



Government
of South Australia

Continence Care Plan

for education and care

CONFIDENTIAL

To be completed by the parent or legal guardian.

Please note children requiring invasive health support (catheter, colostomy care) require a continence care plan completed by a health professional and referral to AAP

This information is confidential and will be available only to relevant staff and emergency medical personnel.

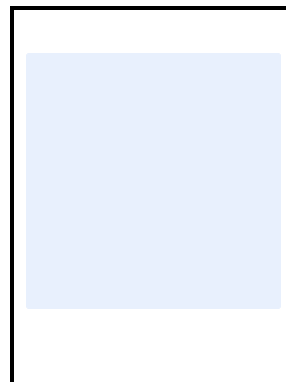
Name of child/young person:

DOB:

Review date:

Allergies:

Education or care service:



ROUTINE PERSONAL CARE AND SUPERVISION FOR SAFETY

Support time needed

Disruption to the child or young person's socialisation and participation in curriculum if total support time is greater than 30 minutes per day

Generally will take about minutes times each day

<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 type="checkbox"/>	Has continence aids (ie nappy/catheter)		

Nature of support

This child or young person is likely to need support related to:

<input type="checkbox"/>	Self-managed toileting		
<input type="checkbox"/>	Reminders	<input type="checkbox"/>	Timing
<input type="checkbox"/>	Encouragement with fluid intake	<input type="checkbox"/>	Other

Provide further detail:

☐ Assisted toileting (to be provided in accordance with Child protection in schools, early childhood education and care policy)

<input type="checkbox"/>	Verbal prompts	<input type="checkbox"/>	Assistance with clothing	<input type="checkbox"/>	Assistance with washing hands
<input type="checkbox"/>	Supervision	<input type="checkbox"/>	Encouragement with fluid intake	<input type="checkbox"/>	Assistance with hygiene (cleaning, menstrual mngmnt)
<input type="checkbox"/>	Support to weight-bear*	<input type="checkbox"/>	Lifting onto toilet*	<input type="checkbox"/>	Support for transfers*

*Must have transfer and positioning care plan if this box is ticked

<input type="checkbox"/>	Other
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Provide further detail:

☐ Catheterisation

Programs which allow for catheterization at (specify preferred times)

<input type="checkbox"/>	Self-managed	<input type="checkbox"/>	Self-catheterises with supervision*	<input type="checkbox"/>	Other (eg visiting health service) *
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*Referral to Access Assistant Program is required if this box is ticked

Provide further detail:

HSP230

CONTINENCE CARE PLAN

Health Support Planning



CONTINENCE SUPPLIES

Equipment or continence aids required:

Location of equipment/continence aids:

Emergency contact for supplies:

ADDITIONAL INFORMATION

UNPLANNED EVENTS

Describe any events, not already covered in this plan that may happen infrequently. Provide details of the unplanned event (what could be expected) and what action is required, or how this could be managed.

UNPLANNED EVENT

i.e. usually continent but could occasionally wet or soil

⇒

⇒

can change and clean up independently but will require reassurance

⇒

⇒

⇒

⇒

ACTION OR MANAGEMENT

AUTHORISATION AND AGREEMENT

(To be signed after form has been completed)

The following settings have been considered in the development of the health care plan and is appropriate for use in the following:

<input type="checkbox"/>	Children's centre, preschool or school	<input type="checkbox"/>	Childcare, Out of School Hours Care
<input type="checkbox"/>	Camps, excursions, special event, transport (incl. aquatics)	<input type="checkbox"/>	Work experience or other education placement
<input type="checkbox"/>	Respite, accommodation	<input type="checkbox"/>	Work
<input type="checkbox"/>	Other (specify)	*Note, it is not safe to provide continence care during transport	

Treating health professional

(print name & practice/hospital or stamp)

Professional role

Email or signature

Telephone

Date

Parent or legal guardian; or adult student

- I understand and agree with the health care plan as indicated above
- I approve the release and sharing of this information to supervising staff and emergency medical staff (if required).
- I understand staff may seek additional information and/or advice regarding the medical information contained in the individual first aid plan from the Access Assistant Program (AAP) to inform duty of care.

(name)

(relationship)

(email or signature)

(date)

REVIEW

This continence care plan remains current until superseded due to different management being required.
Parent/ guardian/ adult student to sign every 12 months to confirm that this continues as the current plan.

Date	Name	Relationship	Email or Signature
(date)	(name)	(relationship)	Email or signature
(date)	(name)	(relationship)	Email or signature
(date)	(name)	(relationship)	Email or signature

