This form is developed in partnership and has co-ownership with the South Australian Department for Education and the Department for Health and Wellbeing, Women's and Children's Health Network

Government of South Australia

Continence Care Plan

for education and care

CONFIDENTIAL

HSP230

To be completed by the treating health professional and parent or legal guardian.

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

☐	Indicates when toilet is needed	☐	May need to be changed
☐	Needs timing	☐	Will always need to be changed / assisted
☐	Has continence aids (ie nappy/catheter)		

Nature of support

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

☐ Self-managed toileting

	☐	Reminders	☐	Timing
	☐	Encouragement with fluid intake	☐	Other

Provide further detail:

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

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

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

☐ Other

Provide further detail:

☐ Catheterisation

Programs which allow for catheterization at *(specify preferred times)*

	☐	Self-managed	☐	Self-catheterises with supervision*	☐	Other (eg visiting health service) *

*Referral to Access Assistant Program is required if this box is ticked

Provide further detail:

CONTINENCE SUPPLIES

Equipment or continence aids required:

CONTINENCE CARE PLAN

Health Support Planning

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	ACTION OR MANAGEMENT
ie usually continent but could occasionally wet or soil	can change and clean up independently but will require reassurance

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:

☐	Children's centre, preschool or school	☐	Childcare, Out of School Hours Care
☐	Camps, excursions, special event, transport (incl. aquatics)	☐	Work experience or other education placement
☐	Respite, accommodation	☐	Work
☐	Other (specify)	*Note, it is not safe to provide continence are 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)