H&H Care SA Pty Ltd	Form25. Catheters Stomas Enteral Feeding and Other Complex Care Australian Government Support at Home Program		
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Policy and procedure 25

H&H Care SA Pty Ltd | Support at Home services

This policy establishes the safeguards for complex care delivered in a client's home. Care must follow an individual clinical plan, device instructions and verified worker competence. This policy does not replace a clinical procedure or authorise a worker to perform an unfamiliar task.

Document control	Details
Policy number	HH SAH COMPLEX 025
Version and status	1.0 — Draft for Director and Clinical Lead RN approval
Prepared	24 October 2026
Policy owner	Director and Clinical Lead RN
Approved by	Director: Huy Le Clinical Lead RN: Thi Ngoc Bich Tran
Effective date	24 October 2026
Review due	12 months after approval or earlier following change or incident
Applies to	Nurses, support workers, coordinators and approved personnel providing complex care

1 Purpose and scope

Support safe, respectful care for urinary catheters, bowel and urinary stomas, and enteral feeding devices. Other complex care is accepted only after a separate clinical and operational readiness review. The client's preferences, consent, dignity, communication and ability to self-manage guide care.

For services delivered on behalf of The Fig Trees, confirm the written service request, agreed tasks, clinical accountability and escalation arrangements. A nursing service listing or NDIS registration does not automatically authorise every complex procedure or extend the brokerage agreement.

2 Responsibilities

The Director confirms contract scope, insurance, resources and workforce cover. The Clinical Lead RN assesses readiness, approves task allocation, verifies clinical plans and competence, and reviews incidents. Treating clinicians prescribe or approve clinical regimens within their scope. ENs practise within their scope and RN supervision arrangements.

Coordinators roster only authorised competent workers and ensure backup. Workers follow the current plan, check consent, monitor response, document care and escalate concerns. The Fig Trees retains its registered provider obligations; H&H retains responsibility for the safety and quality of its work.

3 Client partnership

Explain procedures, choices and foreseeable risks using interpreters or communication aids as required. Confirm consent at each episode. Respect refusal, assess immediate risk and seek clinical advice; do not force care. Verify substitute decision-making authority where relevant. Support independence without making the client responsible for unsafe service gaps.

Assessment planning and worker authorisation

4 Acceptance and readiness

Before the first service, the Clinical Lead RN completes a clinical and home readiness assessment with the client and relevant clinicians. Obtain current discharge instructions, device information, clinical orders, allergies, infection risks, baseline observations and emergency history.

- Confirm the exact task, device, route, complexity, visit duration, clinical oversight and availability of help between visits and after hours.
- Obtain an individual plan signed or otherwise authenticated by the appropriate clinician. Resolve conflicting, incomplete or outdated instructions before proceeding.
- Confirm clean work space, hand hygiene, waste disposal, power and pump backup, storage, supplies, transport and emergency access.
- Assign competent workers, named RN oversight and backup cover. Do not start essential care unless a workable continuity arrangement exists.

5 Individual complex care plan

Record device type, purpose, location and identification, insertion or change history, relevant baseline, routine care, monitoring and review dates. Specify clinician-set limits, warning signs, emergency actions, contacts and tasks permitted or prohibited for each worker role.

For enteral feeding, include tube position verification method, prescribed formula, route, volume, rate, schedule, water flushes and water type, positioning, medicine instructions, oral intake status and interruption plan. For catheters and stomas, include products, output monitoring, change schedule, skin care and specialist review arrangements.

6 Competence and delegation

A generic certificate does not establish competence for a particular client or device. The RN verifies theory, supervised practice and observed performance against the individual procedure, including recognising complications and escalation. Record assessor, date, limits, supervision, review and reassessment triggers.

Delegation must be lawful and appropriate to the client, task and worker, with clear instructions, supervision and an available escalation pathway. Workers must decline and report a task outside their authorisation. RN oversight does not remove each worker’s accountability.

Insertion, replacement, irrigation, invasive manipulation and specialised interventions require separate clinical approval, procedure and verified competence. Routine care sign-off does not authorise these tasks. Reassess following device changes, hospitalisation, deterioration, incidents or a lapse in practice.

Urinary catheter support

7 Routine care

Confirm the client and plan, explain the task, obtain consent and provide privacy. Perform hand hygiene and use appropriate PPE and clean or aseptic technique as required by the procedure. Check tubing, securement, drainage and the surrounding skin without pulling or placing tension on the catheter.

- Keep drainage unobstructed, with the bag below bladder level and off the floor. Avoid kinks and traction. Maintain the closed system and avoid unnecessary disconnections.
- Provide hygiene, bag emptying and product changes according to the plan and manufacturer instructions. Prevent outlet contact with the receptacle and use client-dedicated equipment as required.
- Record output when required, with time, volume, appearance and relevant symptoms. Follow individual fluid advice, including any restriction; do not impose a standard intake target.

The plan must identify urethral, suprapubic or intermittent catheter care separately. Intermittent catheterisation requires its own technique, schedule, equipment and competency assessment. Catheter changes and specimen collection are performed only by authorised competent personnel under the relevant procedure.

8 Reduced drainage and other concerns

For reduced or absent drainage, check only permitted external causes such as a kink, full bag or bag position. Promptly contact the RN or treating service if drainage remains reduced, the client has pain, distension, leakage, blood, fever, rigors or new deterioration. Do not assume leakage means the bladder is draining.

Do not flush, irrigate, remove or reinsert a catheter, change balloon volume, or disconnect the system to troubleshoot unless explicitly authorised and competent under a clinical procedure. Do not diagnose infection from cloudy or odorous urine alone or start treatment without a prescriber.

A displaced suprapubic catheter requires immediate clinical contact because the tract may close quickly. Do not wait for the next visit or attempt unapproved reinsertion. Severe pain, major bleeding, suspected sepsis, collapse or rapid deterioration requires 000. Clients at risk of autonomic dysreflexia need a specific emergency plan; suspected episodes require urgent emergency action.

9 Follow up

Report recurrent blockage, leakage, trauma and skin damage for clinical review. The RN seeks review of ongoing catheter need, change arrangements and prevention measures. Record advice, actions and the person responsible for follow up.

Bowel and urinary stoma support

10 Routine stoma care

Confirm stoma type, usual output, products and individual instructions. Colostomies, ileostomies and urostomies have different care needs; never substitute one regimen for another. Preserve privacy and involve the client in emptying, changing and observing the appliance as they choose.

Prepare the prescribed pouching system and skin products. Remove appliances gently, clean and dry the skin as directed, observe the stoma and surrounding skin, and fit the appliance according to the assessed plan. Protect the stoma from trauma. Do not apply unapproved creams or alter aperture size or products without appropriate advice.

Document appliance changes, leakage, skin condition, output and symptoms according to the plan. Ensure supplies and a travel or emergency kit are available. Arrange stomal therapy nurse review for persistent leakage, skin injury, difficult fitting or a change in stoma shape.

11 Changes requiring action

Finding	Required response
Marked colour change, including dusky, purple or black stoma	Seek urgent medical assessment immediately. Call 000 if severe symptoms or deterioration.
Persistent or significant bleeding	Urgent clinical assessment; 000 for major bleeding, collapse or shock. Distinguish this from minor surface spotting and still report concerns.
Little or no output with pain, distension, nausea or vomiting	Urgent medical assessment for possible obstruction. Do not irrigate or give unprescribed laxatives.
High or unusually watery output, thirst, dizziness or reduced urine	Prompt RN/medical advice and assessment for dehydration; follow clinician-set thresholds and fluid plan.
Prolapse, retraction, swelling, repeated leakage or skin breakdown	Prompt RN and stomal therapy review; do not attempt unapproved reduction or manipulation.

Stoma irrigation, digital interventions and complex bowel procedures require a separate prescribed plan and authorisation. This policy does not provide an invasive bowel care procedure. For a urostomy, follow its urinary drainage plan and escalate reduced output or infection concerns promptly.

12 Ongoing support

Respect body image, cultural preferences and sexuality. Support usual clothing and activities where safe. Refer nutrition, fluid and product concerns to the appropriate clinician rather than imposing generic dietary restrictions.

Enteral feeding and medicines

13 Before every use

Confirm identity, consent, current regimen, tube type and route, formula, expiry, storage, equipment and pump settings. Check symptoms, site and securement. Verify tube position by the documented device-specific method before feed, water or medicine and whenever displacement is suspected. Do not use a tube when position is uncertain.

Nasogastric position verification requires an approved clinical method and trained staff. Air insufflation with auscultation is not an acceptable position check. External markings alone do not establish safe internal placement. Obtain qualified assessment where the prescribed check cannot confirm position.

14 Safe delivery

Use enteral-only connectors and equipment; trace the line from the client to the source before connecting. Never connect enteral fluids to an intravenous line. Deliver the prescribed feed, water and rate, observing the client and pump. Follow the individual positioning plan during and after feeding. Stop and escalate if safe positioning cannot be maintained.

Follow manufacturer and clinical instructions for formula handling, opening times, hang times, equipment changes, cleaning and storage. Do not improvise formula, dilute feed or change the regimen. Maintain oral care and follow the separate swallowing plan for any oral intake.

Flush using the prescribed water type, amount and timing, accounting for fluid restrictions. Never force a blocked tube or use sharp objects or unapproved substances. Stop use and seek clinical advice if blockage, pain, resistance, leakage or displacement occurs.

15 Medicines through feeding tubes

Apply Policy 20. Obtain prescriber and pharmacist instructions for each medicine, formulation, tube route, feed interaction and flushing. Do not crush modified-release or enteric-coated products or assume a liquid is suitable. Give medicines separately as directed; do not mix medicines together or into feed. Record medicine administration on the medication record, including omissions and escalation.

16 Complications and interruption

Stop feeding for coughing, choking, breathing difficulty, vomiting, significant abdominal pain or distension, suspected aspiration, tube displacement or uncertain position. Call 000 for respiratory distress, collapse or other severe deterioration. Do not restart until the appropriate clinician confirms it is safe and provides instructions.

A gastrostomy or jejunostomy tube that falls out or moves requires immediate specialist or emergency assessment because the tract may close and feeding into a displaced tube can cause serious harm. Do not feed, flush or give medicines through it. Do not blindly reinsert a tube or place a substitute unless specifically credentialed under an approved procedure. New tracts and gastrojejunal devices require specialist management.

Notify the RN promptly when feeds, fluids or essential medicines are interrupted. Obtain a time-sensitive alternative plan, including diabetes and hydration considerations. Never compensate by increasing the next rate or dose without an order.

Other complex care and service continuity

17 Additional procedures

Before accepting another complex task, complete a separate risk and scope assessment, obtain an approved procedure and individual orders, verify worker competence and clinical supervision, and confirm contract scope, insurance, supplies and emergency cover. Examples include complex bowel care, specialised injections, drains and vascular devices. This policy gives no authority to undertake them.

Tracheostomy care, ventilation, intravenous therapy and parenteral nutrition are outside this policy's routine scope and require a separately approved service pathway before acceptance. Do not infer capability from general nursing qualifications or previous experience alone.

18 Escalation and missed essential care

For life-threatening symptoms, call 000 immediately and provide first aid within competence. Do not wait for manager or funding approval. For urgent concerns, directly contact the named RN, treating team or emergency service according to severity; use the backup contact if unavailable. An unanswered message is not an accepted clinical handover.

Inform the coordinator and The Fig Trees as appropriate after immediate safety needs. Record who accepted responsibility, advice, action and review timing. Do not leave an unsafe client without an agreed safe response. Escalate missed visits, worker absence, equipment failure or supply shortage before essential care becomes overdue.

Maintain a backup roster, adequate consumables, pump/power contingency and service interruption plan. Family members may assist only by agreement and where safe; they are not an automatic substitute for commissioned care.

19 Records incidents and review

Document tasks actually performed, device/site observations, volumes and units, tolerance, deviations, refusals, clinician advice and follow up. Record feed and flush totals separately from urinary or stoma output. Do not backfill values from the prescription as though delivered. Link medicine records, incident reports and care notes without conflicting duplication.

Use Policy 9 for incidents, near misses and potential SIRS matters, and Policy 10 for open disclosure. The Fig Trees and H&H must coordinate notifications without assuming the other has completed them. Preserve relevant equipment, lot numbers and records where safe.

The RN reviews after hospital discharge, device or regimen changes, deterioration and incidents. At least quarterly, the Clinical Lead samples plans, competencies, records and missed-care events; report themes and corrective actions through Policy 18. Review device safety alerts and communicate new instructions before further care.

Complex care plan and competency record

COMPLEX F01 | Complete with the client and appropriate clinicians. Attach current device-specific orders and procedures; this form alone is not a treatment order.

Client name and identifiers: _____

Condition and device type route site identification: _____

Insertion or change date and treating service: _____

Baseline symptoms output site and client preferences: _____

Consent communication support and authorised decision maker: _____

Current procedure and clinical order reference date version: _____

Routine care tasks and frequency: _____

Feed formula route rate volume schedule and positioning if applicable: _____

Water flush type volume timing and medicine instructions reference: _____

Position verification method and criteria before use if applicable: _____

Monitoring parameters individual thresholds and warning signs: _____

Stop care actions and emergency or device displacement plan: _____

RN contact after hours contact and backup clinical service: _____

Consumables equipment power and missed service contingency: _____

Review date and triggers: _____

Clinician name role approval signature date: _____

H&H RN readiness approval and Fig Trees authorisation reference: _____

Worker authorisation

COMPLEX F02 | One record per worker and client-specific task or device.

Worker and role: _____ Client and device: _____

Task authorised and explicit limits: _____

Training procedure version and supervised practice dates: _____

Observed routine performance infection control and documentation: _____

Observed recognition of complications and escalation response: _____

Outcome competent / further training required: _____

Assessor name qualifications signature date: _____

Supervision backup contact reassessment date and triggers: _____

Worker acknowledgement signature date: _____

Care record references and approval

COMPLEX F03 | Care episode and escalation record. Use additional pages as needed.

Client identifiers: _____ Worker role: _____

Date time task device and plan version: _____

Consent and pre-care checks including position verification where required: _____

Care delivered feed water flush amounts rate route and times: _____

Urine or stoma output amount units time interval appearance: _____

Site skin symptoms tolerance and observations: _____

Deviation refusal interruption or device problem: _____

Immediate action person contacted time advice and response: _____

Follow up responsibility review time and handover accepted by: _____

Worker signature: _____ Related medication / incident record: _____

20 Related policies and references

Read with Policies 1 to 24, particularly consent, assessment, care planning, records, incidents, deterioration, infection prevention, workforce competence, medication, nursing governance, wounds and nutrition. Use manufacturer instructions and current local clinical procedures for each device.

Official guidance checked 24 October 2026. State health guidance informs clinical planning; it does not automatically operate as an H&H procedure. NDIS descriptors are a supplementary competency reference and do not replace aged care obligations.

- Aged Care Act 2024 and Aged Care Rules 2025; applicable strengthened Aged Care Quality Standards, including clinical care. https://www.agedcarequality.gov.au/
- Aged Care Quality and Safety Commission — Supporting safe and high-quality management of indwelling urinary catheters. https://www.agedcarequality.gov.au/news-publications/clinical-alerts-and-advice/supporting-safe-and-high-quality-management-indwelling-urinary-catheters
- Queensland Health — Urinary catheter insertion or change. https://www.health.qld.gov.au/clinical-practice/guidelines-procedures/clinical-pathways/residential-aged-care-clinical-pathways/all-pathways/urinary-catheter-insertion-or-change
- NSW Agency for Clinical Innovation — A clinician's guide Caring for people with gastrostomy tubes and devices. https://aci.health.nsw.gov.au/__data/assets/pdf_file/0017/251063/ACI-Clinicians-guide-caring-people-gastrostomy-tubes-devices.pdf
- Healthdirect — Living with a stoma. https://www.healthdirect.gov.au/treatments-and-self-care/living-with-a-stoma
- NDIS Commission — High intensity daily personal activities practice standards and skills descriptors. https://www.ndiscommission.gov.au/rules-and-standards/ndis-practice-standards/supplementary-module-high-intensity-daily-personal

21 Approval and implementation

Before use confirm clinical scope and Fig Trees arrangements, approve device procedures, obtain client plans and consent, verify competencies, test backup contacts, and make current instructions available to workers.

Director approval: _____ Clinical Lead RN: _____

Effective date: _____ Next review: _____