Bladder & Bowel UK

Children's Bladder and Bowel Care

For healthcare professionals in primary care

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Introduction

Bladder and bowel issues have a huge impact. They cause shame, embarrassment, frustration, social isolation, feelings of difference, reduced self-esteem, loss of social opportunities and lower quality of life for the whole family. Furthermore, for some children and teenagers they affect sleep, which may impact on behaviours and learning in the day and for others they may result in reduced school attendance.

This resource pack includes information to help healthcare professionals working within primary care settings to support children and teenagers who present with common bladder and bowel issues. There are sections covering delayed toilet training, constipation, soiling, daytime bladder issues and bedwetting.

Further advice and support should be available from the local specialist children's bladder and bowel service or via the Bladder & Bowel UK helpline.

Safeguarding children with bladder and/or bowel issues

Most families are supportive of their child and concerned to find ways to support them. However, some families, usually due to a lack of understanding that bladder and bowel issues are medical problems and outside the control of their child may respond punitively. This may become a safeguarding concern.

Families' responses to their child's bladder or bowel issue should be assessed. Parents or carers who are intolerant of their child will focus on the impact on themselves rather than on the child and may use punishment inappropriately. This may result in concerns for the child's wellbeing.

Questions to consider asking include:

- ***What concerns you about the wetting/soiling?*** Supportive families will express concern for the emotional state and wellbeing of their child, impact on their child's social activities and on their self-esteem. Families who may be intolerant are more likely to focus on the impact of extra washing and drying, the smell and the cost of replacing bedding or clothing.
- ***What are the reasons for the wetting/soiling?*** Supportive families may link incontinence to causes outside their child's control, such as deep sleep or family history. Intolerant families may consider their child to be lazy, naughty, doing it on purpose, or doing it to get back at or punish the parents in some way.

- ***What has your child tried to do to stop the wetting/soiling?*** Supportive families may talk about attempts made by their child, such as helping to get changed, or following instructions, e.g. adjusting their drinking, stopping fizzy drinks. Intolerant families are more likely to consider their child can be dry or clean when they want to be, that the chid is not bothered, or has not tried anything.
- ***How does the wetting/soiling make the parent or carer feel?*** Families who are supportive of their child may talk about being empathetic with them and how it is unpleasant for their child. Intolerant families may express hostility, anger, annoyance or frustration with their child.
- ***How do you cope with the wetting/soiling?*** Families who are supportive try to find solutions and cope with practicalities. Those who are intolerant may be punishing their child, humiliating them, showing disappointment, making threats, reprimanding or withdrawing privileges.[1]

It is not unusual for families to consider the impact on themselves as well as their child. However, the clinician should be observant for any signs that may suggest that there are safeguarding concerns. If these are present, appropriate and timely advice should be sought from the Children's Bladder and Bowel Service, and/or from the safeguarding children department with action taken and documented in accordance with the local policies and procedures on safeguarding children.

Promoting Bladder and Bowel Health

FLUID ADVICE

Adequate fluid intake is an important part of treatment for bladder and bowel problems affecting children and teenagers, including daytime bladder symptoms, night time wetting and constipation. It is also important when children are learning the skills for toileting.

Children, teenagers and their families should be advised that:

- Caffeinated drinks, including tea, coffee, hot chocolate, energy drinks and cola, should be avoided as they may have a diuretic effect and may irritate the bladder, contributing to bladder overactivity
- Fizzy drinks should be avoided as they can contribute to bladder overactivity.

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

- Extra water-based fluids will be needed for those doing lots of exercise (including sports, playing out and school playtimes), or if the weather or their environment is hot.
- Milk is healthy, but it 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 this may be due to a sensory issue, behavioural issue, or if the child / teenager may have diabetes insipidus.
- Children and teenagers should be encouraged to take full water bottles (500 – 750mls) to school and drink the contents during the school day.
- Water is the healthiest drink and should be encouraged. However, many refuse to drink it. If children / teenagers do not like to drink water, arrangements should be made for them to take a non-see-through bottle to school with diluted fruit squash (preferably sugar-free).
- Schools should be asked to allow the child / teenager open access to their drink's bottles and to the toilet, particularly if they are being encouraged to increase their drinking, or have daytime bladder or bowel issues.

Age	Sex	Total drinks per day
7-12 months		600 – 900ml
1-3 years	Female Male	900 – 1000ml 900 – 1000ml
4–8 years	Female Male	1200–1400 ml 1200–1400 ml
9–13 years	Female Male	1200–2100 ml 1400–2300 ml
14–18 years	Female Male	1400–2500 ml 2100–3200 ml
Suggested intake of water-based drinks per 24 hours according to age and sex: (Adapted from CG 111 Nocturnal Enuresis NICE 2010)		
NB higher intakes of water are required when children are physically active, or the weather or environment is hot. Overweight children may also require more water.		

Strategies to help children increase their fluid intake:

- 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 what the child should be having each day into a clean jug or plastic bottle. Making all their drinks from that may help them visualise how well they are doing. If they have a drink from a carton or bottle, the equivalent quantity of water from the jug or bottle can be poured away. The child should be encouraged to finish their jug or bottle by the end of teatime 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.
- Build drink times into the family's daily routine.
- Make drink times fun: Suggest that the parent or carer sit together with their child and read a book or play game and do not read any more/throw the dice until the child has had a few more sips. If the child refuses to drink more the parent can put the book or game away.
- Families should be advised to avoid battles over drinks.
- Use straws or a glass or cup, with a design that is appealing to the child.
- Add ice, or give the chid the drink at the temperature they prefer.
- Ice lollies and jellies are high in fluid content, but tend to be high in sugar, so should be used with caution.
- The child should be having half their daily intake by the time they have their midday meal to avoid them having large quantities late in the day, as this may cause or exacerbate nighttime wetting.
- The child / teenager should avoid drinks in the last hour before bed

TOILETING ADVICE

- Encourage the child / teenager to use the toilet regularly during the day, when they feel the need. About two hourly is the correct interval for most if well hydrated. If the child / teenager is experiencing daytime wetting more often than this, the interval should be shorter to try and ensure that they remain dry.
- If the child/teenager has a bladder or bowel issue, suggest that they use the toilet after they have had a drink. If they are toileting about two hourly this can help with fluid intake as well.
- Ensure the toilet is easy to access, clean and well stocked with toilet paper etc. This is particularly important at school.
    - Secondary school students may benefit from a medical or time out pass to ensure open access to the toilet (they may be too embarrassed to use a pass that is for toileting only).
- Primary school children may need the teacher to know about the bladder or bowel issue. Having a signal for the child to indicate to the teacher when they need the toilet and them being allowed to leave the classroom promptly may be helpful.

- Ensure that children and teenagers are sitting in the correct position on the toilet (see picture). They need to be able to sit comfortably, with their bottom well, supported, their feet slightly apart and flat on a firm surface, and their knees higher than their hips. Smaller children will need an insert seat and step to achieve this.

- 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 / teenager feels they need to pass urine urgently or suddenly, they may be encouraged to count to five. If the feeling goes away, they should wait until the next planned toilet visit. If the feeling remains or they are likely to wet if they do not toilet quickly, 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 delay passing urine for longer than a few seconds if a child has urinary urgency or daytime wetting. This should not be encouraged.
- Children / teenagers should be encouraged to remain at the toilet long enough to complete voiding.
- Children / teenagers should be encouraged to sit on the toilet long enough to complete a bowel action. They should be able to sit privately. For those with constipation, soiling or other bowel issues, there is often benefit from allowing them access to the disabled toilet in school, as this is often more private than the main toilets.
- If the child / teenager is incontinent at school it would be helpful to them to have spare clothes, wipes and plastic bags for their clothes, in their school bag to allow changing as needed. Parents/carers should provide these from home and a system be arranged so that they know when replacements are required.
- Children should be supported to learn to change independently as soon as they have the developmental skills to do so. If they are incontinent in school, they may need support with learning to change themselves initially, or until their dexterity is sufficiently good for them to manage alone.
- It is not acceptable for schools and nurseries to request family members to attend to support their children with personal hygiene.

Guidance is available from the Department of Education for educational establishments to help them manage children with medical needs. There is also

Guidance on Managing Bladder and Bowel Issues in Nurseries, Schools and Colleges on the Bladder & Bowel UK website.

DIETARY ADVICE

- Dietary adjustment alone is not an acceptable treatment for chronic constipation in children and teenagers. It does, however, play a part in treatment and health promotion.
- Children / teenagers should be encouraged to eat a varied diet including fruit and vegetables.
- Wholegrain cereals, brown bread and rice can be helpful and are part of a healthy diet.
- Children / teenagers should not be eating unprocessed bran.
- Children over the age of one year should not be having more than a pint of milk or its equivalent (yoghurts, fromage frais, cheese, custards, rice puddings etc) per day. This can exacerbate constipation, reduce appetite and prevent children from having a balanced, varied diet.

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

Promoting Continence

SYMPTOMS OF CONSTIPATION

Constipation is a problem that affects up to 30% of children and teenagers. For many it lasts only a few days, but it can become chronic in about one third and is a frequent reason for referral to children's bladder and bowel services, secondary care and A & E. 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 be having a soft bowel motion most days, but to be constipated if they are only partially emptying the rectum. Some children may only pass loose stools, which means it is not always easy to diagnose constipation in children.

Two or more of the following may be indicative of constipation:

- Infrequent bowel motions (less than three times per week in children over 3 years old)

- Soiling or overflow: offensive smelling stools that are usually passed without the child / teenager being aware of them
- Small, hard or very large stools (rabbit droppings or stools that block the toilet)
- Poor appetite that may improve after a large bowel motion
- Abdominal pain that improves after a bowel motion
- Withholding or appearing to strain to pass stools
- Anal pain
- Painful bowel motions
- Bleeding associated with hard stools
- Previous constipation
- Current or previous anal fissure[2]

The following may also be symptoms of constipation:

- Unpleasant smelling wind or bowels motions
- Excessive flatulence
- Varying texture to bowel motions
- Bowel motions in sleep in children over a year in age
- Abdominal distension
- Lethargy
- Unhappiness, anger or irritability that improves after a large bowel motion

NB. If the child is presenting as acutely unwell, has faltering growth or gross abdominal distension they should be reviewed by their GP or a paediatrician.

TREATMENT FOR CONSTIPATION

First-line treatment of constipation in children and teenagers is laxatives, usually a macrogol, as per NICE Guidance[2] and the BNFc[3]. As laxatives need to be prescribed for children under the age of 12 years, the family should be referred to their GP for initial treatment or to the children's bladder and bowel service, according to locally agreed pathways.

Dietary and fluid intake adjustments, if required, and good toileting habits, are treatment adjuncts. Laxatives should be commenced at sufficient doses to ensure disimpaction, if required, and that there are then good size bowel motions passed once to three times most days.

[2] NICE 2010
[3] British National Formulary for Children (BNFc)

Information, such as that on the Bladder & Bowel UK information library, should be shared with the child and family[4].

SUPPORTING SKILL DEVEOPMENT FOR TOILET LEARNING

Learning the skills required for toileting and becoming independent with this should be among the earliest self-care abilities developed by children and is one of the most important. In traditional societies, most children have attained continence by their second birthdays. In high income countries, the age at which children are introduced to the skills they will need for toileting has increased in recent decades.

All children should start to develop the skills for toilet training in the first year of life. Supporting children to learn the skills required for toileting should not be delayed due to disability. Failure to offer additional assistance and advice to families to enable children with disabilities to develop the skills required for toileting may be considered discriminatory.

When children remain reliant on continence containment products (nappies and pads), rather than being supported to learn the skills for toileting, they may fail to achieve their potential,. This is associated with increased dependence compared to their peers, reduced self-esteem and self-confidence, increased likelihood of abuse and there is more stress for them and their family.

The following may be helpful:

- Ensure the child has adequate fluid intake and a varied diet if possible (see relevant sections of this document).[5]
- Encourage the child to sit on the potty or toilet regularly. The potty may be better for smaller children as they may feel more secure and their feet will be flat and well supported on the floor, their knees will be bent and higher than their hips. 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[6].
- If the child has any physical or sensory issues, they should have an early referral to occupational therapy for assessment of their toileting needs. Information on the impact of sensory issues on toilet training is available on the Bladder & Bowel UK website.

[4] There is information for teenagers about constipation in the Bladder & Bowel UK teenagers information library
[5] See sections on fluid and dietary advice
[6] See picture in section on toileting

- Start by sitting the child on a potty or adapted toilet once a day for short periods of time. 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 family can manage this, otherwise straight away. Also encourage potty / toilet sits after waking from sleep and after meals.
- Tip solid poos down the toilet and then flush them away, with the child present, unless they are frightened of or upset by the noise of the flush.
- 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 other close family members using the toilet.
- Ensure all carers use the same words to describe wee and poo. Avoid using the word 'dirty' for poo as this has other meanings.
- Discuss the difference between wet and dry.
- Consider using picture cue cards, stories, videos, sign language, objects of reference, songs etc. to assist understanding and communication.
- Encourage the child to say (or sign) when they are wet or have opened their bowels.
- Encourage the child to learn to help dress and undress themselves.
- Use clothes that are easy for the child to manage.
- 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 inside the nappy or washable pants to raise awareness of when they are wet or dry.
- Ensure the parent/carer has a plan for dealing with wetting or soiling when away from home and has good routines established.
- Ask the family to keep an hourly record[7] during their child's waking hours for three or four days of when their chid drinks, passes urine or opens their bowels. Use the chart to inform timing of potty or toilet visits but advise the family not to take their child to the toilet more often than once every 60 minutes.
- When the family are catching about half of the voids in the potty or toilet remove the nappies during the day and continue with timed toilet / potty visits. Washable training pants may be helpful.

[7] This can be done on an app, electronic record or a paper diary

- If the child is wet between toilet / potty visits, the family may reduce the interval between visits, but should not take their child more than once every 60 minutes. This interval can be gradually increased as their child becomes dry between visits, until they are able to go about two hours.
- Praise and reward success. Respond to wetting or soiling by changing the child in the bathroom with minimum fuss and feedback.
- Consistency is important and once progress is being made, the family should be encouraged not to return to nappies during the day. Many children will have lots of little voids in their underwear in the first few days after removal of nappies. This usually improves as the children learn to recognise the bladder signals and to empty their bladder fully on the toilet.

There is more information on the Bladder & Bowel UK website and in the National Guidance for Supporting Skill Development for Toilet Training

TOILETING ASSESSMENT

Information about skill development for toilet training should be provided to all families in the first year of life. If a child has a physical or learning disability, assessment for toilet learning should commence as soon as it is identified that there is any disability or condition that may impact the child learning the skills for toileting.

Assessment should be dynamic process, with a programme put in place to address any issues. The child should be reassessed regularly, 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 resources and dynamics, with some families needing frequent review and others minimal intervention.

The first stage of a toileting assessment involves asking the family to keep a full toileting diary for at least three days. This may be done using an appropriate app, electronic diary or the toileting chart. 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.

- Families should be provided with instructions on how to complete toileting records. They may use a paper record, an app or electronic diary[8]
- Families should be advised to keep records for all the child's waking hours for at least three full days. This must be done on days when the child is with the parent/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 kitchen towel inside the nappy, if the child will tolerate this, as it is 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 and
    - to see if they can stay dry for more than an hour at a time: if the child is wet every hour the family should be asked to check their child every ten to fifteen minutes for one to two hours. If they are still wet every time they are checked, they should be referred to paediatrics to exclude an underlying congenital anomaly. If they are dry on some occasions, then the bladder and bowel service should be asked for advice.
- As promotion of bladder and bowel health is the priority for all children, families 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 family about diet, fluid or milk intake.

Once the toileting chart is completed and returned the assessment tool for toilet skills chart (or similar) must 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 skills that need additional support to be identified, alongside any underlying pathology. The

[8] Instructions on how to complete a toileting diary are on the back of the sample chart

assessment tool can then be used to inform an individualised toileting skills 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 bladder and bowel service.
- Products are not normally provided for children who are wet during sleep (see section (c)), as this is considered a treatable condition. If the child is dry during the day, the enuresis pathway should be followed.
- Overnight bowel motions in a child who is more than one year old (section d) 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 learn the skills for toileting. Efforts should be made to address the problems:
  - If a child is not sitting, then this should be gradually introduced using incentives and encouragement and appropriate equipment.
  - If a child is not giving any indication of needing to go to the toilet, then sign language, or picture communication, objects of reference or other communication aids may need to be introduced. Individual advice may be sought from the children's bladder and bowel service.
  - Inability to handle clothes is not a reason for a child to be prevented from learning other skills for toileting. Assistance should be given to help the child to learn to handle their clothes, where possible. Advice should be provided to the family 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, including 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 behaviour problem (section (j)) does not mean that a child cannot learn the skills for toileting. 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. Any required referral to occupational therapy or physiotherapy should be made promptly.
- If a child is not responding to basic commands (section (m)), changing routines or introducing picture cue cards, social stories or other communication strategies 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.

An individualised toilet training programme should be put in place to support the child develop the required skills. This should include:

- Teaching the child to sit in the correct place and position for sufficient time to complete bladder or bowel empyting (with support or adaptations if required), by gradually increasing the time and frequency of potty/toilet sits.
- Games[9] and appropriate communication to increase the child's understanding of what is expected.
- Appropriate use of praise and rewards for desired behaviour around toileting.
- Teaching the child to manipulate their clothing and wash their hands.
- Introduction of timed toileting when the child is most likely to need to pass urine or open their bowels, informed by a toileting chart.
- Removal of the nappies when the child is passing about half of their voids into the potty or toilet.

The children's bladder and bowel service should be consulted if there are any concerns or the child is not progressing as expected.

There is more information on the Bladder & Bowel UK website and in the National Guidance for Supporting Skill Development for Toilet Training.

[9] There are some games designed to support toilet skills development on the Twinkl website

DAYTIME BLADDER ISSUES: INITIAL ADVICE

Children /teenagers who experience day time wetting, damp underwear, urinary urgency, or urinary frequency should have a urinalysis done to exclude urinary tract infections. The child / teenager should also be advised about regular daytime drinking and toileting. Together these form bladder training, which may be helpful.

If these measures do not help within 8 – 12 weeks, or if there are other bladder or voiding symptoms the child / teenager should be referred to the local children's blader and bowel service or paediatric urology, according to their symptoms, the daytime wetting pathway and locally agreed pathways.

NIGHT TIME WETTING: INITIAL ADVICE

If bedwetting has only started in the last few days or weeks consider whether it might be caused by systemic illness.

If the child also has daytime symptoms (e.g. urgency, frequency, daytime wetting), refer to the daytime wetting pathway.

- Explain that the bedwetting is not deliberate, it is not the child's fault. The child should not be told off or punished.
- Explain the usual causes of bedwetting.
- Exclude constipation. If suspected or present, offer appropriate advice and interventions or refer for these
- If children have snoring or sleep apnoea arrange referral for ENT assessment.
- Encourage daytime water-based drinks.
- Do not limit fluid intake during the day, unless excessive (see fluid advice).
- Advise the child and parent that they should avoid caffeinated, fizzy and energy drinks. Tea, coffee, hot chocolate, cola and many energy drinks contain caffeine.
- 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 last hour before sleep.
- Avoid high salt and high protein foods late in the day (these increase urine production).
- Avoid use of electronic screens beyond recommended limits for age (no more than two hours per day, excluding homework, for those aged 5 – 17years).

- Do not lift/wake the child to use the toilet after they have gone to sleep. 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/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, washable or disposable products. E.g. a waterproof sheet on the mattress, or absorbent pants.
- If the child is using products (e.g. disposable pants, nappies) and family circumstances allow, consider a trial of not more than 14 consecutive nights without. If the child continues to wet, they may choose to use products while waiting treatment. Using products while awaiting interventions should not be discouraged if it reduces stress to the family and child.
- Consider access to the toilet at night. If this is difficult, try to find ways to make it easier e.g. torch by the bed or potty in the room.
- Consider whether the child can get out of bed or has anxieties or fears that may result in difficulties getting up e.g. fear of the dark.
- Advise parents/carers to only use rewards for things that are in their child's control. A child cannot control what happens when they are asleep. Therefore, while encouragement and positive comments should be made for dry nights, rewards (if used) should focus on things that are in the child's control, such as drinking recommended levels and toileting during the day, for toileting before sleep, helping to strip their own bed etc.
- Monitor progress by keeping a diary of wet and dry nights, of waking after wetting, of waking to use the toilet.

If there is no improvement with initial advice, consider first line treatment options such as desmopressin[10] or an alarm[11] or refer to the children's bladder and bowel service. There is evidence that persisting with lifestyle adjustments alone, is not helpful in overcoming bedwetting.

[10] Information on desmopressin for healthcare professionals and for families is available on the Bladder & Bowel UK website

[11] Information on alarms for families is available on the Bladder & Bowel UK website

TOILET SKILLS ASSESSMENT TOOL

Child's Name: .....

NHS Number: .....

Date of Birth: .....

Date of 1st assessment: .....

Date of 2nd assessment: .....

Date of 3rd assessment: .....

Assessment 1 completed by: .....

Job Title: .....

Assessment 2 completed by: .....

Job Title: .....

Assessment 3 completed by: .....

Job Title: .....

BLADDER /BOWEL MATURITY		**Date of assessment:**	Assess	Assess	Assess
Bladder function – bladder emptied					
1 More than once per hour,	Check fluid intake – adjust if necessary. Toilet training is likely to help and is advised. If frequency persists after 5th birthday, consider assessment for constipation and bladder issues. E.g. Overactive bladder				
2 Between 1-2 hourly	Indication of developing bladder maturity – toileting skills development advised				
3 More than 2 hourly	Maturing bladder. Start /continue toileting skills development				
(b) Bowel function					
1 Opens bowels more than three times a day or less than once every three days	Exclude/treat any underlying constipation or bowel pathology and work on toileting skills development				
2 Does not always have normally formed bowel movements i.e. is subject to constipation or diarrhoea	Address underlying bowel problem while commencing / continuing work on toileting skills development				
3 Has regular normally formed bowel movements	Mature bowel – consider a toileting skills devleopment programme				
(c) Night-time wetting					
1 Wet most nights or every night	To be expected in a child who has not toilet trained				
2 Has occasional or some dry nights	Indication of developing bladder maturity: start/continue work on toileting skills				
3 Is usually or always dry at night	Mature bladder – start / continue work on toileting skills development				
(d) Night-time bowel movements					
1 Occur more than once per week	Assess for constipation – treat as appropriate while working on toileting skills				
2 Occur less than once a week	Consider constipation – treat as appropriate while working on toileting skills				
3 Never or rarely occurs	Start / continue work on toileting skills development				

INDEPENDENCE / AWARENESS		Assess	Assess	Assess
(e) Sitting on the toilet / potty				
1 Afraid, unable, or refuses to sit even with help	Refer to OT and physio for assessment, advice and appropriate equipment			
2 needs additional support to sit on toilet / potty	Liaise with OT if necessary re toilet adaptation/equipment			
3 Sits without help for long enough to complete voiding	Start / continue to work on toilet skills development			
(f) Going to the toilet / potty				
1 Gives no indication of need to go to the toilet / potty	Consider introducing strategies to raise awareness of wet/dry/soiled as part of skill devleopment for toileting			
2 Gives some indication of need to go to the toilet	Introduce positive reinforcement for target behaviour			
3 Sometimes goes to or asks for toilet of own accord	Continue to use strategies, such as motivators, to reinforce this behaviour			
(g) Handling clothes at toilet				
1 Cannot handle clothes at all	If child physically able introduce programme to encourage child to learn to dress / undress			
2 Attempts or helps to dress/undress for the toilet	Introduce positive reinforcement for this behaviour			
3 Pulls clothes up and down without help	Reinforce this behaviour as part of toilet skills development programme			
BEHAVIOUR				
(h) Bladder control				
1 Never or rarely passes urine on toilet/potty	Complete baseline bladder chart to identify voiding interval and then start toilet potty sitting at times when bladder most likely to be full (at least 60 mins apart)			
2 Passes about half of all voids on the toilet	Reinforce behaviour. Remove nappies when about half voids on toilet /potty			
3 Can initiate a void on request	Remove daytime nappy and continue to work on toilet skills development			
(i) Bowel control				
1 Never or rarely opens bowels on toilet/potty	Complete baseline bowel chart to identify frequency of bowel movements and then start toilet / potty sitting at a time when bowel more likely to be emptied e.g. after meals			
2 Opens bowels on toilet / potty sometimes	Start / continue to work on skills required for toilet training			
3 Opens bowels on toilet / potty every time	Evidence of bowel control. Consider removing nappies if doing well with voids (see section h above)			
(j) Behaviour problems, that interfere with toileting process e.g. potty / toilet refusal				
1 Occurs frequently, i.e. once a day or more	Consider causes, modification to the environment and individualised strategies			
2 Occurs occasionally, i.e. less than once a day	Consider assessment to identify trigger factors for behaviour e.g. sensory issues			
3 Never occurs	Start / continue work on toilet skills development			
(k) Response to basic commands, e.g. “come here”,				
1 Never/ unable to respond to commands	Discuss with MDT to explore strategies that may help			
2 Occasionally responds to commands	Consider routines for toileting and using or adapting child’s communication strategies			
2 Usually responds	Start / continue to work on toilet skills development			

PLEASE COMLETE IN BLACK INK

Toileting Chart

Instructions Overleaf

Name: .....

NHS No:.....

Service contact details

Tel: .....

Email:

	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. 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.
3. If your child uses the toilet or potty successfully, put (T) in the urine column.
4. Record poos in the bowel column.

Please continue for at least three full 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

PLEASE COMLETE IN BLACK INK

Frequency Volume Chart

Instructions Overleaf

Name: .....

NHS No:.....

Service contact details

Tel: .....

Email:

	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

Please continue for at least two full 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

Children's Bladder and Bowel Initial Assessment Tool for all children 0 – 19 years old (Including those with additional needs)

Child's Name	Date of birth
	NHS No:
Initial Assessment Completed by: Contact details:	Presenting problem:
	Date

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 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/or 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 infant directly to paediatrician, discuss older child with children's bladder and bowel service

Red Flags	YES	NO	ACTION
Symptoms apparent within first few weeks of life			If yes refer infant directly to paediatrician. Discuss older child with children's bladder and bowel service
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			
Less than 3 bowel movements / week (in formula fed baby or weaned child)			If yes consider constipation – refer to pathway
Has frequent daily soiling?			If yes consider faecal impaction – refer to constipation pathway
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 (possible 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 children's bladder and bowel service, 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			If yes refer to GP for further investigation
Any reported straining to void or weak stream			If yes refer to GP for further investigation
History			
Voids either > 7 or < 4 times per day			If yes check fluid intake to ensure within recommended amount and refer to daytime wetting pathway

Red Flags	YES	NO	
Is toilet trained and has urinary incontinence during the day			If yes refer to daytime wetting pathway
Some reported frequency (voids > x7) or urgency (has to dash to the toilet)			Advise re regular toileting (e.g. 2 hourly) plus regular drinks
Child has not achieved day time dryness at all by age 3 years			If yes refer to toilet training pathway
Other? (describe)			If concerned discuss with children's bladder and bowel service

Toileting issues:

	YES	NO	
Behavioural problems or anxieties about using the toilet?			Consider behavioural support techniques
Has mobility or sensory problem interfering with ability to sit on toilet safely?			Consider referral to physiotherapy and OT
Gives no indication of needing to use toilet?			If yes refer to toilet skill development pathway
Never or rarely passes urine or opens bowels on the toilet/potty?			If yes refer to toilet skill development
Insists on nappy for opening bowels or other toilet refusal issue?			If yes consider behaviour modification programme
Other? (Describe)			If concerned refer to toilet skill development pathway and discuss with children's bladder and bowel service

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)
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 children's bladder and bowel service 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)	
Date for reassessment / review:	
Referred to children's bladder and bowel service	date
Signature	date

References and Resources

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

Birth to Five HSCNI http://www.publichealth.hscni.net/publications/birth-five

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

NHS England 2023 National primary care clinical pathway for constipation in children https://www.england.nhs.uk/publication/national-primary-care-clinical-pathway-for-constipation-in-children/

Resources for families:

There are a range of resources for families available on the Bladder & Bowel UK website

Resources for professionals:

Best practice guidelines for professionals, supporting skill development for toilet training in all children, including those with learning disabilities and developmental differences: A consensus document Down Syndrome UK and Bladder & Bowel UK 2023

Guidance for the provision of continence containment products to children and young people A consensus document Bladder & Bowel UK 2025

Managing Bladder and Bowel Issues in Nurseries, Schools and Colleges Guidance for school leaders, proprietors, governors, staff and practitioners Bladder & Bowel UK and ERIC 2025

There are other resources for professionals on the Bladder & Bowel UK website

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