

**A GUIDE TO  
HELPING EARLY  
YEARS SETTINGS AND  
SCHOOLS MANAGE  
CONTINENCE**

**The  
Right  
to**



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## Note:

For ease of reading, in this guidance:

- all references to child or children refer to children, young people and teenagers up to the age of 19 and
- all references to schools refer to educational settings for pupils up to the age of 19 including nurseries, schools and colleges.

# The Right to Go

## A Guide to Managing Childhood Continence for Schools and Nurseries



### Introduction

Achieving continence is one of many milestones which children are expected to reach before they start school. However, for a number of reasons, a percentage of children may not manage to achieve this prior to starting school. If not managed correctly, wetting and / or soiling problems can cause high levels of stress for children, parents and teaching staff.

This booklet is designed to work through the issues around toileting problems in schools in a very practical way, to ensure that everyone involved in the child's care understands the reasons why children can have problems with incontinence: how it can persist; how schools, parents and health agencies can work in partnership to ensure that the child's incontinence is managed effectively and where possible, help the child to achieve continence.

### Admission to school

The School's Admissions Code (Department of Education, 2012) states that it is for admission authorities to formulate their admission arrangements, but they must not discriminate against or disadvantage disabled children or those with special educational needs.

This is in line with the Equality Act 2010 which states that a person has a disability if they have a physical or mental impairment, which has a substantial and long term adverse effect on that person's ability to carry out day to day activities. It is not acceptable to refuse admission to school to children who are delayed in achieving continence.

### Health Care Plan

A comprehensive Individual Health Care Plan (IHCP) regarding meeting the child's toileting needs is the key to success. If incontinence is not managed properly, it impacts not only on the education of the child, but on the whole class. The IHCP needs to include commitment from the parents / carers, schools and where possible, the child. This is to ensure the best possible outcome.

Health agencies may need to be involved, depending on the severity of the problem and the needs of the child. These may include: the school nurse, health visitor, children's continence team, occupational therapist, physiotherapist, speech and language therapist etc.

### Resources

Resources to provide staff to support these children should not be an issue with the enhanced staffing levels of provision within the Early Years Foundation setting, but additional funding from the inclusion / deprivation element of the budget should be available.

Funding may also be available for further Inclusion Funding (IF) where there is a medical or physical need or another type of Special Educational Need (SEN). In Reception classes, schools may need to allocate additional resources from their delegated SEN budget (North Yorkshire County Council, 2011).

Time spent changing a child should be used as a positive learning experience. It may take 10 minutes or more to change a child, but this is not dissimilar to the time allocated to working with a child on an individual learning target.





## Childhood development and continence

Like any other childhood milestones, such as walking and talking, there is a range of ages for children to achieve continence.

### **In the absence of any anatomical or medical problems, the ability to become toilet trained is the interaction of two processes:**

- The maturation and development of the bladder and bowel and how they connect to the control centre in the brain
- The socialisation and understanding of the child

A problem with either of these two processes can lead to a delay in bladder and/or bowel control.

In many developed countries, the age for toilet training is generally accepted as being around the 2-3 year old age range. However, the age of toilet training has increased since the introduction of disposable nappies.

Brazelton (1962) found that 97% of children had achieved the milestone of becoming continent by the age of 36 months of age. However Blum et al (2003) found that 40-60% of children completed toilet training during the day by the age of 36 months and Juris (2010) found that only 51% of the study sample were toilet trained by 36 months.

Adults will normally get the first message their bladder needs to be emptied when their bladder is half full, allowing plenty of time to get to the toilet. The message becomes stronger as the bladder becomes fuller, with less time to get to the toilet.

Younger children and those in the process of toilet training will usually only get a message that their bladder needs emptying when their bladder is nearly full. This means they will get a strong and urgent message to go to the toilet, which if they do not recognise or respond to appropriately, will result in the emptying of a full bladder before a suitable receptacle is reached.

The other thing to bear in mind is that the child's bladder grows as the child grows. A 4 year old child is likely to have a maximum bladder capacity of about 150mls. As the kidneys will usually produce urine at 60mls per hour (depending on the amount of fluid the child has drunk), it is unreasonable to expect any child in a reception class to last more than two hours without needing a wee. If they forget to go to the toilet in break time, it is very likely that they will ask to go to the toilet before the next break.

As the child gets older, they will be able to hold on for longer, but it is not good for the bladder or any continence issues for the child to hold on for too long. There is some evidence to say that if children are encouraged to 'hold on' too long on a regular basis it may cause problems in the future with poor bladder emptying (Yang & Chang, 2008) and this leads to an increased risk of urine infections and dysfunctional voiding (problems emptying the bladder).

On the other hand, if children are made to go to the toilet at too frequent intervals, this may lead to reduced bladder capacity and also the child will not get the opportunity to experience 'full bladder' messages which they would learn to recognise as signals to go to the toilet.

A normal number of times to go to the toilet for a wee during daytime hours for older children and adults is between 4-7 times per day.

A normal number of times to go to the toilet for a poo is anything between 3 times per day to 3 times per week. It is normal for the urge to have a poo to occur after eating a meal, particularly after breakfast.





## Common childhood continence problems

Continence problems in childhood are common and as a result it will not be unusual for schools to have at least one child with a wetting or soiling problem. The trend for later potty training means that a number of children will also be starting nursery classes still in nappies.

Approximately 900,000 children and young people in the UK aged 5-19 years, out of a population of 8,500,000, have a continence problem.

### For example at 4.5 years:

- 15.5% have daytime wetting
- 9% have daytime faecal incontinence (NICE, 2010)

Continence problems can have a significant emotional impact and can increase the risk of bullying and of behavioural problems in children. Managing the problem can be stressful for parents and carers and can strain family relationships.

While most parents do not get angry with their child as a result of wetting or soiling problems, there is evidence of a link with child punishment, including physical abuse by parents or carers. Children with continence problems should therefore always be dealt with sympathetically and in a non-punitive way.

Wetting and soiling problems are usually linked to an underlying bladder and/or bowel problem and any 'accidents' happen outside the child's control and may take many months or years to resolve, so it is important that they are diagnosed and managed early. If the conditions are not managed appropriately and become chronic they may result in the need for referral, treatment and/or surgery.

For children whose continence or toileting problem first presents at school, it is important that staff do not make presumptions regarding the cause of the child's problems and discuss the issues with the parents.

In some cases it may be necessary to refer the child to the most appropriate health care professional (with the parent's consent) – such as the school nurse – for timely assessment and the introduction of a treatment plan as soon as possible.

Toilet training and evidence-based treatment for continence problems can be effective, using a variety of interventions ranging from simple drinking and toileting programmes, to drug treatments or wetting alarms with more complex and comprehensive treatment plans. It is important that treatment is adapted to the needs and circumstances of the child and their family and fit within school dynamics.

### a. Delay in achieving continence

The age at which children are potty trained has gradually increased over the last fifty years and the majority of children are now not fully toilet trained until around the age of 3 years, with the rest becoming fully trained by the time they are 4 years. This means that there may be some children starting nursery school at 3 years who are still in nappies and schools need to be aware of this. Most of these children will become toilet trained quite quickly without much formal intervention and will go on to have no further problems.

However, there will be a group of children who may require extra support until full toilet training is achieved and another smaller group of children who, because of underlying medical problems will require support for toileting and changing for a considerable length of time.

### Reasons for delay in achieving full bladder and bowel control may include:

- General developmental delay, for example linked to Autism or Down's Syndrome
- Behavioural / psychological issues
- Underlying medical problem with the bladder (e.g. an overactive bladder (OAB))
- Underlying medical problem with the bowel (e.g. constipation with overflow soiling)
- Underlying physical problem (e.g. cerebral palsy)
- Congenital abnormality directly affecting the bladder or bowel (e.g. Hirschsprung's disease)
- Congenital abnormality or injury to the spine (e.g. spina bifida)

There are a number of conditions that can result in children having difficulties around achieving full bladder and bowel control, but with time the majority of these children will be able to have their continence managed in such a way that they will eventually be able to stay clean and dry during the school day.



## Continence assessment

If a child is starting school without having achieved continence, it is essential that they have a continence assessment. A continence assessment should initially be carried out by a school nurse or health visitor, to identify what is delaying continence and what support the child and family need. This can help inform which interventions may be necessary in developing an effective toilet training programme and may range from a referral to a urologist or gastroenterologist consultant, to providing appropriate parental guidance and support.

An assessment will also help identify whether the issue is likely to be due to an underlying bladder or bowel problem, or whether it is related to socialisation and a child's understanding. Even if the child shows a lack of awareness of being wet or soiled, this does not prevent a child becoming toilet trained at an appropriate age.

## Children with disabilities

The majority of children with disabilities are able to achieve continence. It is important to recognise that wetting or soiling problems may be linked to underlying bladder or bowel problems rather than disability per se.

Research shows that children with mild or moderate learning disabilities can learn to be continent at around the same time as children without learning disabilities. Some children with severe learning disabilities also do very well with their toilet training.

It is therefore important to give all children the opportunity to attempt to become continent, rather than assuming that their disability will prevent them achieving this important milestone. There are parents who have been told by a consultant that their child will never be continent, only to discover that when a structured toilet training programme has been put in place, the child has become continent both day and night.

## Delayed continence in a geographical area

If it becomes apparent that a large number of children in a geographical area are starting school with delayed continence there needs to be a dialogue between the school and local school nurses and health visitors to identify what measures can be put in place to promote the achievement of continence in the local community at an appropriate age.

## b. Daytime wetting problems

The International Children's Continence Society (2011) defines urinary incontinence as 'involuntary wetting at an inappropriate time and place in a child 5 years old or more'.

## Overactive bladder

Children with daytime wetting problems often have a condition called 'overactive bladder' (OAB) which typically presents with frequency and urgency:

## i. Frequency

Children from age of 5 years usually go to the toilet around 4-7 times in a day. Some children may have a problem with their bladder when the muscle around the bladder (detrusor muscle) starts to contract to empty the bladder before it is full.

This results in the child feeling the need to go to the toilet at very frequent intervals, sometimes up to 3 or 4 times per hour. It can be upsetting for the child and also disruptive if the child has to leave class frequently to go to the toilet.

In the first instance it is best to check with the parents whether the child has been seen by a health care professional for an assessment and/or had their urine tested to exclude an infection which may be causing these symptoms.

## ii. Urgency

With urgency the child feels the sudden and urgent need to pass urine straight away without giving the child the chance to 'hold on' for any length of time.

Urgency commonly occurs in conjunction with frequency but it can occur on its own or as a result of an infection. Unless the child has immediate access to a toilet there will be a problem of incontinence.

A child with urgency problems will require easy access to the toilet and may need encouragement and support throughout the programme – such as prompting to go to the toilet, for example at the end of a lesson, to ensure that the bladder is emptied regularly. The child will usually need to undergo a bladder training programme, established in collaboration with parents/carers and a healthcare professional, in order to learn to recognise and respond appropriately to signals from their bladder.

Children with an OAB will normally require some intervention from a healthcare professional (school nurse, continence advisor, general practitioner, paediatrician, urologist – depending on the severity of the problem) to achieve normal bladder control.

Interventions such as correcting fluid intake and toileting routines, a bladder re-training programme or medication may be needed. A typical programme may involve the child going to the toilet 'by the clock' at 1-2 hourly intervals initially. It may also include the child being required to drink a certain amount of drinks spread evenly during the school day.



## Dysfunctional Voiding

This occurs when the child (usually girls) fails to empty their bladder properly and as a result is prone to urinary tract infections (UTI) because of urine being left in the bladder (residual urine).

Wetting accidents may be the first indication of an underlying problem with dysfunctional voiding which if not treated correctly, can lead to potential long term damage. It is important therefore that all children with daytime wetting problems are referred for a full continence assessment.

### c. Soiling and faecal incontinence

Soiling is the leakage of faeces (stool, poo) from the bottom (anus) into the child's underwear. It can occur for several reasons. The most common reason is constipation with overflow soiling. More rarely it can be due to an underlying congenital abnormality affecting the bowel – this is then usually labelled as faecal incontinence.

In both cases the soiling happens outside the child's voluntary control and in many cases the child may be unaware that the soiling accident has occurred.

### i. Constipation and overflow soiling

The majority of cases of constipation are termed 'idiopathic' which means the underlying cause is unknown and cannot be explained by anatomical or physiological abnormalities.

Idiopathic constipation is difficulty, pain or straining when passing stools, and/or passing stools less often than normal and may remain undiagnosed until the child starts soiling.

The National Institute for Health and Clinical Excellence (NICE, 2010) state that the signs and symptoms of 'idiopathic' constipation include: infrequent bowel activity, foul smelling wind and stools, excessive flatulence, irregular stool texture, passing occasional enormous stools or frequent small pellets, withholding or straining to stop the passage of stools, soiling or overflow, diarrhoea, abdominal pain, distension or discomfort, poor appetite, lack of energy, an unhappy, angry or irritable mood and general malaise.

A study of British children aged between 4-11 years identified that 34% had been constipated with 5% experiencing chronic constipation lasting more than 6 months (Yong & Beatty, 1998).

### Overflow soiling

Overflow soiling is the involuntary passage of stool into the child's underwear as a direct result of chronic constipation and importantly, it may be the first symptom that the child presents having suffered with constipation undetected for many months previously. Chronic constipation is the cause of soiling in 95% of affected children.

The soiling is thought to be due to a variety of factors including over-secretion of mucus due to rectal irritation and some straightening of the ano-rectal angle of the bowel and decreased rectal sensation. This is combined with reflex relaxation of the anal sphincter, all of which are provoked by the retained stool in the lower bowel.

It is important to stress that overflow soiling occurs outside the child's voluntary control and children need to be treated

sympathetically when it occurs. Children can suffer from low self esteem and shame as a result of the soiling and are often at risk of bullying and name calling.

## Toilets

Many children are reluctant to open their bowels in school because of lack of privacy. However, as most children being treated for constipation and soiling will be on large doses of laxatives and will also be told not to 'hold on', easy access to private toilet facilities is an essential part of the treatment programme.

Teachers should ensure the child has easy access to a 'user friendly' toilet that offers privacy, good ventilation and has a good supply of toilet paper. Some schools make use of redundant staff toilets for such children or allow them to use the 'disabled' toilet. Schools should work to safeguard children from bullying which often takes place around the toilet area.

### ii. Faecal Incontinence due to a medical problem with the bowel

Some children are born with bowel problems, such as Hirschsprung's disease, an ano-rectal abnormality or conditions such as spina bifida which affect the ability of the child to control their bowels. Although affected children often undergo surgery in infancy to help correct the abnormality, almost all will have ongoing bowel problems to a greater or lesser degree throughout childhood.

Other children may develop a problem such as coeliac disease, which once diagnosed and treated, should mean the bowel problem resolves. Bowel problems may be part of other syndromes and conditions – cerebral palsy, autism or Down's syndrome.

### d. Encopresis

Encopresis is the term for the passage of a normal stool in an inappropriate place. This is usually in pants but it may be elsewhere and is not associated with constipation.

Children who have this problem usually have an underlying behavioural problem or severe learning disability and the soiling can occur for a number of reasons. The child may not have the full understanding to recognise when they need to open their bowels or they may have a 'learned behaviour' of not using the toilet to open their bowels.

Some children may have a phobia or fear of sitting on the toilet. These children will require a different approach to help them overcome their problems and the involvement of the Child and Adolescent Mental Health Service (CAMHS) team is often required.

### e. Children with more complex bladder and / or bowel problems

A small number of children may require more intimate care procedures to be carried out in schools such as catheterisation of the bladder or changing a stoma bag. The document *Managing Bowel and Bladder Problems in Schools and Early Years Settings* (PromoCon, 2006) sets out guidance for children who require such intimate care in schools.





# 4

## Promoting bladder and bowel health in schools

There are some very basic steps which can aid children to have healthy bladders and bowels:

- Drinking 6-8 drinks per day of water based drinks can help with both bowel and bladder health. Three of these drinks should be during the school day
- Water based drinks should be encouraged. Schools should provide adequate facilities to enable children to have 3 drinks during a school day
- Rehydration should be encouraged, particularly after playing sports or in hot weather
- Drinks with caffeine in, such as cola, hot chocolate, tea or coffee have been shown to 'irritate' the bladder. Sometimes, excluding dark coloured drinks, like blackcurrant cordial, can improve wetting for some children.
- Promote a healthy diet – 5 portions of fruit and vegetables a day will help to maintain healthy bowels
- Exercise stimulates the muscles in the bowel and a helps maintain a regular bowel movement
- Toileting routines may be particularly useful in reception and infant classes – to ensure the whole class is reminded to go to the toilet at key times of the day

Further information is available from the Healthy Schools Programme (DH, 2005) with additional support from the school nurse.







## School toilets

Currently, the only legislation governing pupils' toilets is limited to the numbers of toilets required. There is nothing to specify that they have to be suitable, accessible, clean or maintained. This is in stark contrast to the legislation for adults, including teachers in schools, which sets out comprehensive requirements. Just think about the toilet facilities your school has. Would you be happy to use them?

The School Premises (England) Regulations 2012 stipulate that the following standards for school toilets should be met:

### Toilet and washing facilities

4. - (1) Subject to paragraph (3), suitable toilet and washing facilities must be provided for the sole use of pupils.

(2) Separate toilet facilities for boys and girls aged 8 years or over must be provided except where the toilet facility is provided in a room that can be secured from the inside and that is intended for use by one pupil at a time.

(3) Where separate facilities are provided under paragraph (1) for pupils who are disabled, they may also be used by other pupils, teachers and others employed at the school, and visitors, whether or not they are disabled.

(4) Suitable changing accommodation and showers must be provided for pupils aged 11 years or over at the start of the school year who receive physical education.

### ERIC's Bog Standard campaign

Many children avoid using toilets at school because they are dirty, smelly, not private enough, or frequented by bullies. ERIC's Bog Standard campaign aims to achieve standards for pupils' toilets in the UK equivalent to those for adults, backed up by legislation and advocates that good quality toilets and free access are vital to pupils' health.

It also seeks to ensure that children have access to school toilets whenever they need to go. Avoiding emptying, or not being allowed to empty the bladder and bowels when needed can lead to serious health problems, both now and later in life.

The Bog Standard campaign website ([www.bog-standard.org](http://www.bog-standard.org)) provides information on how pupils, parents, schools and other organisations can get involved to bring about the changes needed to improve facilities for pupils in schools.

### Including:

- The Bog Standard School Toilet Charter
- Suggestions for schools on how to improve facilities
- Sample letters for pupils and parents to use to improve school facilities
- 'You tell us' page – let ERIC's Bog Standard know what the toilets are like in your school
- A School Toilet Award for great facilities

ERIC's Bog Standard campaign has been developed with School Councils UK, the Community Practitioners' and Health Visitors' Association and the British Toilet Association.





## Hand washing

Schools have an important role to play in teaching and encouraging hand washing from an early age. Hand washing habits learnt at school can last a lifetime.

### Did you know?

- Nearly 22 million school days are lost each year due to the common cold?
- 52.2 million cases of the common cold affect children under 17 years of age each year?
- Children have about 6-10 colds a year?
- Adults average 2-4 colds a year?
- Some viruses and bacteria can live from 20 minutes up to 2 hours or more on surfaces like cafeteria tables, doorknobs and desks?

Hand washing after using the toilet and before eating, along with thorough and regular cleaning of surfaces that harbour germs from faeces, colds and flu are important measures for reducing sickness rates for all schools. Door handles, taps and toilet flush handles are particular hot spots for harbouring germs.

If possible liquid soap and disposable paper towels should be used as bars of soap and towels can spread germs from one person to another. Roller towels are not recommended, but if used, should be inspected regularly and changed as soon as they are visibly wet or dirty. Soap and paper towel dispensers should be fitted at a level that is accessible for smaller children.

Hand driers are another option for drying hands, although there is some debate about how hygienic this method really is. Some children, especially those with sensory issues, can find the noise of hand driers particularly difficult to cope with and will avoid using public toilets for fear of the hand drier!





## Practical toilet issues for children with special needs

In some circumstances standard toilet facilities are not suitable for all children, especially those with disabilities. The occupational therapist is key to assessing facilities for individual children. Sometimes a small adaptation, such as a handrail, can make a huge difference to a child being able to independently toilet themselves.

### a. Holistic Functional Assessment of the child – the school environment

An assessment of the child, their home, family needs and the school environment is often carried out by an occupational therapist (OT). This can take place at any point during the child's life and takes into account current, emerging and future needs of the child.

Liaising with relevant health professionals early on is important to ensure that attention is given to the appropriate selection of any specialist equipment that will support the toilet training process. During which, it is important to consider all environments where the child spends time including the school, home and wider family contacts.

The aim of occupational therapy with regard to toileting issues for a child is to provide professional advice and support to enable the child to maximise independence with toileting.

### b. How does the OT promote independent toileting?

- Problem solving (e.g. advice regarding adopting different methods to use, provision of equipment and adaptations)
- Liaison with other services (e.g. local authority regarding home adaptation, education building department regarding any adaptations to the school environment)
- Treatment to improve physical ability (e.g. mobility, balance, hand function, co-ordination)
- Teaching appropriate methods (transfers, sit to stand, etc)
- Advice to parents, carers and the school regarding appropriate methods, equipment and management options

### c. Assessment of toileting needs

An assessor should adopt the same principles when assessing the child and their environment as used in a standard risk assessment:

- What are the risks for the child, carer?
- How can the environment be adapted to minimise these risks?

Duty of care for the child and their carer must extend beyond the initial assessment. It is important to remember the child is developing and must be enabled to develop to their maximum potential.

### d. Toileting risk assessment

Risk assessment is a holistic process with several interrelating aspects. TILE is the acronym used for a simple checklist and is a useful starting point when considering the toileting process and how supportive / hindering the environment is to this.

- Task
- Individual
- Load
- Environment

Key factors to consider in each of these elements are:

#### i. The Task

What is the activity? In this instance, the task is concerned with enabling the child to achieve the skill of continence, e.g. to be able to empty their bladder or bowels at a socially accepted time and socially accepted place (toilet, potty, etc).

#### ii. The Individual

The Individual is the child's carer. This could be a parent, school support assistant or social carer. Assessment of the child's abilities will help to identify the level of support that is or will be required e.g. equipment, hoist, physical support.

Does the carer require unusual strength or height for the activity, are they pregnant, disabled or suffering from a health problem. Is specialist knowledge or training required?

Does the child have any challenging behaviours that could present as potential risks to the carer?

#### iii. The Load

In this instance, the child is the Load.

Does the child have any challenging behaviours that could present as un-measurable variables in the risk assessment?

There is a need to identify all of the number of variables as this will help to minimise the potential risk to the child. Identifying as many variables as possible during the assessment process will also ensure that provision of support and equipment will be more accurate. There will also be a clearer indication of possible future needs.

### Examples of the types of variables to be taken into account include:

- medical diagnosis
- prognosis
- functional abilities in relation to age
- cognitive functioning in relation to age
- mobility / transfer abilities in relation to age
- any challenging behaviour patterns
- manual dexterity skills, etc



#### iv. The Environment

This relates to the physical space used for toileting.

Are there space constraints, uneven, slippery or unstable floors, variations in floor levels, variations in room temperature, poor lighting, poor ventilation, etc?

Has any toileting equipment been provided or will it be required?

Will the child's clothing require alteration to promote independent toileting?

#### e. Focus on environmental issues

The fundamental questions to be asked should be: "Is the environment suitable to promote / enable independence in toileting?" and "Is there consistency between what is available at home and at school?"

To promote the toilet training process / enable independent toileting, the child will need:

- easy access to a toilet and wash basin
- a toilet cubicle of the correct size for the child
- possible access to a changing area
- space to manoeuvre, with or without mobility equipment
- toilet facilities near to where they are
- safe toileting space

#### f. Environmental adaptations

Education providers are required to make "reasonable adjustments" for disabled pupils and staff. This duty covers all areas of education including schools, colleges and universities.

The Equality Act 2010 enforces the requirements of the previous Disability Discrimination Act (DDA) 2005 which applies to anyone who provides a service to the general public. It stipulates that the organisation must act reasonably.

An excellent tool to help schools in the process of creating an inclusive service, ensuring that they meet their responsibilities to the Equality Act is a Disability, or DDA, Access Audit. A disability access audit maps a disabled person's journey through the educational environment. It examines the accessibility, identifies barriers, measures usability and provides options for improvement.

All Local Education Authorities will have access audit tools that can be used by school staff (often completed by the SENCO (Special Educational Needs Coordinator)) or by a Local Authority specialist access auditor.

#### g. Provision of support equipment

Examples of specialist equipment that may be needed to promote or support toilet training include:

- Support rails
- Special toilet seats
- Hand-held urinals
- Commodes and potty chairs
- Equipment to use when travelling away from home or school

Where possible, it is useful to include the child in process of selecting equipment as this may help with their motivation and compliance.

Transforming Community Equipment Services (Department of Health, 2009 & 2010) occurs when a suitably qualified or social care professional has assessed the needs of the child and a piece of equipment (assistive technology) is recommended, the professional will then 'prescribe' the equipment on a special prescription form which will be left with the family. Using the 'Retail Model', the family can choose a retailer from a local accredited list to redeem the prescription. Some items of toileting equipment will be available under this scheme but there may be local variances.

In general, equipment prescriptions only allow for the provision of basic equipment such as toilet frames, grab rails etc, but the Retail Model allows the family to 'top up' the basic prescribed piece of equipment and self fund any additional costs if a different model is preferred.

Should the child require a very specialist or bespoke item then the health care professional will apply for specialist funding on behalf of the child, usually to the local Health Trust or Education Authority.

#### h. Equipment for schools:

Local council education services may provide equipment needed during education in school. This includes access devices such as ramps, adaptations to school premises, wheelchairs for mobility at school, special furniture and writing, speech and communication equipment.

It may be necessary to refer to equipment needs in the child's Statement of Educational Need. For example equipment for an individual such as a wheelchair or chair with dropdown or removable armrests or a self lift seat. Alternatively, it could be equipment for general use around a school e.g. ramps, platform lifts, hoists and stair lifts.

There is an abundance of equipment available that can be found on general child-care websites or high street retailers. Web links for more information on the provision and supply of equipment can be found in the further information section at the end of this guide.





## Continence policies for schools

The aim of a school continence policy is to ensure that wetting and soiling incidents are minimised, but when they do occur they are dealt with in an appropriate manner. This section outlines the general requirements for a school continence policy.

Children with toileting problems who receive support and understanding from those who act in loco parentis are more likely to achieve their full potential. Although teachers' pay and conditions do not include continence care, teachers do act in loco parentis. Continence management is normally included in the job description for care staff, teaching and midday assistants but some teachers unions have provided guidance for teachers with children in their care who wet and soil.

Asking parents to come into school to change their child is likely to be a direct contravention of the Equality Act (2010) and leaving a child in a soiled nappy or clothes for any length of time pending the arrival of a parent is a form of abuse (Leicester, Leicestershire and Rutland Specialist Community Child Health Services).

For those children who have ongoing toileting needs – particularly with wetting and soiling – it is important that their needs are identified and individual health care plans drawn up so that those needs are met.

Parents of children who have continence issues should be made aware of the school continence policy and sign any parental consent forms regarding the child being changed. Wherever possible, this should happen at entry meetings or prior to the child starting the school.

### a. General principles that school continence policies should address

#### i. The procedure for personal care

- Staff involved in the process should be aware of the guidelines for personal care. This will ensure they follow the correct procedure.
- If at all possible children should be changed standing up. This makes it easier for the child to be involved in the process and start to make steps to becoming independent.
- If the child needs to be laid down to be changed, then once the child has been changed and has left the changing area, the surface should be cleaned with warm soapy water and left to dry.
- The child's skin should be cleaned with a disposable wipe. (Flannels should not be used to clean bottoms).
- Nappy creams/lotions should be labelled with the child's name and used only if prescribed for that child - **they must not be shared.**

- Any creams should be used sparingly as if applied too thickly they can reduce the absorbency of a nappy.
- Disposable gloves and plastic aprons should be supplied by the school and should be worn when changing nappies.
- Hands should be thoroughly washed afterwards.

#### ii. Partnership working

Issues around toileting should ideally be discussed before a child starts school so that appropriate arrangements are made to support the child once they start school. An individual care plan can then be developed and a consent form for toileting needs completed prior to school entry – this is detailed further in the individual health care plan section of this guide.

It is important that the school and family work in partnership and the following points may need to be considered when formulating an agreement outlining responsibilities.

This might include:

#### Parents / carers

- Agreeing to change the child at the latest possible time before coming to school
- Providing enough spare nappies, wet wipes, changes of clothes, plastic bags or nappy sacks in which to put soiled clothing, to meet the child's needs
- Informing school if there is a change in medication or routine which may affect their continence e.g. an increase in laxatives
- Understanding and agreeing the procedures to be followed during changing at school
- Agreeing to inform school should the child have any marks or rash
- Agreeing how often the child should be routinely changed during the school day and who will do the changing
- Agreeing to encourage the child's participation in toileting procedures wherever possible to promote independence
- Continuing toileting routines at home, to optimise the potential of achieving full continence, where possible
- Agreeing to review the arrangements, in discussion with the school, should this be necessary.



## The school

- Agreeing a procedure with the parents to change the child should they soil / wet themselves
- Agree how the school will inform parents of any poos or wetting or soiling accidents – possibly via a home/school book. This can help with making sure the plan in place is effective
- Agreeing how often the child should be routinely changed if the child is in school for the full day and who will be changing them
- Agreeing a minimum number of changes
- Agreeing to report to the Head Teacher or SENCO should the child be distressed or if marks or rashes are seen
- Agreeing to review arrangements, in discussion with parents / carers, should this be necessary
- Agreeing to encourage the child's participation in toileting procedures wherever possible to promote independence
- Discussing and taking the appropriate action to respect the cultural practices of the family.

If the issues surrounding continence are more complex it would be appropriate to include relevant healthcare professionals in the plan.

These might include some or all of the following:

- School Nurse
- Paediatric Continence Advisor
- Speech and Language Therapist
- Occupational Therapist
- Physiotherapist

Staff should take care (both verbally and through their body language) to ensure that the child is never made to feel as if they are being a nuisance.

When a child with complex continence needs starts a school, the child's healthcare professional will need to be closely involved and a separate, individual toilet-management plan may be required.

### iii. Safeguarding

The normal process of assisting with personal care, such as changing a nappy, should not raise safeguarding concerns. Staff who do not have a relevant Criminal Record Bureau (CRB) check should not be involved with any intimate care procedures.

It is good practice that the adult who is going to change the child or carry out a procedure informs the teacher that they are going to do this. There is no requirement that two adults must be present and staff will need to make their own judgement based on their knowledge of the child and family (Carlin, 2006). If there is known risk of false allegation by a child, then a member of staff should not change a child on their own.

Safeguarding procedures must be adhered to. If any member of staff has concerns about physical changes to a child, e.g. marks, bruises, soreness etc. they should immediately report concerns to the appropriate designated person for Safeguarding.

Ideally, the parents and, if appropriate, the child should be involved in the decision made about the choice of staff member delegated to provide the intimate care. If a child becomes distressed or unhappy about being cared for by a particular member of staff, the matter should be looked into and outcomes recorded. Parents / carers should be contacted at the earliest opportunity as part of the process of reaching a resolution; staffing schedules may need to be altered until the issue(s) are resolved.

### iv. Health and safety

Schools and all settings registered to provide education will already have a policy relating to hygiene and infection control as part of their health and safety policy. This is a necessary statement of the procedures the setting / school will follow when a child accidentally wets or soils or is sick while on the premises. The same precautions apply for nappy changing.

The statement is likely to include:

- Staff to wear disposable gloves and aprons while dealing with the incident
- Soiled nappies to be double wrapped
- Changing area to be cleaned after use according to local policy and guidelines
- Hot water and liquid soap available to wash hands as soon as the task is completed
- Hot air dryer or paper towels available for drying hands

It is important that consideration is given to a suitable place for changing children and that privacy and dignity are ensured at all times (e.g. a 'Do not enter' sign on a toilet door).

The Department of Health has issued clear guidance in 'Good Practice in Continence Services' (DH, 2000) about the facilities that should be available in each school.

### v. Job Descriptions

It is likely that most of the personal care will be undertaken by one or more of the teaching assistants and staff who cover school lunch times. It is recommended that job descriptions include statements such as:

'A duty of personal care to support and promote independent toileting and other self care skills may be necessary at times'.

Teachers are responsible for facilitating, supporting and releasing teaching assistants to fulfil this role.





## Individual Health Care Plan for continence

When a child has a continence problem which affects them at school it is useful for everyone involved to work together to resolve the issues.

To establish an effective continence care plan the following areas need to be discussed in a meeting with parents and school:

### a. The nature and extent of the problem

To establish the true nature of the problem, it is necessary for the parents and school staff to meet. It is appropriate to invite a healthcare professional - this may be the school nurse or a Paediatric Continence Advisor - to the meeting. If there is no healthcare professional involved, then the school nurse should be asked to assess the child's continence issues and ensure that any appropriate referrals are made.

Other healthcare professionals who may be involved are:

- Speech and language therapist – this may be crucial if the child has communication difficulties. Social stories, Picture Exchange Systems (PECS) and Timelines are some of the tools which can make a difference
- Occupational therapist – can assess the child and ensure suitable toileting seating is in place and the environment is conducive to that child's toileting
- Physiotherapist – can help with moving and handling/toileting positioning/ toileting slings and other equipment.

### b. Outline of support required:

It is important to establish the level of support required to manage the child's continence.

- **Independence:** What is required of the support staff to ensure that the child can be as independent as possible? A young child is likely to need help to change if soiled. It needs to be clear who is to support the child – for example, is there a midday or teaching assistant to support a child's toileting after lunch, as this is likely to be a time when the child needs to be toileted
- **Toileting times:** Does the child need to be prompted at regular intervals, or does the child initiate toileting? This should be an individual assessment. Some children will know when they need to go and do not need to be asked to go to the toilet, others will wet if they are not prompted
- **Communication:** How does the child let you know they need the toilet – bear in mind that some children are extremely embarrassed by even having to ask to go to the toilet. If a discreet system can be put in place, this will aid the child to have more confidence to use the toilet when they need to, reducing the likelihood of accidents. As lunchtime is a key time for toileting, it is important to involve midday assistants to be aware of children's toileting needs in order to facilitate easy access to the toilets
- **Toilet facilities:** The environment, facilities and the distance to an appropriate toilet need to be taken into account to allow adequate time for toileting to be undertaken. It may be necessary for a child to use a toilet that affords more privacy. Involving

the child in these discussions is useful, as often they have valid reasons for not wanting to use a certain toilet – no lock, other children peering under the door, the hand dryer may scare them

- **Manual handling and lifting:** Does the child need to be hoisted when toileted or for nappy changing? Is the equipment available? Is this manageable by one person? Is any training needed?
- **Consistency:** For any toileting programme to be effective there needs to be consistency. The family / carers have a responsibility to ensure that toileting routines are continued at home, to supply spare clothes, wipes and plastic bags and to attend any appointments which support the child to achieve continence
- **Liaison:** If the parents / carers are unable to manage this, school staff should liaise with the parents and possibly the school nurse to see if there are any particular issues at home that are making it difficult for the family to engage with the toileting programme and schools requests for supplies etc.
- **TAC meeting:** If school's concerns are not addressed then they should consider calling a 'Team around the child' (TAC) meeting to discuss and identify any causal factors and possible solutions.

### c. Management of 'unplanned' events

Planning for 'unplanned' events means that should the child have a wetting or soiling accident it is dealt with swiftly and in a sympathetic manner. Parents need to provide spare clothes, wipes and plastic bags, which are kept in school, in an easily accessible, discreet location. There must be a private area, such as disabled toilet, where the child is able to get cleaned and changed with the support of a member of school staff if necessary.

### d. Specific advice re interventions such as catheterisation or stoma care

If a child has a specific continence issue which needs to be addressed, such as a catheter or a stoma, the staff involved in the child's care need to be trained and fully understand the procedure.

For children who have specific intimate care needs, there should be a health care professional involved, who can, in conjunction with the parent, teach staff and set up an individual health care plan. Depending on local provision it may be the urology or stoma nurse from the hospital, or a continence nurse based in the community. The school nurse can also be invaluable.

The document 'Managing Bowel and Bladder Problems in Schools and Early Years Settings' (PromoCon, 2006) also sets out guidance for children who require such intimate care in schools.





## Bowel problems: Summary of how school staff can help support children with bowel problems

### a. Constipation and soiling

Constipation is very common in childhood - a study of children identified that up to 30% had been constipated with symptoms becoming chronic in more than a third (NICE, 2010).

Overflow soiling is the involuntary passage of stool into the child's underwear as a direct result of chronic constipation and importantly it may be the first symptom of constipation that the child presents, with the child having suffered with undetected constipation for many months previously. In fact chronic constipation is said to be the cause of soiling in 95% of affected children.

### b. Congenital bowel problems

Hirschprung's disease and ano-rectal malformations are congenital abnormalities (occurring from birth) that affect the normal development of the infant's anus, rectum and colon. About 1 in 5000 children are born with such a congenital abnormality that can lead to long term problems with constipation and delay in achieving full bowel control. This condition is also more common in children with Down's syndrome.

Affected children may start school without having achieved full bowel control or may have ongoing problems with constipation and soiling. A number of affected children can also have a problem with their bladder which may result in problems with bladder control as well.

### What schools can do to help

- Understand, that any bowel problems or delayed control are the result of the chronic constipation or abnormality in the development of their gastrointestinal tract, which could include their anus, rectum and bowel
- Recognise that the achievement of full bowel control can take time and some children may require further intervention in order to be able to achieve this
- Ensure that each affected child has an individual care plan drawn up in conjunction with the parents and school nurse or other appropriate health care professional to ensure that the child's toileting needs are appropriately managed in school
- Positively reinforce desired behaviours – good drinking, poo's in the toilet etc.
- Support any bowel or toileting programme by allowing free access to the toilet as necessary
- Promote independence as much as possible by supporting the child to enable them to self manage the toileting in an age / developmentally appropriate way
- Be alert to the potential for bullying and name calling by addressing any wetting accidents as discreetly as possible
- Respect the child's right to privacy – the child and family should decide how much and exactly what other pupils are told about the condition.







## Bladder Problems: Summary of how school staff can help support children with bladder problems

We know that at 36 months up to 50% of children may not be fully toilet trained (Juris, 2010) and at 4.5 years approximately 15.5% will have a problem with daytime wetting problems (DH, 2010).

The school should work closely with the family and healthcare professional involved with the child to ensure a proactive approach to managing the child's problem is taken and appropriate treatment plans are put in place.

### What schools can do to help

- Understand that any bladder problems or delayed bladder control may be the result of a number of factors – most of which are outside the child's control
- Recognise that the achievement of full bladder control can take time and some children may require formal training programmes in order to be able to achieve this
- Ensure that each affected child has an individual care plan drawn up in conjunction with the parents and school nurse or other appropriate health care professional to ensure that the child's toileting needs are appropriately managed in school
- Positively reinforce desired behaviours – good sitting, good drinking, wee's in the toilet etc.
- Support any bladder or toileting programme by allowing free access to the toilet as necessary
- Promote independence as much as possible by supporting the child to enable them to self manage the toileting in an age / developmentally appropriate way
- Be alert to the potential for bullying and name calling by addressing any wetting accidents as discreetly as possible
- Respect the child's right to privacy – the child and family should decide how much and exactly what other pupils are told about the condition.



## Further Information

### 1. ERIC (Education and Resources for Improving Childhood Continence)

A registered charity which offers information and support to children, young people and their families and professionals on childhood continence problems including bedwetting, daytime wetting, soiling and constipation and toilet training.

[www.eric.org.uk](http://www.eric.org.uk)

### 2. PromoCon

Part of the charity Disabled Living, provides qualified impartial advice and information regarding resources, products and services for children and adults with bowel and/or bladder problems.

[www.promocon.co.uk](http://www.promocon.co.uk)

### 3. CHESS – Child health and education support services

[www.chess.sa.edu.au](http://www.chess.sa.edu.au)

### 4. Information on provision of adaptations and equipment provision for schools

[www.gov.uk](http://www.gov.uk)

### 5. Information about the supply of assistive technology using the Retail Model

[www.csed.dh.gov.uk/TCES/AnOverviewforUsersandCarers](http://www.csed.dh.gov.uk/TCES/AnOverviewforUsersandCarers)

### 6. A useful guide to the provision and supply of equipment:

[www.allaboutequipment.org.uk](http://www.allaboutequipment.org.uk)

### 7. ERIC's Bog Standard

ERIC's campaign to promote better toilets for pupils.

[www.bog-standard.org](http://www.bog-standard.org)



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## **ERIC**

(Education and Resources for Improving Childhood Continence)

**0845 370 8008**

**info@eric.org.uk**

**www.eric.org.uk**

ERIC is a registered charity which offers information and support to children, young people and their families and professionals on childhood continence problems including bedwetting, daytime wetting, soiling and constipation and toilet training.

## **PromoCon**

Helpline: **0161 607 8219**

email: **promocon@disabledliving.co.uk**

**www.disabledliving.co.uk**

PromoCon, part of the charity Disabled Living, provides qualified impartial advice and information regarding resources, products and services for children and adults with bowel and / or bladder problems. Charity no: 224742.



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