H&H Care SA Pty Ltd	Form19. Personal Care and Continence Australian Government Support at Home Program		
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Policy and procedure 19
H&H Care SA Pty Ltd | Support at Home services

This policy sets out how H&H Care SA provides safe, respectful personal care and continence support that protects dignity, skin health and independence. It explains assessment, daily care, worker limits, observation, escalation and individual planning.

Document control	Details
Policy number	HH SAH PERSONAL 019
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Prepared	24 October 2026
Policy owner	Director and Clinical Lead RN
Approved by	Director: Huy Le RN: Thi Ngoc Bich Tran
Effective date	24 October 2026
Next review	12 months after approval, or earlier following relevant change
Applies to	Coordinators, nurses, workers and approved contractors providing bathing, grooming, toileting, continence and related personal support

1 Purpose and scope

Personal care must reflect the person's choices, culture, privacy, routines and abilities. Support the client to do what they safely can themselves, with consent for each task. Continence support aims to maintain or improve bladder and bowel function, comfort and participation; it is not simply the routine application of a product.

This policy applies to Support at Home delivery on behalf of The Fig Trees and other approved registered providers. It covers routine assistance with washing, dressing, grooming, oral care, toileting, continence products and related observation. Catheter insertion/change, irrigation, stoma treatment, rectal interventions, complex bowel care, wound treatment and other clinical procedures require separate plans, authority, training and competency; this policy does not authorise them.

2 Responsibilities

The Coordinator confirms consent, authorised tasks, visit timing, supplies and safe staffing. The Clinical Lead RN assesses clinical and skin concerns, arranges continence or other specialist review and establishes escalation instructions within scope. Workers follow current plans, protect privacy, observe changes and report promptly without diagnosing or changing treatment.

The Director ensures resources, competence, clinical oversight and clear service boundaries. Agree with The Fig Trees who arranges assessments, products, equipment, clinical referrals, authorisations and essential care continuity. It retains registered-provider duties; H&H Care retains responsibility for safe delivery and its workforce. A funded personal care allocation alone does not authorise an invasive task.

Assessment consent and care planning

3 Individual assessment and plan

Before support, identify the person's goals, usual routines, abilities, sensory and communication needs, cultural preferences, preferred worker characteristics and what assistance is acceptable. Assess privacy, pain, fatigue, skin, mobility, falls and transfer risks, equipment and bathroom access under Policies 5 and 14. Obtain current clinical instructions and clarify missing or conflicting information.

For continence concerns, arrange a proportionate assessment by an appropriately qualified clinician, including a continence nurse where indicated. Consider usual bladder and bowel pattern, urgency, leakage, constipation, medicines, intake, mobility, cognition and toileting access. New incontinence is not automatically an unavoidable part of ageing. The clinician decides whether diaries, examination, testing or treatment are needed.

The individual plan must describe tasks and assistance, toileting preferences and timing, products and skin care, equipment, staff numbers, relevant clinical directions, monitoring and escalation. Identify responsibilities between visits and overnight; do not assume family will provide assistance. Record what is not covered and escalate unmet essential needs to The Fig Trees.

4 Consent dignity and refusal

- Introduce yourself, explain each task and seek ongoing consent. Address the person directly and use an interpreter or communication aids as needed. A service agreement is not blanket consent for intimate care.
- Ask about worker, cultural and privacy preferences and meet them where reasonably practicable. If a preference cannot be met, discuss alternatives without pressure and record agreement.
- Close doors/curtains, offer a towel or cover and expose only the area being cared for. Do not invite observers or trainees without appropriate consent.
- Avoid infantilising language, jokes about continence, public discussion or leaving a person exposed. Use the person's preferred respectful terms.
- If the person refuses or becomes distressed, pause, ask about discomfort or preferences and offer another time, method or worker where safe. Do not force care, threaten, restrain or label refusal as misconduct.

Record declined or incomplete care and significant risk, notify the Coordinator/RN and agree follow-up. Consider pain, fear, past trauma, communication problems, illness or unfamiliar routines. If decision-making or authority is unclear, use supported decision-making and qualified advice under Policies 2 and 3 rather than assuming family can consent to everything.

Safe daily personal care

5 Prepare and provide care

- Read the current plan, check client identity, consent and actual condition. Confirm supplies, safe equipment and required trained workers. Pause unsafe transfers or an unassessed change in ability.
- Prepare a warm, private space with accessible towels, clothing, products and safe non-slip arrangements. Check lighting, trip hazards, hand hygiene and clean/dirty separation.
- Use standard precautions and task-appropriate gloves/PPE. Perform hand hygiene and change gloves between contaminated and clean tasks. Clean reusable equipment and handle linen/waste under Policy 13.
- Check water temperature by a safe method before and throughout bathing, considering client sensation and scald risks. Follow assessed limits and equipment instructions; do not rely only on the client's ability to feel heat or on an unverified tap setting.
- Encourage safe participation, explain each step and use the assessed assistance and mobility method. Never leave a person needing supervision unattended in a shower, bath or on a commode.
- Wash gently with agreed products, rinse as appropriate and dry carefully, including skin folds. Observe skin with consent. Avoid rubbing fragile skin or using unapproved products.
- Assist dressing, grooming and positioning according to preferences and clinical/transfer plans. Leave the person comfortable, with required aids, call/phone access and essential belongings safely within reach.

6 Specific grooming and oral care limits

Provide oral care under the individual plan, including support with teeth or dentures and safe storage. Follow swallowing instructions and seek review for pain, sores, bleeding, loose teeth or poor intake. Do not force oral care or put a person at aspiration risk. Professional dental care is arranged through the appropriate pathway.

Use agreed shaving methods and suitable personal equipment, taking account of skin and bleeding risks. Do not share razors or personal grooming items. Routine nail care must follow assessed competence and risks; diabetes, poor circulation, altered sensation, infection, ingrown nails or other concerns may require nursing or podiatry advice. Workers must not cut corns, treat infections or perform high-risk nail procedures without appropriate authority.

Intimate hygiene must follow assessed, taught methods, respecting anatomy and preferences and preventing contamination. Do not force tissue retraction or undertake internal cleansing/examination. Pain, swelling, bleeding, discharge or an unexpected anatomical concern requires RN/clinical review rather than improvised treatment.

Toileting continence products and skin health

7 Support toileting and independence

Ask about usual patterns and timely toilet access. Offer prompting or assistance according to the agreed plan, preferences and actual need rather than a rigid schedule for staff convenience. Provide privacy while remaining close enough to meet assessed supervision and safety needs. Check safe clothing, transfers, toilet height, rails or commode requirements.

Allow reasonable time without rushing or leaving someone waiting in wet/soiled clothing. Do not use continence products as a substitute for requested or clinically appropriate toileting. Do not restrict drinks simply to reduce leakage or workload; follow any prescribed fluid restriction and seek advice for intake concerns. Support agreed activity, meals and prescribed exercises, but do not independently prescribe bladder training, pelvic floor exercises or bowel treatment.

8 Select and change continence products

Use the assessed product type, size, absorbency, fit and change arrangements, with client preference and manufacturer instructions. Check stock, comfort, leakage and skin. Do not double-pad, improvise an occlusive layer or reuse single-use products contrary to instructions. Unresolved leakage needs review, not automatically a larger product or restricted fluids.

Change promptly when soiled and according to need, skin condition and the plan, including between scheduled rounds if required. Clean gently after urine/stool exposure and dry carefully; change gloves and perform hand hygiene before clean activity. Apply agreed skin protection only under the plan and product guidance; medicated preparations follow medication requirements. Document significant observations and refer persistent skin problems.

9 Skin integrity and pressure risk

With consent, observe redness, pain, rash, moisture damage, broken skin and pressure-area concerns. Report changes to the RN promptly and document location and appearance factually without diagnosing the lesion. Do not massage reddened pressure areas or independently initiate wound treatment. Use a separately assessed positioning/pressure plan and suitable equipment; continence products do not relieve pressure.

Do not take intimate or clinical photographs on personal devices. Any necessary image requires a specific care purpose, appropriate consent or other lawful basis and approved secure handling under Policy 3. Do not expose a person solely to obtain a routine image.

10 Catheter or stoma related assistance

Where a person has a catheter or stoma, identify the exact tasks authorised and the separate clinical plan. Routine bag-related assistance is not authority to insert, remove, flush, irrigate or change a device. Any permitted task requires competence, consent, infection controls and escalation instructions. Do not disconnect a closed system or manipulate a blocked device outside authorised clinical practice. Seek immediate clinical help for pain, absent drainage, displacement or other acute concerns.

Bowel bladder monitoring and escalation

11 Record patterns within the individual plan

Use a bladder/bowel diary only when indicated, with clear purpose, duration and review owner. Record times, actual output or leakage, stool consistency using the approved tool if instructed, pain, urgency, products, skin observations and action. Do not estimate unmeasured volumes as exact or ask clients to disclose irrelevant details.

The RN or treating clinician sets individual constipation and urinary escalation triggers based on usual pattern, conditions and treatment. Do not apply a universal number of days without stool or assume small amounts of diarrhoea exclude constipation/overflow. Laxatives, enemas, suppositories, digital stimulation or manual evacuation require relevant prescriptions, plans, authority and competency; routine personal care does not authorise them.

12 When to seek help

Concern	Required response
Emergency symptoms	Call 000 for collapse, abnormal breathing, severe deterioration, significant bleeding, severe acute pain with concerning symptoms or other emergency signs. Follow Policy 12.
Unable to pass urine or catheter not draining with pain	Obtain immediate clinical assessment or emergency department care as advised; call 000 if seriously unwell. Do not wait for the next visit or attempt unapproved device intervention.
Blood in urine or stool new pain or marked bowel change	Seek prompt RN/medical advice, with urgent escalation for heavy bleeding, black/tarry stool or systemic illness. Record facts and timing.
Possible infection or acute confusion	Prompt clinical review; escalate urgently if rapidly unwell. Do not diagnose a urinary infection from smell, cloudy urine or confusion alone.
Constipation diarrhoea vomiting or reduced intake	Follow individual thresholds and obtain RN/clinical advice; consider dehydration, severe pain, distension and vomiting as urgent concerns. Do not independently change treatment.
New leakage skin damage or care unmet	Notify the RN/Coordinator and arrange assessment, products or care changes. Escalate promptly if there is pain, broken skin, pressure concerns or persistent wet/soiled care gaps.

Record the advice, person contacted, time, agreed action and named follow-up owner. If a clinician cannot be reached and risk is significant, use backup or emergency services; an unanswered message is not a completed escalation. Inform The Fig Trees of relevant changes, unmet needs and authorisation requirements. Follow incident/safeguarding procedures for neglect, injury or repeated omitted care where relevant.

13 Review and continuity

Review after changes, hospital discharge, new products, falls, skin injury, complaints, distress or altered elimination patterns, and on the individual plan's scheduled date. Confirm trained workers, supplies, time and essential care between visits. Track referrals and outcomes, update instructions and obtain written authorisation for ongoing service changes under Policy 6.

Individual personal care and continence plan

PERSONAL F01 | Complete with the client and appropriate clinical input. Link specialist instructions; this form does not authorise invasive procedures or new treatment.

Client and identifier: _____
Assessment author role/date and plan version: _____
Client goals routines and preferences: _____
Communication support consent and authority if relevant: _____
Allergies skin sensitivities and linked clinical plans: _____

Care area	Instructions and assistance required
Bathing dressing and grooming	_____ _____
Oral/denture care and shaving	_____ _____
Toileting pattern prompting and privacy	_____ _____
Transfers staffing and equipment	_____ _____
Continence product fit and changes	_____ _____
Skin cleansing/protection and pressure plan	_____ _____
Bowel/bladder monitoring and thresholds	_____ _____

Tasks excluded or requiring separate authorisation: _____
_____
Clinician-set escalation signs timing and contacts: _____
_____
Client refusal/distress response and safe alternatives: _____
Stock ordering funding and responsibility: _____
Between-visit/overnight care and contingency: _____
Client involvement agreement or unresolved needs: _____
RN/continence clinician review where needed: _____ Date: _____
Coordinator and provider authorisation reference: _____
Workers briefed/competence checked: _____
Review date and earlier triggers: _____

Daily care and bladder bowel records

Personal care and continence support record

PERSONAL F02 | Client: _____ Worker/date: _____
Visit times and plan version: _____
Consent preferences and participation: _____
Tasks delivered and assistance level: _____
_____
Toileting/product changes and actual observations: _____
Skin observations location and client report: _____
Refused/incomplete care reason and alternative: _____
_____
Escalation advice person/time and action: _____
Follow-up owner/time and outcome: _____
Author authentication/entry time: _____

Bladder and bowel monitoring record

PERSONAL F03 | Use only where indicated; continue on extra pages as needed.
Client: _____ Recording period: _____
Purpose and clinician/plan reference: _____
Usual pattern and individual escalation threshold: _____
Measurement/description method and review owner: _____

Date and time	Bladder/bowel event or leakage	Observation discomfort and action
_____ _____	_____ _____	_____ _____
_____ _____	_____ _____	_____ _____
_____ _____	_____ _____	_____ _____
_____ _____	_____ _____	_____ _____

Record measured amounts with units only when actually measured and instructed; otherwise use factual descriptions. Record stool consistency using the agreed tool where applicable and identify the author for each entry. Do not make a diagnosis from a diary.

Review findings/client feedback: _____
Clinical advice and changes approved: _____
Next review and current plan update: _____

Implementation oversight and references

14 Competence resources and oversight

Before offering relevant tasks, confirm assessments, consent, supplies, safe transfer equipment, sufficient visit time and required workers. Assess practical competence in dignified personal care, intimate hygiene, continence product use, skin observation, IPC, refusal and escalation. Complex clinical tasks require separate authorisation and competency under the workforce and clinical policies.

The Coordinator checks unresolved essential care and supply gaps each service day and escalates promptly. As internal controls, management reviews skin/continence concerns, missed care, complaints and client experience monthly and audits a risk-based sample of plans, records and competencies quarterly. Review plans at least annually as an internal minimum, with more frequent clinician or risk-based review and immediate review of relevant changes.

Use client feedback to assess privacy, comfort, preferred timing, participation and whether staff respond promptly to toileting needs. Do not judge quality only by product usage, absence of complaints or completion ticks. Correct gaps with named owners, resources and due dates and verify outcomes. Report repeated care omissions and safeguarding concerns through Policies 9 and 11.

15 Records and related policies

Keep assessment and care plans, relevant prescriptions/clinical instructions, consent, monitoring, staff competence, referrals, skin concerns, incidents and review evidence securely under Policy 8. Document only relevant intimate information and share it on a lawful need-to-know basis. Use the current plan and preserve versions and historical records.

Related documents: Policies 1 to 18; medication and clinical governance; pressure injury and wound care; oral health; catheter/stoma and complex bowel care where separately approved; nutrition/hydration and prescribed activity. This policy does not replace those clinical procedures.

16 References

- Aged Care Act 2024 and Aged Care Rules 2025, rights and Code of Conduct; applicable strengthened Quality Standards; relevant consent, privacy, WHS and professional requirements; The Fig Trees agreement and variations.
- Aged Care Quality and Safety Commission — Outcome 5.5 Safety of clinical care services, including continence assessment. https://www.agedcarequality.gov.au/strengthened-quality-standards/clinical-care/safety-clinical-care-services
- healthdirect — Urinary retention. https://www.healthdirect.gov.au/symptoms/urinary-retention
- healthdirect — Urinary incontinence. https://www.healthdirect.gov.au/conditions/kidney-and-urinary-problems/urinary-incontinence
- healthdirect — Catheter problems. https://www.healthdirect.gov.au/conditions/kidney-and-urinary-problems/catheter-problems
- Australian Commission on Safety and Quality in Health Care — Aged Care Infection Prevention and Control Guide. https://www.safetyandquality.gov.au/resources/aged-care-infection-prevention-and-control-guide

Official guidance checked 24 October 2026. Apply current individual clinical directions and product instructions. This policy provides a routine care framework, not a prescription or complete procedural guide for invasive continence care.

Director approval: _____ Clinical Lead RN approval: _____
Effective date: _____ Next review: _____
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