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.

- ☐ *Indicates when toilet is needed*
- ☐ *Needs timing*
- ☐ *Has continence aids (eg wears nappies or has catheter)*
- ☐ *May need to be changed*
- ☐ *Will always need to be changed/assisted*

Generally support will take about______________ minutes ________________times each day.

Nature of support

This person is likely to need support related to:

☐ **Self-managed toileting** (*Please describe*)

- ☐ *Reminders*
- ☐ *Encouragement with fluid intake*
- ☐ *Timing*
- ☐ *Other*

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☐ **Assisted toileting** (*Please describe*)

- ☐ *Verbal prompts*
- ☐ *Supervision*
- ☐ *Encouragement with fluid intake*
- ☐ *Lifting onto toilet*
- ☐ *Assistance with clothing*
- ☐ *Support to weight-bear*
- ☐ *Assistance with hygiene (eg cleaning body, menstruation management)*
- ☐ *Other*
- ☐ *Assistance with washing hands*
- ☐ *Support for transfers*

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☐ **Catheterisation** (*Please describe*)

- ☐ Programs which allow for catheterisation at *(specify preferred times)* ______________________
- ☐ *Self-managed*
- ☐ *Other (eg visiting health service)*
- ☐ *Self-catheterises with supervision*

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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*).

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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.

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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: *

☐ School/education	☐ Outings/camps/holidays/aquatics
☐ Child/care	☐ Work
☐ Respite/accommodation	☐ Home
☐ Transport	☐ Other *(please specify)*

AUTHORISATION AND RELEASE

Health professional ____________________ Professional role ____________________

Address ______________________________

______________________________ Telephone ____________________

Signature ______________________________ Date ____________________

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.

Parent/guardian
or adult student/client ____________________ Signature ____________ Date ____________
Family name (please print) First name (please print)