre. An overview of care insurance benefits is in Wissensraum No. 1.

◆ 11. The Honest Worst Case

The worst case is not compulsory placement, but the gap without a legal basis.

The worst case arises when there is considerable need for care but as yet no concrete danger, no consent from the wife to a voluntary solution and no available care. Then there is no nationwide uniform immediate solution.

Legally the position is clear, even if it feels unsatisfactory. The wife may not be placed against her will solely because of the dementia diagnosis, her husband's absence or a missing care place. Placement involving deprivation of liberty requires special statutory conditions: under the state placement laws in case of considerable danger; by a guardian only with an expressly assigned scope of duties and in principle with the approval of the guardianship court (§ 1831 BGB); in urgent cases the court can order a provisional measure (§ 331 FamFG). Nor may the hospital serve as a substitute for a missing care place.

What remains is the least intrusive help that is actually available: the husband is treated, the wife is recorded as a case in her own right, her risk and her will are assessed, and the acute danger is limited on site as far as possible. The case is passed on the same evening to the guardianship authority and the guardianship court and pursued bindingly on the next working day. In the worst case, the wife initially remains at home with only makeshift safeguards. **This is exactly where the real care gap shows.**

◆ 12. Regional Models and Seven Building Blocks

A different structure is possible.

Some regions show which building blocks a support system can contain. **Hamburg** operates a care emergency telephone line available around the clock, which explicitly also addresses situations in which a caregiver suddenly drops out. It combines a central number, professional assessment, practical bridging through a one-off care-service visit and a reserved emergency place in short-term care. In **Oldenburg**, care planning, the Alzheimer Society, the care support centre and other partners have developed a guidance document that leads from the acute situation to applying for a care level – no night service, but a shared regional framework for action. **Berlin** and **Bavaria** run crisis services around the clock for psychological and psychiatric crises, which can also help on site if needed. They are not a general care emergency service and do not replace missing care provision.

The models are not directly comparable. From the case and the examples, a model of seven building blocks nevertheless emerges. At the beginning stands a **contact point**, available around the clock, regionally anchored and responsible for care emergencies. It carries out a joint **initial assessment** of medical risk, care needs, decision-making capacity and concrete danger. A **mobile service** bridges the first hours in the home, and **emergency places** are bindingly available instead of non-binding telephone lists. A current, digital **capacity overview** shows free outpatient and inpatient places. On the next working day a standardised **handover** takes place to care counselling, care insurance fund, social welfare provider and guardian. And finally, every household whose care rests mainly on one person needs a **contingency plan**.

In rural areas it would additionally have to be settled which service covers what distance, who provides transport, how long the journey may take, who stays with the person until arrival and how short-term funding is clarified. Three demands follow: **integrated municipal crisis services** that close the night-time gap between medical emergency and public safety; **designated short-term care beds** strictly reserved for unforeseeable failures of family carers; and **binding alert routes** between dispatch centre, public safety authorities and guardianship authorities, so that no one falls through the net.

◆ 13. The Resilient Crisis Plan — Preparation Begins Before the Power of Attorney

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

An advance directive does not answer who spends the night with the wife. A power of attorney creates authority to represent, but no local support network. Legal guardianship enables legal action, but not constant presence. A genuine emergency plan therefore contains at least a **key arrangement**, such as a deposited key or key safe with a local person, and **local contacts** – at least two people close to her who live nearby and can be reached.

To this come **advance agreements** with a known care or support service that provide for a night-time solution, and a **residential backup**: a list of short-term care facilities already contacted, together with a transport plan. The **medical data** – current medication plan, diagnoses, and notes on communication and habits – are immediately to hand, as are the **documents** such as powers of attorney and guardianship papers in a known place. Last, there needs to be **case management**, that is, clear information on who takes over the case after the first emergency day.

The plan is not a document for the drawer. It is discussed together, kept up to date and made known to the people who are to act in an emergency. Its questions are simple, and they must be answered before the emergency.

“Who has the key? Who comes? Where to?”

◆ 14. Conclusion — Weaving the Net Before 8:30 pm

The wife does not live in fragments.

The case does not show that nobody is responsible. It shows that many bodies are responsible for individual fragments: the ambulance service for the heart attack, public safety for a concrete danger, the guardian for legal matters, the care insurance fund for defined benefits, care counselling for care planning and the service providers for the actual care. But at 8:30 pm the wife needs no catalogue of responsibilities. She needs a responsible interface that recognises, decides, connects and triggers concrete help.

The attitude can be summed up in three sentences. **I see two people** – not one case and one footnote. **I separate what must be separated** – diagnosis, decision-making capacity and danger. **I make sure someone stays** – responsibility becomes help only when a person is there.

The final question is therefore not only: Who is responsible? But: Why does the answer to a foreseeable care emergency still depend on the federal state or district in which a person lives? A foreseeable care emergency must not be organised only once the sole caregiver is already lying in the ambulance. Care counselling, medical care, legal representation and public safety are different tasks – only together do they become security.

| *“The net must be woven before 8:30 pm.”*

∞ Further Exploration

Those who wish to pursue the questions touched on here will find adjacent explorations in the WISSENSRÄUME series:

- Wissensraum No. 1 — Navigation Atlas Dementia – Forms, Causes & Holistic Care
- Wissensraum No. 4 — Palliative Care 2026 – The Architectural Foundation
- Wissensraum No. 6 — Survival Is Not a Cure

◇ Sources & Lines of Thought

This Wissensraum does not make a scientific argument. The following works show the legal and professional lines of thought to which its central statements connect — above all those of chapters 5, 7, 8, 10 and 11.

- German Civil Code (Bürgerliches Gesetzbuch, BGB): §§ 1358, 1817, 1821, 1831. Spousal emergency representation, substitute guardian and several guardians, the guardian's personal contact, approval of placement involving deprivation of liberty.
- Act on Proceedings in Family Matters and in Matters of Non-Contentious Jurisdiction (FamFG): §§ 300, 301, 331. Provisional appointment of a guardian and interim measures in case of imminent danger.
- Social Code (SGB) XI, Social Long-Term Care Insurance: §§ 7a, 39, 42, 42a. Care counselling, respite care, short-term care and the joint annual amount; legal position as of October 2026.
- Social Code (SGB) V, Statutory Health Insurance: § 39c. Short-term care in the absence of a need for care and its conditions.
- Social Code (SGB) XII, Social Assistance: Chapter 7 (assistance with care). Subsidiary benefits in case of a need for care.
- Federal Ministry of Health (Bundesministerium für Gesundheit): press release “Kabinett beschließt Pflege neuordnungsgesetz” (Cabinet adopts Care Reorganisation Act). 30 September 2026. Government draft; legislative process not yet completed.
- DGPPN, DGN: S3 Guideline “Dementia” (Demenzen). AWMF register no. 038-013, current version. On behavioural changes in dementia, on delirium and physical causes, and on person-centred accompaniment.
- Regional practice models: care emergency telephone line Hamburg, guidance for care emergencies in Oldenburg, crisis services Berlin and Bavaria. In each case as presented by the local providers.

○ WISSENSRÄUME — Appreciation

The WISSENSRÄUME series is a labour of love — free of charge, but not to be taken for granted. If these impulses have meant something to you and you would like to give something back, I welcome a voluntary donation: [PayPal.me/VossKati](https://paypal.me/VossKati)

Thank you for your appreciation. It helps such content continue to come into being — quietly, lovingly, and in the service of wholeness.

△ WISSENSRÄUME — Notes

The WISSENSRÄUME serve professional orientation, deepening and personal engagement with themes from health, nursing, palliative care, spiritual care, psychology and philosophy. They do not replace individual medical, therapeutic, nursing or legal advice — for acute or serious concerns, please turn to appropriately qualified professionals.