

Continence care plan

for education, child/care and community support services*

CONFIDENTIAL

To be completed by the TREATING HEALTH PROFESSIONAL and the PARENT/GUARDIAN and/or ADULT STUDENT/CLIENT.
This information is confidential and will be available only to supervising staff and emergency medical personnel.

Name of child/student/client _____ Date of birth _____
Family name (please print) First name (please print)

MedicAlert Number (if relevant) _____ Date for next review _____

Routine personal care/supervision for safety

Support time needed

disruption to the child/student/client's socialisation and participation.

- | | |
|--|--|
| <input type="checkbox"/> Indicates when toilet is needed | <input type="checkbox"/> May need to be changed |
| <input type="checkbox"/> Needs timing | <input type="checkbox"/> Will always need to be changed/assisted |
| <input checked="" type="checkbox"/> Has continence aids (eg wears nappies or has catheter) | |

Generally support will take about _____ minutes _____ times each day.

Nature of support

This person is likely to need support related to:

- | | |
|---|---------------------------------|
| <input checked="" type="checkbox"/> Self-managed toileting (Please describe) | |
| <input checked="" type="checkbox"/> Reminders | <input type="checkbox"/> Timing |
| <input checked="" type="checkbox"/> Encouragement with fluid intake | <input type="checkbox"/> Other |

- | | | |
|---|--|--|
| <input checked="" type="checkbox"/> Assisted toileting (Please describe) | | |
| <input checked="" type="checkbox"/> Verbal prompts | <input type="checkbox"/> Assistance with clothing | <input type="checkbox"/> Assistance with washing hands |
| <input checked="" type="checkbox"/> Supervision | <input type="checkbox"/> Support to weight-bear | <input type="checkbox"/> Support for transfers |
| <input checked="" type="checkbox"/> Encouragement with fluid intake | <input type="checkbox"/> Assistance with hygiene (eg cleaning body, menstruation management) | |
| <input checked="" type="checkbox"/> Lifting onto toilet | <input type="checkbox"/> Other | |

- | | |
|---|---|
| <input checked="" type="checkbox"/> Catheterisation (Please describe) | |
| <input checked="" type="checkbox"/> Programs which allow for catheterisation at (specify preferred times) _____ | |
| <input checked="" type="checkbox"/> Self-managed | <input type="checkbox"/> Self-catheterises with supervision |
| <input checked="" type="checkbox"/> Other (eg visiting health service) | |

Continence supplies

Equipment/continence aids that are required _____

Location of equipment/continence aids _____

Emergency contact for supplies _____

Unplanned events

Are there any events, not covered in this plan, which could happen infrequently? If so, please give details of what could be expected and how it could be managed (*eg person is usually continent but could wet or soil occasionally; can change and clean up independently but will need reassurance*).

Staff will contact the parent/emergency contact if the person displays signs of possible difficulties such as sweating, discomfort, is flushed or pale, or has a headache.

Catheter management

If a person is self-managing his or her catheter and has difficulty, staff will routinely:

- *reassure the person and encourage him or her to relax and try again*
- *suggest the person wait for half an hour and come back and try again.*

If the person is still not successful, the parent/emergency contact will be informed. A health professional can be nominated by the family as the emergency contact person in this case. Staff will also contact the parent/emergency contact if the person displays signs of possible difficulties such as sweating, discomfort, is flushed or pale, or has a headache.

If no-one can be contacted, an ambulance may be called to transport the person to medical assistance.



Please nominate emergency contact and any different/additional steps in relation to this person’s catheter management.

Additional information attached to this care plan

- Medication authority
- Individual emergency plan (if different to standard first aid)
- General information about this person’s condition
- Other (please specify) _____

This plan has been developed for the following services/settings: *	
<input type="checkbox"/> School/education <input type="checkbox"/> Child/care <input type="checkbox"/> Respite/accommodation <input type="checkbox"/> Transport	<input type="checkbox"/> Outings/camps/holidays/aquatics <input type="checkbox"/> Work <input type="checkbox"/> Home <input type="checkbox"/> Other (<i>please specify</i>)
AUTHORISATION AND RELEASE	
Health professional _____ Professional role _____ Address _____ _____ Telephone _____ Signature _____ Date _____	
<p><i>I have read, understood and agreed with this plan and any attachments indicated above. I approve the release of this information to supervising staff and emergency medical personnel.</i></p> Parent/guardian or adult student/client _____ Signature _____ Date _____ <small style="display: flex; justify-content: space-around; width: 100%;"> Family name (please print) First name (please print) </small>	