Bladder & Bowel UK
Supporting people with bladder and bowel problems
part of Disabled Living

Children's bladder and bowel care

Level One Resource Pack

Document reader information

Title	Children's Bladder and Bowel Care: Level One Service's Resource Pack
Document purpose	To assist in the provision of standardized, integrated pathways and guidance for services providing care to children with bladder and bowel problems.
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Target audience	Healthcare professionals, service providers, children and young people, families and carers.
Description	This resource pack provides a framework of best practice to facilitate an appropriate service delivery to children and young people with bladder and bowel problems. It aims to support clinicians who have the underpinning knowledge and skills necessary to undertake assessments and introduce treatments at level/tier one and information about when to refer children to level/tier two continence services

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Charts:

Care pathways (appendix five):

Introduction

This guidance has been developed to provide information to health care professionals to assist them with the promotion and management of children's bladder and bowel care. Early intervention with bladder and/or bowel problems promotes children and young people's health and wellbeing, as well as reducing costs to the NHS

Bladder and bowel problems in childhood affect up to 28% of all children at any time. They include difficulties with toilet training, day and night time wetting, constipation and soiling. Younger children are affected more often than older children, but problems can happen at any age. In the interest of clarity and brevity the terms child, children and childhood are taken to include all children and young people.

Bladder

While the most common problem is night-time wetting, children may also be affected daytime wetting, having to rush to get to the toilet (urgency), or having to go to the toilet more often than is normal (frequency), or a combination of any or all of these. Less common problems include urinary tract infections (UTI) and, more rarely congenital problems affecting the urinary tract.

Bowel

Constipation is a common in childhood frequently results in referral to secondary care. However, early effective management and support improves outcomes for children and prevents long-term problems.

Toilet training

Many parents and carers worry about toilet training their children, particularly if their child has additional needs. Parents and carers mistakenly believe that toilet training should be delayed until the child is showing awareness. However, early training may support bladder maturity and reduce likelihood of continence problems later.

It is important that all children who have delayed toilet training, particularly those with additional needs, have an early assessment of their bladder and bowel health to identify any underlying problems, with treatment and management offered as appropriate.

Fluid advice

Adequate fluid intake is an important part of the management of continence problems, including toilet training, daytime wetting, and constipation.

- Caffeinated drinks (e.g. tea, coffee, hot chocolate, energy drinks and cola) should be avoided as they may have a diuretic effect and can contribute to bladder overactivity
- Fizzy drinks should be avoided as they can contribute to bladder overactivity
- Children will need extra water-based fluids if they are doing lots of exercise (including sports, playing out and school playtimes), or if the weather or their environment is hot. See table one for suggested fluid intake
- Milk is healthy, but is used by the body as a food. It should not be encouraged instead of, or as part of total water-based drinks
- Do not restrict fluid intake. If fluid intake is excessive, consider whether it is a behavioural issue, or a medical problem such as diabetes insipidus, or diabetes mellitus and refer to the appropriate service
- Water is the healthiest drink and should be encouraged. However, many children refuse to drink it. If a child will not drink water, other water-based drinks should be considered and arrangements discussed with the school
- Children should be encouraged to take full water bottles (500 – 750mls) to school and drink the contents. Schools should be encouraged to allow the child open access to their drinks bottles and to the toilet

Table 1: Suggested intake of water-based drinks per 24 hours by age and sex:

Age	Sex	Total drinks per day
7 – 12 months	Female	600 – 900 mls
	Male	600 – 900 mls
1 – 3 years	Female	900 – 1000 mls
	Male	900 – 1000 mls
4 – 8 years	Female	1200 – 1400 mls
	Male	1200 – 1400 mls
9 – 13 years	Female	1200 – 2100 mls
	Male	1400 – 2300 mls
14 – 18 years	Female	1400 – 2500 mls
	Male	2100 – 3200 mls

(Adapted from CG 111 Nocturnal Enuresis NICE 2010 and American dietary requirements, cited in CG 99 Constipation in Children and Young People, NICE 2010)

Strategies to help children increase their fluid intake:

- Parents and carers should use positive reinforcement for drinking well, including use of appropriate charts and rewards
- Start with expecting the child to drink only slightly more than they currently are and gradually increase expectations
- Measure out the total volume that the child should be drinking in a day into a jug or plastic bottle. Making all their drinks from this can help them visualise how well they are doing. The child should be encouraged to finish their jug or bottle by the end of their evening meal each day
- Some children manage well if given a full glass and are told to drink half; others do better if given half a glass and are told to finish it
- Parents and carers should build drink times into the family's daily routine
- Make drink times fun. Sitting together with a book or game and refusing to read any more/throw the dice until the child has had a few more sips. Use straws or a different glass or cup or try adding ice
- Ice lollies and jellies are high in fluid content, but also tend to be high in sugar, so should be used with caution
- Families should be advised to avoid battles over drinks
- Parents and carers should ensure that the child is having half their daily intake by midday. Avoid children having large quantities to drink late in the day. This may cause or exacerbate night-time wetting

Dietary advice

NICE (2010) guidelines recommend that dietary interventions alone are not appropriate as a first-line treatment for idiopathic constipation. However, NICE do advise that dietary modifications should be recommended to ensure a child has a balanced diet and that sufficient fluids are consumed.

- Children should be encouraged to eat five or more portions of fruit and vegetables per day
- Wholegrain cereals, brown bread and rice can be helpful and are part of a healthy diet

- Children over the age of one year should not be having more than one pint of milk or its equivalent (dairy products such as yoghurts, cheese and milk puddings) per day. This can exacerbate constipation, reduce appetite and prevent children from having a balanced, varied diet
- Children should not be encouraged to eat large amounts of high fibre foods (such as wheat biscuit or bran cereals as this can exacerbate constipation if fluid intake is inadequate)
- Children should not be eating unprocessed bran

Please always follow any advice from the dietician and ensure that the child does not have any foods to which they may have intolerances or allergies.

Toileting Advice

- Most children empty their bladders 4 – 7 times per day
- Children should be encouraged to use the toilet regularly during the day. About two hourly is the correct interval for most to pass urine. However, if the child is wet more often than this, the interval should be shorter to try and ensure that they remain dry
- Parents and carers should suggest that the child uses the toilet after they have had a drink. When the child is toileting two hourly this can also help with fluid intake
- Ensure the toilet is easy to access, clean and well stocked with toilet paper etc. This is particularly important at school. Secondary school children may benefit from a toilet pass. Primary school children may need the teacher to know about the continence problem. Having a signal to indicate that the child is going to the toilet may be helpful, rather than them having to wait to ask to go
- Ensure that smaller children have an insert seat and stool, so they are able to sit comfortably, well supported and with their feet on a firm surface
- Ensure that children with mobility difficulties or sensory issues have been referred to an occupational therapist for assessment of their toileting needs
- If the child feels they need to pass urine urgently or suddenly, they may be encouraged to count to five and if the feeling goes away to wait until the next planned toilet visit. If the feeling remains, or they are likely to wet if they do not

toilet quickly, then they should go straight to the toilet. Open access should be arranged for the toilet at school

- There is no evidence of benefit from trying to put off passing urine for longer than a few seconds if a child has urgency or day time wetting. This should not be encouraged
- Children should be encouraged to remain at the toilet long enough to complete voiding
- Children should be encouraged to sit on the toilet long enough to complete a bowel action. They should be able to sit privately. For children with constipation and soiling, there is often benefit from allowing them access to the disabled toilet in school as this is often more private than the main toilets
- Children with constipation should be encouraged to sit on the toilet at least once a day for a few minutes, ideally at the same time each day
- If the child is wetting/soiling at school it would be helpful to them to have spare clothes, wipes and plastic bags for the damp clothes, in their bag to allow changing as needed. Parents and carers should provide these from home and arrange replacements as needed
- Children should be supported to learn to change independently as soon as they have the developmental skills, which is usually from about four years old. If they are wetting/soiling in school, they may need support with learning to change themselves initially, or until their dexterity is sufficiently good to manage alone
- It is not acceptable for schools and nurseries to request parents or carers attend to support their children with personal hygiene
- Guidance is available from the Department for Education for schools (Supporting pupils with medical conditions at school December 2015 available from https://www.gov.uk/government/publications/supporting-pupils-at-school-with-medical-conditions—3)

Management of constipation

Chronic constipation is usually idiopathic (it happens spontaneously and/or the cause is not known). Symptoms vary between children. It is possible for children to have a bowel motion most days, but yet be constipated if they are only partially emptying the

rectum. Other children may only pass loose stools. This means that it is not always easy to diagnose constipation in children.

Symptoms of constipation in children are:

- infrequent bowel motions (less than three times per week in children over three years)
- unpleasant smelling wind or bowels motions
- excessive flatulence
- varying texture to bowel motions
- small, hard or very large poos
- withholding or appearing to strain
- soiling or overflow
- bowel motions in sleep in children over one year of age
- abdominal pain and/or distension
- poor appetite, often improves after a large bowel motion
- lethargy
- unhappiness, anger or irritability that improves after a large bowel motion

If the child is presenting as acutely unwell, has faltering growth or gross abdominal distension they should be reviewed by the GP or a paediatrician.
(NICE clinical guideline 99, 2010.)

NICE Guidance is available: Constipation in Children and Young People: diagnosis and management.

NICE has a range of useful resources which are freely available to download: at: Constipation in Children and Young People: tools and resources.

Constipation initial advice

Children and their families should be provided with appropriate fluid and dietary advice and encouraged to establish good toileting routines. However, these should not be used alone to treat constipation in children.

Children with constipation should be prescribed sufficient laxatives to ensure that they pass a soft stool daily (see constipation pathway). If there is no progress within three months they should be referred to level two services (see constipation care pathway).

Enuresis (bed wetting) initial advice

If bedwetting has only started in the last few days or weeks consider whether it might be caused by an underlying medical condition or a significant life event.

- Explain that the bedwetting is not deliberate, nor is it the child's fault and that the child should not be told off or punished
- Explain the causes of bedwetting
- The child should be encouraged to drink appropriate amounts of water-based drinks during the day(see fluid advice). Avoid caffeinated, fizzy and energy drinks
- Do not limit fluid intake during the day, unless excessive (see fluid advice)
- Encourage regular daytime toileting (about two hourly)
- Encourage the child to try and pass urine before settling for sleep each night
- Advise that the child should avoid all food and drink in the hour before sleep
- Avoid high salt and high protein foods late in the day (these increase urine production)
- If the child is using products (e.g. pyjama pants, nappies) consider a trial without these for at least two consecutive nights
- Do not lift/wake the child when parents or carers go to bed. The only times when lifting may be acceptable is in the short term when it is particularly important that the bed stays dry e.g. when on holiday
- If the child wakes themselves during the night, ask parents and carers to encourage them to use the toilet before settling back to sleep
- Discuss ways of reducing the impact of the wetting, such as bed protection
- Consider access to the toilet at night. If this is difficult try to find ways to make it easier e.g. a torch by the bed, or a potty in the room
- Consider whether the child is able to get out of bed, or has anxieties or fears that may result in difficulties getting up e.g. fear of the dark
- Advise parents and carers to only use rewards for things that are in the child's control. Remember that a child cannot control what happens when they are asleep
- Encouragement and positive comments should be made for dry nights, but rewards (if used) should focus on things that are in the child's control, such as

drinking recommended levels, toileting during the day, helping to strip their own bed etc

- Parents and carers should monitor progress by keeping a diary of wet and dry nights, of waking after wetting and waking to use the toilet

Further initial advice and information can be obtained from Bladder and Bowel UK at www.bbuk.org.uk or from http://www.stopbedwetting.org

Daytime wetting initial advice

If daytime wetting has started in last few days or weeks consider whether it may have been caused by illness such as urinary tract infection or constipation. Ensure appropriate assessment and treatment for these if suspected. If it is associated with increased thirst consider whether it may be caused by diabetes insipidus or diabetes mellitus.

- Advise that daytime wetting is common and can be associated with urgency or holding manoeuvres such as 'dancing', the child putting their hands in their groin area, or crouching. Explain that the children are often unaware of the need to void at these times but that parents and carers should encourage the child to use the toilet/potty if these actions are noticed
- The child should be encouraged to drink appropriate amounts of water-based drinks during the day (see fluid advice). Avoid caffeinated, fizzy and energy drinks
- Encourage good toilet routines (see toilet advice)
- Arrange open access to drinks and the toilet at school
- Review regularly and if no progress refer to level two continence service

Skills for toilet training

Toilet training is one of the earliest self-care skills developed by children and is one of the most important. The age of toilet training has increased in the last 50 years. However, there is research that suggests children should start toilet training in their second year.

Working on the skills for toilet training should not be delayed due to disability. Failure to offer this support and advice to a child with disabilities may be considered discriminatory. Childen who remain reliant on continence containment products becuase they have not been supported wtih toilet training, may fail to achieve their potential. The associated increased dependence compared to their peers, reduced self-esteem and poor self-confidence may lead to more stress for them and their family.

- Ensure the child has a varied diet and adequate fluid intake (see relevant sections of this document)
- Encourage the child to sit on the toilet or potty regularly. The potty may be better for smaller children allowing them to feel more secure and have their feet well supported on the floor. However, if the toilet is used, smaller children must have an insert seat and stool on which they can rest their feet when sitting, to ensure they are in the correct position to pass urine or open their bowels
- If the child has any physical or sensory issues, they should have an early referral to the occupational therapist for assessment of their toileting needs
- Start by sitting the child on a potty or adapted toilet once a day for short periods of time and gradually increase frequency and time of sitting. Do not sit the child for more than 3-4 minutes
- Encourage regular drinks (about 2 hourly) and then potty/toilet times after drinks. About 10-15 minutes later is often best if parents and carers can manage this, otherwise straight away
- Tip solid poos down the toilet and then flush them away, with the child present.
- Change all nappies in the bathroom
- If the child is mobile ensure they are standing to have their nappy changed. Encourage them to be as involved as possible and tip any solid matter down the toilet, involving the child in flushing the toilet
- Have an open door policy for toileting so the child sees parents/carers and siblings using the toilet
- Ensure all carers use the same words to describe wee and poo. Avoid using the words such as ‘dirty’ for poo as this has other meanings
- Suggest how the family can teach the difference between wet and dry

- Consider using stories, videos etc to help the child understand what they are being asked to do
- Children who have communication, processing or learning difficulties are often helped by the use of picture cue cards
- Encourage the child to learn to help dress and undress themselves
- Use clothes that are easy for the child to manage
- Encourage the child to say (or sign) when they are wet or have opened their bowels
- Modern nappies are very efficient at drawing moisture away from the skin, so reduce the child's awareness of passing urine, or opening their bowels
- Consider using cotton underwear or paper kitchen towel inside the nappy to raise awareness of when they are wet or dry
- Ensure the parent or carer has a plan for dealing with wetting or soiling when away from home and has good routines established
- At a time when the child appears to be progressing and the parent or carer is able to be home for most of a couple of days remove nappies
- Start using washable underwear or training pants during the day. There are pads available in most large supermarkets that are designed to support toilet training by containing some urine but allowing the child to feel wet
- Praise and reward success, change in the bathroom when needed with minimum fuss and feedback
- Consistency is important and once progress is being made, the parent or carer should be encouraged not to return the child to nappies during the day

Children who give no indication of needing to use the toilet:

- Consider using cotton underwear or paper kitchen towel inside the nappy to raise awareness of when they are wet or dry
- Consider a trial without nappies for at least a few days. Parents/carers will need to have a strategy for managing on trips out. For children aged from 4-5 years with disabilities, a wetting alarm (the same as a body-worn enuresis alarm) may be helpful
- Regular drinks, (about two hourly) followed by regular trips to the toilet/potty can help the child by ensuring they are voiding more often during the day

- Keeping a record, using a toileting chart (see appendix five) for at least three days, of when the child is drinking and when they are passing urine, can help parents/carers to see their child's natural pattern and help them to get the child to the potty/toilet at the right time
- Doing all changing in the toilet or bathroom, flushing solid stools down the toilet and sitting the child on the toilet when changing them can all be helpful
- Using positive reinforcement (praise, reward charts with time based rewards) for targeted behaviours

Continence Foundation of Australia 2010 'One Step at a Time - A Parent's Guide to Toilet Skills for Children with Special Needs.'
A. C. Jursi 'Toilet training of infants and children 2010 parental attitudes and practices'. (The Restraint Project UNSW)

Toileting assessment

Toileting assessment should commence in the child's second year, when there is an identified physical disability of learning difficulty, or as soon as it is identified that there is a delay in toilet training. It should be dynamic process, with a programme put in place to address any issues. The child should be reassessed every one to three months (depending on individual needs), with the family given an individualised programme to follow in the meantime. The amount of support required will depend on the child's needs and the family dynamics, with some families needing frequent review and others minimal intervention.

The first stage of a toileting assessment involves asking the parents/carers to keep a full toileting diary for at least three days using the toileting chart (appendix five). This is important as part of promoting bladder and bowel health, even for children who are unlikely to ever be able to toilet train due to the extent of their disability. Failure to fully assess a child's bladder and bowel health may result in problems being missed, with serious long-term consequences. Any problems detected on assessment, such as constipation, constant dribbling of urine, inability to sit, behaviour problems etc, must be addressed.

- The toileting chart should be printed so that the parents/carers have a copy of the instructions that are on the reverse

- Parents and carers should be advised to keep records for all the child's waking hours for at least three full days if possible. This must be done on days when the child is with the parent or carer all day (i.e. not on school days) and these days do not need to be consecutive. They should also keep records of the child's bowel motions for at least seven consecutive days
- As modern disposable nappies are so absorbent, it is sometimes difficult to tell the child has voided, if they have only passed small amounts of urine. Therefore it is recommended that the child wear cotton pants inside the nappy, or that the parent/carer fold a piece of paper kitchen towel inside the nappy. It is very obvious when these are wet. The pants or piece of kitchen towel should be changed if they are wet when the nappy is checked, but the nappy does not need to be changed more often than usual
- The toileting chart should be reviewed when completed to see if:
    - the child is having the recommended intake of drinks
    - to ensure they are not having excessive milk
    - to see whether they appear to be having normal bowel actions
    - to see if they are able to stay dry for more than an hour at a time
- As promotion of bladder and bowel health is the priority for all children, parents and carers should be offered advice as appropriate from the information received from the toileting chart
- Where a dietician is involved, they should be consulted prior to advice being given to the parent/carer about diet, fluid or milk intake

Once the toileting chart is completed and returned the assessment tool for toilet skills assessment chart (appendix three) must then be completed. This should be done with the child and parent/carer, so that the child can be observed in their normal environment, the parent/carer is involved and advice is given in an appropriate and timely way. Carrying out the assessment will allow skill deficits to be identified, alongside any underlying pathology. The assessment tool can then be used to inform an individualised toilet skill development programme.

- Sections a) and b) of the toilet skills assessment, must be completed using the toileting charts and information observed by the assessor. Normal formed bowel movements (section (b) 2 and 3) refer to a child passing type 3 – 5 stools three times a day to once every three days. Any bowel or bladder problem

should be addressed using the relevant pathway, or discussed with the continence service

- Products are not normally provided for children with enuresis (night time wetting- see section (c)), as this is considered a treatable condition. If the child is dry during the day, the enuresis pathway should be followed
- If a child is opening their bowels (section d) at night and is more than one year old, this is normally an indication of constipation. The constipation pathway should be followed
- Low scores for the section titled INDEPENDENCE (sections (e), (f), and (g)) do not mean that a child cannot toilet train. Efforts should be made to address the problems
    - If a child has poor sitting balance liaise with their OT for advice re suitable potty chairs or toileting equipment
    - If a child is refusing to sit, this should be gradually introduced using incentives and encouragement and appropriate equipment e.g. toilet seat reducer and step for their feet
    - If a child is not giving any indication of needing to go to the toilet, sign language or picture communication may need to be introduced. Individual advice may be sought from the continence service
    - Inability to handle clothes is of itself not a reason for a child to be prevented from toilet training. Assistance should be given to help the child to learn to handle their clothes, where possible. Advice should be provided to parents and carers about using clothes that are easier to adjust, or about appropriate adaptations. The occupational therapist may be able to make suggestions or offer help.
- If it is found that a child never passes urine or opens their bowels on the toilet or potty (sections (h) and (i)) then appropriately timed toileting should be tried. The toileting chart can be used to see if there is any pattern to wetting/soiling, or if these are related to drinks or meals. This information can be used to inform toilet visits. A daytime wetting alarm may increase the child's awareness of when they are voiding
- High scores for section (j) – behaviour problem – do not mean that a child cannot toilet train. Efforts should be made to address the problems. Learning disability services may be able to offer some suggestions

- If a child is likely to require toileting aids or adaptations (section (l)), this should be addressed early and may require referral to the occupational therapist
- If a child is not responding to basic commands (section (m)), then changing routines, or introducing picture cue cards, or social stories may be helpful
- Diet (section (n)) and fluids (section (o)) should be assessed and any changes required discussed with the family, paying heed to individual children's needs or advice given by a dietician if involved

The toilet skills assessment should be reviewed and actions should be taken as indicated by the prompts. If these actions are felt to be inappropriate this should be documented with the reasons in the child's notes. It is not acceptable to ignore highlighted problems. These must be treated where possible and the child then reassessed for their ability to toilet train.

A formal toilet training programme should be put in place once the child is achieving the skills to enable training to take place. These include:

- a maturing bladder that is starting to hold urine for increasing time periods
- a bowel that is not constipated
- an ability to sit on the toilet/potty for sufficient time to complete bladder or bowel empyting (with support or adaptations if required)

The continence service should be consulted as required. In line with the National Guidance for Provision of Continence Containment Products 2016 (reviewed 2019) products will only be provided to children who are at least four years old and have undertaken full assessment and toilet training trial as above. However, every child will be considered on an individual basis and decisions will be made based on the outcome of assessment.

More resources to support toilet training are available online from Bladder and Bowel UK.

Parental support and advice

It is what parents and carers do at home that makes the difference. Therefore it is important to support parents and carers in the management of their child's continence difficulties.

Parents and carers typically worry about their child's bladder or bowel problems and about the impact these problems have on their child. Some parents may however, become intolerant of their child's continence difficulties and lack of progress. This may have a negative impact on the management of the child's bladder or bowel problems and also on the parent/carer/child relationship.

Therefore it is important to support parents and carers in the management of their child's continence difficulties and in overcoming the many causes of frustration when dealing with a chronic illness.

Questions to ask parents and carers to assess their tolerance include:

- What concerns you about the wetting/soiling?
- What are the reasons for the wetting/soiling?
- What has your child tried to do to stop the wetting/soiling?
- How does the wetting/soiling make the parent or carer feel?
- How do you cope with the wetting/soiling?

(Adapted from Nocturnal Enuresis Resource Pack, Charts Questionnaires and Information to Assist Professionals, R Butler, fifth edition, 2006. Pub: ERIC)

Supportive parents or carers will express concern for the emotional state and wellbeing of the child, impact on the child's social activities and on their self-esteem. They may link incontinence to causes outside the child's control, such as deep sleep or family history.

Supportive parents or carers may talk about attempts made by the child, such as helping to get changed, following instructions from the parents, such as drinking more

or less, stopping fizzy drinks. They will be empathetic, find solutions and cope with practicalities.

Many parents and carers will discuss the impact of extra washing and drying, the smell of urine and faeces and the cost of replacing bedding or clothing, but these may make some parents and carers less tolerant. Causes for concern may include parents or carers who focus on the impact of the wetting or soiling on them, rather than the child; punitive responses to the incontinence, threats, hostility towards, or humiliation of the child.

If health professionals have any safeguarding concerns they should take appropriate action in accordance with the local policies and procedures.

References

Austin PF et al 2016 The Standardization of terminology of lower urinary tract function in children and adolescents: update report from the standardization committee of the International Children's Continence Society Neurourology and Urodynamics 35 471-481

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http://www.publichealth.hscni.net/publications/birth-five

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Healthy child programme 0 to 19: health visitor and school nurse commissioning
https://www.gov.uk/government/publications/healthy-child-programme-0-to-19-health-visitor-and-school-nurse-commissioning

Jursi A C 'Toilet training of infants and children 2010 parental attitudes and practices'. (The Restraint Project UNSW)

NICE 2010 Constipation in children and young people: diagnosis and management
https://www.nice.org.uk/guidance/cg99

NICE 2014 Constipation in children and young people – Quality Standard
https://www.nice.org.uk/guidance/qs62

NICE 2010 Bedwetting in children and young people – Guidance
https://www.nice.org.uk/guidance/cg111

NICE 2014 Bedwetting in children and young people – Quality Standard
https://www.nice.org.uk/guidance/qs70

Nocturnal Enuresis Resource Pack, Charts Questionnaires and Information to Assist Professionals, R Butler, fifth edition, 2006. Pub: ERIC

Appendix one

Definitions

Continence	The ability to hold onto urine or faeces until a socially acceptable time and place to pass urine or defecate is reached.
Continuous incontinence	The constant leakage of urine, throughout the day and night. This is usually due to congenital malformations such as ectopic ureter or functional loss of the external urethral sphincter.
Constipation	Two or more of the following: Fewer than three stools per week (Type 3 or 4 on the Bristol stool chart); overflow soiling (often smelly stools, usually passed without sensation); type one stools; large, infrequent stools that block the toilet; poor appetite that improves after a large bowel action; waxing and waning of abdominal pain, that improves after a bowel action; retentive posturing; straining, anal pain.
Daytime urinary incontinence	Intermittent incontinence when awake. (The term diurnal enuresis to describe daytime wetting is no longer used).
Enuresis	Wetting in discrete amounts during sleep. If a child has urinary incontinence in discrete amounts when both awake and asleep they should be described as having daytime urinary incontinence and enuresis. Enuresis is still sometimes referred to as nocturnal enuresis, although the word 'nocturnal' was removed by the International Children's Continence Society.
Faecal incontinence	The involuntary leakage of faeces.
Frequency	Passing urine more than seven times a day.
Soiling	The involuntary passing of stools into the underwear. The child is often unaware of the soiling and it is usually associated with chronic constipation (NICE 2010)
Straining	Having to increase intra-abdominal pressure to initiate and maintain voiding (Austin et al 2016)
Toilet training	The process of learning to pass urine and stools at an appropriate time, in a socially appropriate place.
Urgency	The sudden, unexpected and immediate need to pass urine. In children this is often accompanied by holding manoeuvres such as squatting, dancing or holding the groin, followed by rushing to the toilet. Parents often describe the child as being lazy, or leaving going to the toilet to the last minute.
Urinary incontinence	The involuntary leakage of urine.

Appendix two

TOILET SKILLS ASSESSMENT	
Child's Name: ……	**Date of Birth: ……..** **NHS No .....**
Initial Assessment completed by: ……	Date of 1st assessment: …… Date of 2nd assessment: ..... Date of 3rd assessment: .....

		Assess 1	Assess 2	Assess 3
(a) bladder function – bladder emptied:		√	√	√
1 More than once per hour				
2 Between 1-2 hourly				
3 More than 2 hourly				
(b) Bowel function:				
1 Has more than three bowel actions per day				
2 Does not always have normally formed bowel movements i.e. is subject to constipation or diarrhoea				
3 Has regular normally formed bowel movements				
(c) If night-time wetting occurs:				
1 Frequently i.e. every night				
2 Occasionally i.e. has occasional dry nights				
3 Never				
(d) If night-time bowel movements:				
1 Occur frequently i.e. every or most nights				
2 Occur occasionally i.e. has some clean nights				
3 Never occurs				
INDEPENDENCE				
(e) Sitting on the toilet:				
1 Afraid or refuses to sit				
2 Sits with distraction or encouragement				
3 Sits briefly with or without toilet adaptation				
4 Sits long enough to complete voiding or a bowel action				
(f) Going to the toilet:				
1 Gives no indication of need to go to the toilet				
2 Gives some indication of need to go to the toilet				
3 Sometimes goes to or indicates need for toilet of own accord				

		Date	Date	Date
(g) Handling clothes at toilet:		√	√	√
1 Cannot handle clothes at all				
2 Attempts or helps to pull pants down				
3 Pulls pants down by self (if physically able)				
4 Pulls clothes up and down without help				

Other components				
(h) Bladder control:				
1 Never or rarely passes urine on toilet/potty				
2 Passes urine on toilet sometimes				
3 Passes urine on toilet every time				
4 Can initiate a void on request				

(i) Bowel control:				
1 Never or rarely opens bowels on toilet/potty				
2 Opens bowels on toilet sometimes				
3 Opens bowels on toilet every time				

(j) Behaviour problem that interferes with toileting process e.g. screams when toileted, faecal smearing:				
1 Occurs frequently				
2 Occurs occasionally i.e. less than once a day				
3 Never occurs				

(k) Wears disposable nappies, "pull ups" or similar:				
1 Yes				
2 No				

(l) Toilet:				
1 Requires toileting aids or adaptations				
2 Uses normal toilet/potty				

(m) Response to basic commands, e.g. "come here":				
1 Never responds to commands				
2 Occasionally responds				
3 Always responds				

(n) Diet:				
1 Refuses/unable to eat any fruit/veg				
2 Will occasionally eat fruit/veg each day				
3 Eats adequate amount (child's age + 5 = grams fibre per day)				

(o) Fluid intake:				
1 Drinks poor amount < 50ml/kg per day				
2 Drinks 50mls/kg per day < (4-5 drinks)				
3 Drinks 80ml/kg per day (6+) drinks				

Appendix three

PLEASE COMLETE IN BLACK INK

Frequency Volume Chart

Instructions Overleaf

Name: ……..

NHS No: .....

Children's Continence Service

Tel:

	DAY 1 Date.....				**DAY 2** Date.....				**DAY 3** Date.....			
	Drinks		**Urine**	**Bowels**	**Drinks**		**Urine**	**Bowels**	**Drinks**		**Urine**	**Bowels**
	Type	Amount			Type	Amount			Type	Amount		
6 am												
7 am												
8 am												
9 am												
10 am												
11 am												
Midday												
1 pm												
2 pm												
3 pm												
4 pm												
5 pm												
6 pm												
7 pm												
8 pm												
9 pm												
10 pm												
11 pm												
Midnight												
1 am												
2 am												
3 am												
4 am												
5 am												
TOTAL												

INSTRUCTIONS

Please record

1. Type and amount of all drinks in mls
2. The amount of urine passed in mls (measure in a jug)
3. The time and type of bowel movements, using the Bristol Stool Chart opposite ►
4. Any wet beds or wet clothes (write wet in the urine column). If wetting occurs estimate the amount by writing
   WS for a small amount
   WM for a medium amount
   WL for a large amount
5. Indicate bedtime by writing B in the urine column
6. Indicate time of waking by writing M in the urine column

BRISTOL STOOL CHART

Type 1. Separate hard lumps, like nuts (hard to pass)

Type 2. Sausage-shaped but lumpy

Type 3. Like a sausage but with cracks on the surface

Type 4. Like a sausage or snake, smooth and soft

Type 5. Soft blobs with clear-cut edges (passed easily)

Type 6. Fluffy pieces with ragged edges, a mushy stool

Type 7. Watery, no solid pieces, entirely liquid

Appendix four

PLEASE COMLETE IN BLACK INK

Toileting Chart

Instructions Overleaf

Name: ……..

NHS No .....

Children's Continence Service

Tel:

	DAY 1 Date.....				**DAY 2** Date.....				**DAY 3** Date.....			
	Drinks		**Urine**	**Bowels**	**Drinks**		**Urine**	**Bowels**	**Drinks**		**Urine**	**Bowels**
	Type	Amount			Type	Amount			Type	Amount		
6 am												
7 am												
8 am												
9 am												
10 am												
11 am												
Midday												
1 pm												
2 pm												
3 pm												
4 pm												
5 pm												
6 pm												
7 pm												
8 pm												
9 pm												
10 pm												
11 pm												
Midnight												
1 am												
2 am												
3 am												
4 am												
5 am												
TOTAL												

It is important that you complete this chart as part of the assessment of your child's bladder and bowel health and their ability to toilet train.

INSTRUCTIONS

Please record

1. Type and amount of all drinks (in mls)
2. When your child has a meal or food
3. Check your child's nappy every hour, when they are awake, and record whether wet (W) or dry (D). This can be difficult with modern "super absorbent" nappies. We suggest that you put something inside the nappy, so that you can easily tell whether your child is wet or dry. Folded kitchen roll works well; if the kitchen roll is wet, change it, but the nappy can stay on until it will not hold any more urine
4. If your child uses the toilet or potty successfully, put (T) in the urine column
5. Record poos in the bowel column

Try and carry on for as many days as you can. Please continue for at least four days.

Bristol Stool Chart

Type 1. Separate hard lumps, like nuts (hard to pass)

Type 2. Sausage-shaped but lumpy

Type 3. Like a sausage but with cracks on the surface

Type 4. Like a sausage or snake, smooth and soft

Type 5. Soft blobs with clear-cut edges (passed easily)

Type 6. Fluffy pieces with ragged edges, a mushy stool

Type 7. Watery, no solid pieces, entirely liquid

Appendix 5 Children's Continence Initial Assessment Tool

Child's forename and surname	Date of birth (day month year)
	NHS No:

Children's Continence Initial Assessment Tool – for all children 0-19 yrs

(Including those with additional needs)

Prior to undertaking the assessment the child and family should complete a bladder diary for 48 hours and bowel and night wetting diary for one week using standard documentation. Include:

- Fluid intake (what, when and how much the child has drunk)
- Frequency & consistency of bowel movements (use Bristol Stool Form chart) Expected frequency of no more than x3 per day / no less than x3 per week
- Any soiling including time, amount, location
- Number of voids including any wetting (normal range 4 – 7 voids per day)
- Volume of voids (Expected bladder capacity = age x 30 + 30)
- Any bedwetting with estimated size of wet patch and time if known

Fluid intake (refer to chart in resource pack for age appropriate intake)**:**

	YES	NO	ACTION
Good fluid intake: drinks 6-8 water based drinks per day (total appropriate for age)			If no advise to adjust intake accordingly
Poor fluid intake (less than 80% of expected for age) and/or includes fizzy and caffeinated drinks			If yes advise to adjust fluid as necessary
Drinks spread evenly throughout the day?			If no advise re regular drinks including three drinks in school and last drink an hour before bed

Bowel Function:

Red Flags	YES	NO	ACTION
Any delay in passage of meconium (>48 hrs)			If yes refer child under one year directly to paediatrician; discuss older child with continence nurse
Symptoms apparent within first few weeks of life			If yes refer child under one year directly to paediatrician; discuss older child with continence nurse
Passing ribbon (very narrow) stools from birth			If yes refer directly to paediatrician
Concern re abdominal distension with vomiting			If yes refer directly to paediatrician
Recent leg weakness noticed			If yes refer to paediatrician

History	YES	NO	
Less than 3 bowel movements / week (in non breast fed baby and weaned child)			If yes consider constipation – refer to pathway
Has frequent daily soiling?			If yes consider faecal impaction – refer to constipation pathway

Child's forename and surname	Date of birth (day month year)
	NHS No:

Stool consistency (use Bristol Stool Form Chart) reported to be 1-3 or 6-7			If yes consider potential for constipation – refer to pathway
Often or occasionally opens bowels during sleep?			If yes consider if toilet refusal in the day (behavioural issue) or if underlying constipation
Struggles to open bowels, withholds, has pain with bowel motions, has frequent abdominal pain?			If yes suggestive of constipation – refer to pathway
Other? (describe)			If concerned discuss with continence nurse, or refer on to GP or paediatrician, as appropriate

Daytime Bladder Problems:

Red Flags	**YES**	**NO**	
History of repeated UTIs			If yes refer to GP for further investigation
Child (particularly girls) reported to be always wet during day (continuous incontinence)			If yes discuss with continence service or refer to GP for further investigation
Any reported straining to void or weak stream			If yes refer to GP for further investigation

History	**YES**	**NO**	
Voids either > 7 or < 4 times per day			If yes check fluid intake to ensure within recommended amount and refer to daytime wetting pathway
Is toilet trained and has wetting accidents during the day			If yes refer to daytime wetting pathway
Some reported frequency (voids > x7/day) or urgency (has to dash to the toilet)			Advise re regular toileting (e.g. 2 hourly) plus regular drinks
Child has failed to achieve day time dryness at all by age 3 years			If yes refer to toilet training pathway
Other? (describe)			If concerned discuss with continence nurse

Toileting issues (from age 2 years including those with additional needs):

	YES	**NO**	
Behavioural problems that may impact on toileting or toilet training			Consider behavioural support techniques
Anxieties or toilet refusal			Consider behavioural support techniques
Has a mobility or sensory problem that interferes with ability to sit on toilet safely?			Consider referral to OT

Child's forename and surname	Date of birth (day month year)
	NHS No:

Gives no indication of needing to use toilet?			If yes refer to toilet training pathway
Never or rarely passes urine or opens bowels on the toilet/potty?			If yes refer to toilet training pathway
Insists on nappy for opening bowels or other toilet refusal?			If yes consider behaviour modification programme
Other? (Describe)			If concerned refer to toilet training pathway and discuss with continence nurse

Night time wetting (children over the age of 4 yrs):

Red Flags	**YES**	**NO**	
Reported weight loss or excessive thirst			Refer to GP for investigation (e.g. urinalysis and blood sugar)
Some concern re parental intolerance / safeguarding issues			If yes follow local safeguarding policy

History	**YES**	**NO**	
Is wet more than two nights a week?			If yes clinically significant refer to bedwetting pathway
Wakes after wetting			Possible overactive bladder – confirm no daytime symptoms
Other? (Describe)			Refer to bedwetting pathway and discuss with continence nurse if concerned

N.B. ensure additional information is documented in child's notes and included on any referrals.

OUTCOME:

Advice offered: (provide details) Information sheets provided to family (provide details)
Commenced on pathway: (details of pathway)

Child's forename and surname	Date of birth (day month year)
	NHS No:

Initial assessment completed by (name and job title): Contact details (base and phone number):	Presenting problem: :
Caseload holder (name and contact details if different from above)	Signature of person completing initial assessment
	Date (day month year)

Date for reassessment / review:
Reassessment review undertaken by (name and contact details)
Outcome of reassessment/review (provide details)

Signature of person completing assessment	Date

Referred to continence service / paediatrician / GP / other (specify)	Referral done by (name, job role, contact details if different from above) Date