Royal College of Nursing

Assessment of toilet training readiness and the issuing of products

An RCN care pathway

Royal College of Nursing

This RCN guidance has been developed to help manage children with incontinence and delayed toilet training in a structured, practical way.

It follows the publication of *Good practice in paediatric continence services – benchmarking in action*, cited in the Children's National Service Framework. After this document, it became clear that the provision of a free nappy service for children with continence problems is no longer appropriate, unless there is also a full assessment, including an appropriate treatment or management programme.

This pathway – Appendix 1 – was originally inspired by Valerie Bayliss and her team from North Hampshire, to whom grateful thanks are given. The guidance has been further developed by a group of children's continence advisers, in conjunction with others, who generously shared their own expertise and documentation, peer-reviewing original drafts.

Statements in the pathway form the standard of care. As such, there is no need to write anything unless the standard is not met, in which case the variance from the standard must be recorded. It is these variances that make the pathway dynamic. They will be used to feed into regular revisions that will take place in the future.

Included in this document is an example of a completed care pathway from Liverpool Primary Care Trust. It is acknowledged that this care pathway will need to be adapted for use, using local policies, procedures, guidelines and best practice, and taking into account local resources. It is evidence-based, using current research, and therefore should be reviewed and updated regularly, in the light of both local variances and new research. However, it must not move away from the evidence base.

Many people have been involved at all stages of this pathway and I would like to take the opportunity of thanking them all for their hard work and dedication.

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Contents

Promoting continence – provision of continence products for children

Children's continence promotion services should provide open access support, advice and information for all children aged 0-19 years, and their families. Whilst the aim of the service should be to work towards ensuring healthy bladders and bowels and promoting continence, there may be a number of children for whom full continence is not achievable.

There is no statutory requirement to provide continence products to children under the age of five, although most areas provide products from four years. Those children with a physical or learning disability that impacts directly on their ability to achieve continence, and whose individual continence needs differ from children of a similar age within the general population, will be considered for provision of products

Early referral to the children's continence service should be made as soon as either any bowel or bladder problems are identified or anticipated. We would expect most children with anticipated problems to undergo some sort of programme within their second year, in anticipation of a formal structured toilet training programme once full bowel and bladder maturity is reached.

Under normal circumstances, children who have achieved daytime control, regardless of any special need, would not normally be considered for provision for night time products. This is unless they have received assessment/treatment for nocturnal enuresis, and had a consultation with the children's continence adviser.

All children should have a documented assessment and trial of toilet training, if appropriate, prior to the issue of any product. It could be considered as active discrimination, in relation to the child's disability, if these children are not offered the same continence promotion service as any other child, who presents with a wetting or soiling problem.

When full continence is not achievable, then healthy bladders and bowels should be promoted at all times. The child should be kept under review, with the provision of suitable containment products as appropriate. Products are not normally supplied as containment for a treatable condition – for example, soiling in relation to constipation.

What is normal?

Bladder development

- Babies' bladders are unstable and, as a result, empty frequently with residual urine.
- Between a child's second and third year, their bladders mature, developing a mature filling and emptying cycle.
- New born babies' bladders hold about 30mls urine, increasing by 30mls each year.
- A child's average bladder capacity can be worked out using this equation: (age + 1) x 30 = average voided volume. Therefore the bladder capacity for a three year-old is:
  (3 + 1) x 30 = 120mls.
- Urine is produced from the kidneys at around 60mls per hour. Therefore a three-year-old should be able to stay dry for up to two hours.
- The ability to 'hold on' increases with age.
- The expected number of voids per day is between six and eight.

Bowel development

- Depending on whether bottle or breast fed, the expected number of bowel movements per day can vary from three to five times per day at age one-month, for a bottle fed baby, to two to three times per week, for a breast fed baby.
- Most babies stop opening their bowels at night before they become one year old.
- Expected bowel movements in a child should range from no more than three times per day to no less than three times per week.

- Soiling at night above the age of one year may be an indication of constipation.

Fluid intake

- Children should be encouraged to drink water-based fluids, if possible.
- Children should be discouraged from drinking more than one pint of milk to the exclusion of solid food.
- Children should drink between six to eight cups – 250mls – per day.
- School aged children should have three of those drinks during the school day.

An example of a care pathway

The following example is based upon the care pathway developed by the former Liverpool Primary Care Trust. This care pathway assesses toilet training readiness and the provision of continence products.

Procedure for provision of products

- Continence must be promoted at all times.
- No child should be issued with continence products, without having a prior written assessment and trial of potty/toilet training, if appropriate (see Appendix 2).
- All children should have a full continence assessment, including diet/fluid intake/output /bowel actions/dip stick urine test and physical examination if indicated, and begin the appropriate care pathway.
- An assessment form should be completed for each child.
- A product request form should then be completed and sent to the children's continence adviser for verification.
- The number of disposable products supplied for 24 hours depends on the individual child's needs, but would normally not exceed four products per day, without prior consultation with the children's continence adviser.
- Following the issue of products, after two weeks there should be an initial review of the child by the professional who initiated the product request. Thereafter, reviews should take place at no more than six-monthly intervals.
- Regardless of any change in need, a reassessment slip should be completed and sent to the children's continence service at least every six months, as a record that the child's needs have been reassessed.
- All professionals – for example, a health visitor or school nurse – who initiated the supply of products, should keep the child on their active caseload, unless formally transferred to another professional.
- Families should be informed that they can request a reassessment for a change in need at any time. They should be provided with appropriate contact numbers.

Supply of reusable products

- Following assessment, some children may be considered more suitable for the supply of washable products, such as absorbent pants for daytime and bed pads for during the night.
- The number of washable pants issued will depend on the individual child's needs.
- The number of washable absorbent bed pads issued would not normally exceed two every two years.
- Prior to issuing the full supply of washable products, the child should be issued with a trial product to ensure its suitability.
- Once considered suitable, the child can then be provided with their full supply.

Outcome

- Children with any underlying pathology – for example, constipation – will be identified and referred to their GP or the children's continence service for treatment and advice.
- Continence should be actively promoted for children, achieving a more acceptable level of continence in most cases.
- For those children for whom continence is not currently achievable, healthy bladders and bowels will be promoted.
- Any products supplied to the child will be appropriate to their needs, as determined by their assessment.
- Children will have regular reviews, and contact numbers will be provided, with the aim of overcoming any problems.

Tools

- Assessment tools
  - toilet skills checklist
  - care pathways for daytime wetting/nocturnal enuresis/constipation/soiling/toilet training.
- Symptom profiles.
- Input/output charts.
- Bowel chart.
- Labstix – 10SG.
- Patient information sheets and leaflets.
- Product requisition/request form.
- Referral to children's continence promotion service forms.

Criteria for product provision

Children should only be supplied with products if their assessment demonstrates that continence cannot be promoted, or they do not have the ability to be toilet trained.

The assessing nurse will determine the most appropriate product from the range available. The nurse should consider the following questions when selecting the most appropriate products.

- Will the child be applying the product themselves or with the help of a carer?
- How wet is the child? To provide the child with most appropriate product, the nurse should refer to the absorbency levels of different products.
- If reusable products are being considered, do the family have washing and drying facilities?
- Is the child incontinent of both urine and faeces?
- Do the family and carers know how to fit the product correctly?
- Are the family aware of advice against using talc and creams?

Children should be issued with an appropriate number of products to meet their needs.

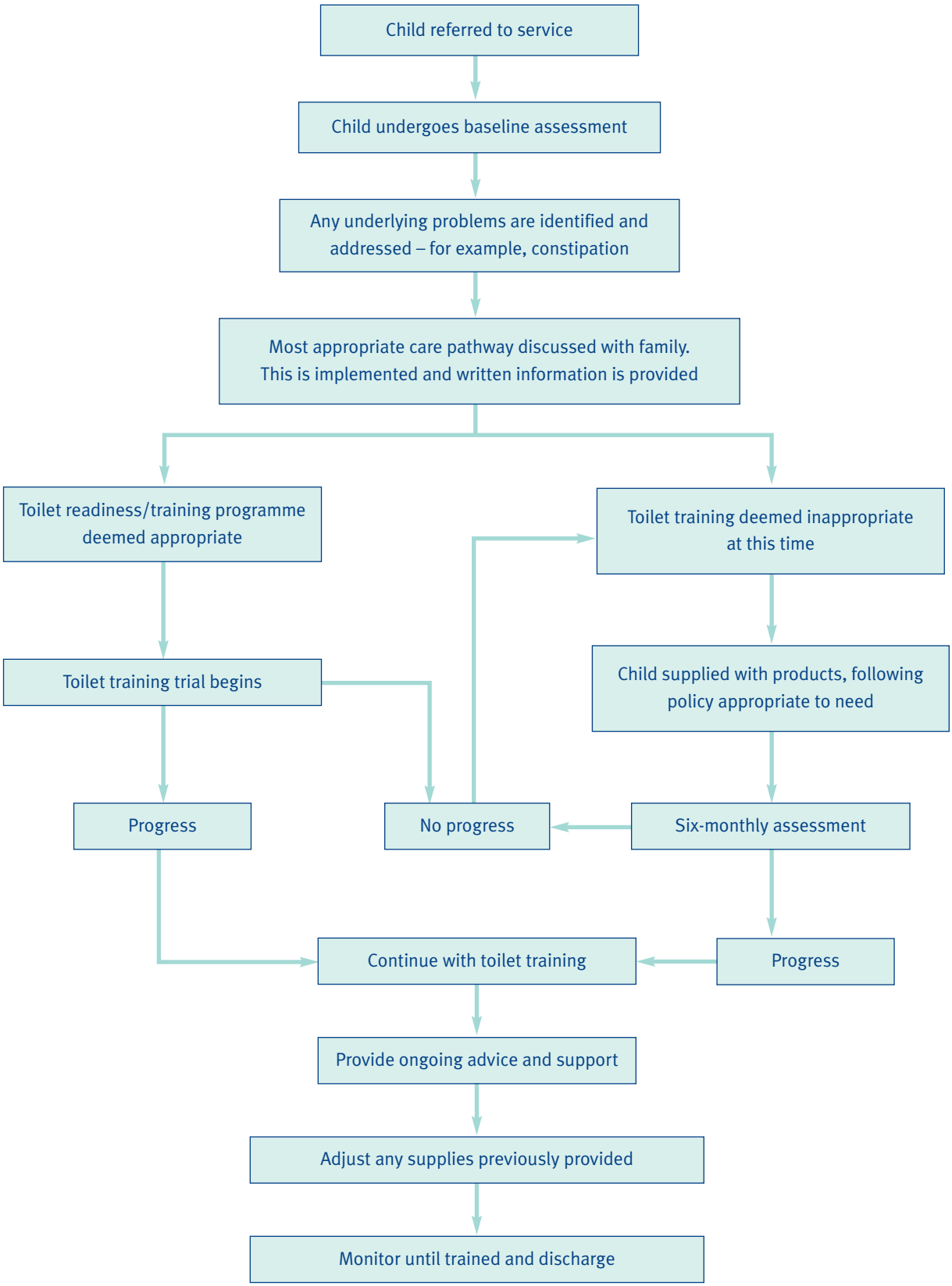
Procedure for ordering products for new patients

- A copy of the completed toilet skills chart – Appendix 2 – and care pathway – Appendix 1 – should accompany all requests for products for new patients. Failure to do so will result in delays in product requests being authorised by the children's continence team.
- The child's family should be informed about the home delivery service, including when to expect their first order and contact details. Alternative delivery points should be included, if necessary.

Procedure for ordering changes in products for existing children

- Children in receipt of products should be reviewed at least every six months.
- When a child is reviewed, a change to order/reassessment slip should be completed, even if there is no change in need. These slips should be sent to the children's continence team, enabling the child's records to be updated for audit purposes.
- Changes will only be made for the next scheduled delivery. Requests for earlier changes must first be discussed with the children's continence adviser.
- The child's family should be informed about any changes to product supply.

Supply of children's continence products



The following is an example of a continence reassessment checklist, based upon that developed by the former Liverpool Primary Care Trust.

Children's continence reassessment checklist

Child's name | Date of birth

Assessor's name | Base

Clinical update

Has the child had any changes to his/her condition or medication that may affect continence? Yes / No

If yes, please give details

Has the child any clinical signs of a urine infection – for example, pain/discomfort when passing urine; strong smell to urine? Yes / No

If yes, do a dipstick urinalysis.

Result

NB: If urine results show abnormalities, seek advice from continence adviser regarding sending urine sample via GP for culture and sensitivity.

How often does the child open their bowels: per day?

per week?

Record type and consistency of stool (use Bristol stool chart)

If outside 'no more than three bowel movements per day to fewer than three per week', contact children's continence adviser for further advice.

Record number of drinks per day

NB if fewer than six, advise accordingly.

Development update

Toilet skills chart reviewed and updated Yes / No

Three to four day input/output chart completed Yes / No

If above charts not completed, please document reason:

continued

Product update

Are products used for: day / night / both (please circle)

bladder / bowel / both (please circle)

Product used during daytime quantity

Product used during night time quantity

Does product fit correctly? Yes / No

Any reported problems with the product they are using at present? Yes / No

If yes, state problem:

Check the following: (please circle answer)

1. Is the product fitted correctly? Yes / No / Not applicable
2. Are net pants/underwear used with shaped pad? Yes / No / Not applicable
   If so, is it a snug fit and pad secure? Yes / No / Not applicable
3. Are products kept in appropriate storage? Yes / No / advise accordingly
4. Are pads removed from packet the night before use? Yes / No
5. Are creams/talc being used? Yes / No / advise accordingly
6. Does parent/carer know how to fold products prior to use? Yes / No
7. Stock levels checked? Satisfactory / overstocked

Comments:

If a change in product absorbency or quantity is required, the child should be measured and product changed as necessary.

Action plan (introduce/adapt management plan as necessary)

Toileting chart

In order to help plan a toileting programme and also to identify if there are any underlying problems, families should be asked to complete the toileting chart that follows. Again, this is based upon that developed by the former Liverpool PCT.

We suggest that you provide the following written information for families to help them understand the importance of the chart.

Toileting chart – some information for families

In order to help plan a toileting programme and also to help us to identify if there are any underlying problems, we ask that you complete the toileting chart that follows.

Modern disposable nappies have what is called 'super absorbency' inside the nappy. This 'locks' away urine, so the top layer of the nappy stays dry next to your child's skin.

However, this also means that it is very difficult for you to know exactly how many times a day your child passes urine and whether, for example, they are dry after a nap.

We suggest that you put something inside the nappy, so that when you check it you can easily feel if they have passed urine (wee). This could be folded kitchen roll – one that does not disintegrate when wet.

Pick days when you are going to be home for most of the time. At the first nappy change of the day, put the kitchen roll liner inside the nappy. Check the nappy every hour and record on the chart whether the pad was wet (W) or dry (D), or if the child opened their bowels (B). If the kitchen roll is wet then change it, but the nappy can stay on until it cannot hold any more urine – in other words, when you would normally change it.

If the child uses the toilet at any time, indicate what happened – wee or poo – in the toileting column.

Each time the child has a drink, record it by putting a tick (√) in the drinks column.

Try and carry on the charting for as many days as you can bear to do it! We recommend that you do at least four days, and the more days that you can do, the better.

Thank you.

	Day 1			Day 2			Day 3			Day 4			Day 5			Day 6			Day 7		
Date																					
Time	Toilet	Nappy	Drink	Toilet	Nappy	Drink	Toilet	Nappy	Drink	Toilet	Nappy	Drink	Toilet	Nappy	Drink	Toilet	Nappy	Drink	Toilet	Nappy	Drink
7.00																					
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Toilet training skills checklist

See Appendix 2

Before beginning a toilet training programme it is important to assess if the child has all the skills needed to enable training to take place. Carrying out assessment ensures that any skill deficits can be identified, alongside any underlying pathology, such as constipation or an unstable bladder.

Assessment should begin in the child's second year and should be a continuous, dynamic process. In other words, following assessment, a programme should be put in place to address any main issues that are identified. For example, if a child will not sit on the potty or toilet, the family can be advised upon what strategies to use – for example, engaging the child in a pleasurable activity that will encourage them to sit for an increasing length of time. This programme would continue until the child is able to sit for long enough to complete a void or evacuate their bowels. If the child is unable to sit through lack of balance etc, referral to an occupational therapist should be made, so the child's needs can be assessed for a potty chair or other toileting aid.

The child should be reassessed every three months or so, and the family given programmes to follow in the meantime. The amount of support required for each child will depend upon the individual child's needs and the family dynamics. Some families need regular review and support, while others require minimal intervention. As the child achieves each statement on the assessment form, the area is shaded. Work continues until the full skill is achieved.

Before beginning assessment, a baseline record should be taken of the child's bowel and bladder habits. The main aim of the bladder assessment is to identify a bladder that is able to complete a normal micturition cycle. In order for this to be identified, the frequency of voids needs to be recorded. See the previous section of this publication (page 9) for an example of a toileting chart, including an information leaflet for families.

For a three-year-old child, bladder capacity is expected to be around 120mls, with between six and eight voids per day at no less than one to two-hourly intervals. A frequency of more than eight voids per day may indicate an unstable bladder. This may warrant further investigation if it is still occurring above the age of five. Any other issues – such as urinary tract infections – would warrant earlier investigations.

Many children with special needs are prone to developing constipation for a variety of reasons. The bowel assessment should help to identify whether this is an underlying problem. The family should identify the type of stool produced using the Bristol stool chart, recording the timing, frequency and bowel action. Normal bowel development follows a pattern of cessation of bowel movements at night at around one year of age, with awareness of control at around 18 months to two-and-a-half years. If a child aged two to three years-old is still soiling at night, it may indicate an underlying problem, such as constipation. Any children identified should follow the constipation care pathway.

Assessing a child's cognitive level of awareness is not always easy if the child demonstrates poor communication skills and an apparent lack of awareness. When formal assessments take place, it can be difficult to know whether a child is unwilling or unable to complete a specific task. Assessing the child in their own home in an informal way, using unobtrusive observational assessment (UOA), has been found beneficial in ascertaining their level of understanding and co-operation.

A formal toilet training programme will be put in place once the child is achieving the physical skills to enable training to take place. For example:

- maturing bladder that can hold urine for around one-and-a-half to two hours.
- bowel that is not constipated.
- ability to sit on toilet/potty for sufficient time.

This toilet skills assessment checklist should form part of a holistic assessment, to include urinalysis and a medical check that excludes any underlying pathology.

Any identified problems – such as constipation/ unstable bladder/nocturnal enuresis – should be addressed using the appropriate care pathway. Further advice and support should be sought from the children's continence promotion service.

Appendix 1

Assessment for provision of children's continence products care pathway

Child's name:	Parent/carer's name:	Date of birth:
Address:		Postcode:
School:		Tel:
GP:	Assessor:	HV:
Date of referal:	Date of assessment:	Referred by:
Past medical history – tick appropriate box: ☐ Learning disability ☐ Physical disability ☐ Congenital abnormality ☐ Neurological ☐ Other (state)		

Primary continence problem: toilet training never really achieved? ☐ Yes ☐ No

Secondary continence problem: ☐ Yes ☐ No Age child first trained _____ Age problem began _____

Only initial if variance from standard statement

Standard statement	tick	Variance from standard statement and reason/comments	Initial	Date
Child has undergone baseline toilet training readiness assessment.				
Child has number of daily voids recorded.				
Child has number/type of bowel movements recorded.				
Child has completed fluid intake/output chart.				
If child has mobility/physical problems affecting ability to be toilet trained, liaise with occupational therapist.				
If child voids outside normal parameters, family given appropriate advice. Refer to daytime wetting guidelines.				
If child drinks volumes outside recommended amount, advise them to drink appropriate amount.				
If child has bowel movements outside the expected normal, family given appropriate advice. Refer to constipation/soiling guidelines.				
If encopresis is suspected, liaise with child and adolescent mental health services (CAMHS) regarding appropriate interventions.				
If child has problems with night time wetting only, family given appropriate advice. Refer to night time wetting guidelines.				
If child has signs of cognitive dysfunction use 'toilet skills assessment chart' to help plan programme.				
Liaise with child's GP regarding any appropriate treatment intervention, using locally agreed drug treatment guidance chart.				
Child commenced on appropriate care pathway, using algorithm – obtaining child/carer's consent to any liaison/treatment/procedures.				
Child to be considered for continence products only if toilet training not appropriate.				
Child to be considered for reusable continence products first, if appropriate.				
Continence products supplied to meet child's needs.				
Child to be reassessed no less than six-monthly. Review date set.				
Establish follow-up procedure.				

Only initial if variance from standard statement Sign to confirm that you have met all standards or recorded variances

Full name	Designation	Initials	Sign	Date

Acknowledgement to care pathway development group. Care pathway reviewed, Jan 2006.

Appendix 2

Toilet skills assessment

Child's name:	Date of birth:
Initial assessment completed by:	Date of first assessment:

Bladder/bowel maturity		Date	Date	Date
(a) Bladder function – if bladder emptied:				
1 more than once per hour, shade in area 1	1			
2 between one-two hourly, shade in areas 1 and 2	2			
3 more than two hourly, shade in areas 1, 2 and 3	3			
(b) Bowel function, if:				
1 has frequent daily soiling, shade in area 1	1			
2 does not always have normally formed bowel movements – is subject to constipation or diarrhoea – shade in area 2	2			
3 has regular normally formed bowel movements – shade in areas 1, 2 and 3	3			
(c) If night time wetting occurs:				
1 frequently – every night – shade in area 1	1			
2 occasionally – odd dry night – shade in areas 1 and 2	2			
3 never, shade in areas 1, 2 and 3	3			
(d) If night time bowel movements:				
1 occur frequently – every night – shade in area 1	1			
2 occur occasionally – some clean nights – shade in areas 1 and 2	2			
3 never occurs, shade in areas 1, 2 and 3	3			

Independence		Date	Date	Date
(e) Sitting on the toilet, if:				
1 afraid or refuses to sit, shade area 1	1			
2 sits with help, shade in areas 1 and 2	2			
3 sits briefly without help, shade in areas 1, 2 and 3	3			
4 sits without help for long enough to complete voiding, shade in areas 1, 2, 3 and 4	4			

continued

Independence		Date	Date	Date
(f) Going to the toilet, if:				
1 gives no indication of need to go to the toilet, shade area 1	1			
2 gives some indication of need to go to the toilet, shade areas 1 and 2	2			
3 sometimes goes to toilet of own accord, shade in areas 1, 2 and 3	3			

(g) Handling clothes at toilet, if:				
1 cannot handle clothes at all, shade 1	1			
2 attempts or helps to pull pants down, shade areas 1 and 2	2			
3 pulls pants down by self, shade areas 1, 2 and 3	3			
4 pulls clothes up and down without help, shade in areas 1, 2, 3 and 4	4			

Other components		Date	Date	Date
(h) Bladder control , if:				
1 never or rarely passes urine on toilet/potty, shade area 1	1			
2 passes urine on toilet sometimes, shade areas 1 and 2	2			
3 passes urine on toilet every time, shade in 1, 2 and 3	3			
4 can initiate a void on request, shade areas 1, 2, 3 and 4	4			

(i) Bowel control, if:				
1 never or rarely opens bowels on toilet/potty, shade in area 1	1			
2 opens bowels on toilet sometimes, shade areas 1 and 2	2			
3 opens bowels on toilet every time, shade areas 1, 2 and 3	3			

(j) Behaviour problem, that interferes with toileting process – for example, screams when toileted, faecal smears, if:				
1 occurs frequently – once a day or more – shade in area 1	1			
2 occurs occasionally – less than once a day – shade areas 1 and 2	2			
3 never occurs, shade in area 1, 2 and 3	3			

continued

		Date	Date	Date
(k) Wears nappies, 'pull ups' or similar, if:				
1 yes, shade area 1	1			
2 no, shade areas 1 and 2	2			

(l) Toilet if:				
1 requires toileting aids or adaptations, shade area 1	1			
2 uses normal toilet/potty, shade areas 1 and 2	2			

(m) Response to basic commands – for example "sit down" – if:				
1 never responds to commands, shade area 1	1			
2 occasionally responds, shade areas 1 and 2	2			
3 always responds, shade in 1, 2 and 3	3			

(n) Diet if:				
1 refuses/unable to eat any fruit/vegetables, shade in area 1	1			
2 will occasionally eat fruit/vegetables each day, shade in area 2	2			
3 eats adequate amount (age+5 = grams fibre), shade in area 3	3			

(o) Fluid intake if:				
1 drinks poor amount – < 50ml/kg per day, shade in area 1	1			
2 drinks 50mls/kg per day – < four to five drinks, shade in area 2	2			
3 drinks 80ml/kg per day – six or more drinks, shade in area 3	3			

Acknowledgement to Smith PS & Smith LJ (1987) *Continence and incontinence: physchological approaches to development and treatment.* London: Croom Helm.

Appendix 3

Children's assessment tool for toilet training readiness and issuing of products

Assessment tool for toilet training readiness and issuing of products

Currently the provision of disposable continence products to children varies across the country – not only in the type but also the number of products allowed per 24 hours. However more worryingly is the fact that many children in receipt of continence products have received them without undergoing an appropriate continence assessment first. This not only means that the child's potential for toilet training is not being fully assessed consequently any skill deficits are not being identified and appropriate skill development programmes not put in place but also any underlying problems (such as constipation) are not being identified and also treated.

The Children's National Service Framework identifies the current issues regarding continence services for children, including inappropriate referral to secondary care as well as providing products rather than putting the child on a supported toileting programme:

'...This currently results in big gaps in service provision, inappropriate hospital/specialist referrals and a waste of money in providing products instead of expertise...'

This assessment tool has been developed to aid clinical decision making when assessing children for toilet training readiness when issuing of containment products is being considered. It is to be used as an aid to decision making but does not replace the need for a comprehensive continence assessment or clinical expertise.

Scoring

30 and above indicates **HIGH** clinical need but may have some potential for toilet training – will probably require long-term disposable products – ensure regular (six monthly) review.

17 – 30 indicates **MEDIUM** clinical need – may have potential for toilet training – should commence a toilet skill development programme. May need short-term supply of disposable products until the appropriate skills for formal toilet training are acquired but may also be appropriate for the provision of washable products with regular (three monthly) review.

Up to 16 indicates **LOW** clinical need – may respond positively to toilet training programme with regular review (at least monthly). May not be appropriate to supply products as prolonged use of disposable products in this group has been found to be unbeneficial.

Exceptions

There will always be exceptions within the scoring system and practitioners need to understand that this tool is designed as an aid to decision making and does not override clinical expertise and specific issues relating to individual children.

For example there may be some children with ano-rectal problems and ongoing soiling (such as imperforate anus or Hirschsprung's disease) who may score LOW but may well be eligible for disposable products, such as pads, while they are waiting for further corrective surgery/treatment intervention.

There may be other children who may score HIGH because they have not been exposed to a toileting routine previously and have total lack of awareness. Many of these children progress well on a training programme and therefore it would not be beneficial to them to provide disposable containment products.

Again it is important to use your judgement.

References

Simon JI, Thompson RH (2006) The effect of undergarment type on the urinary continence of toddlers. *Journal of Applied Behaviour Analysis*, 39:363-368

Tarbox RSF, Williams WL, Friman PC (2004) Extended diaper wearing effects continence in and out of the diaper. *Journal of Applied Behaviour Analysis*, 37:1; 97-100

Suggested further reading

National Service framework for Children and Young People – Part 6 / page 30 / continence (2004) www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4104032.pdf

Good Practice in Children's Continence Services: Benchmarking in Action (2003)
http://collections.europarchive.org/tna/20081112112652/www.cgsupport.nhs.uk/PDFs/articles/good_practice_paediatric_continence_services.pdf

Childrens' assessment tool for toilet training readiness and issuing of products

Child's name:	Date of birth:	**Score** > 30 **HIGH** – consider all-in-one product (according to local policy) 17 – 29 **MEDIUM** – may be able to be toilet trained but may need to consider two piece disposable or washable product short term (according to local policy) < 16 **LOW** – consider toilet training programme and trial removal of disposable product (if worn)
Assessment completed by:	Date of assessment:	

Bladder/bowel maturity			**Score**
(a) bladder function – if bladder emptied:			
1 more than once per hour	3	check fluid intake – adjust if necessary. If frequency persists > aged five years consider assessment for OAB	
2 between 1-2 hourly	2	indication of developing bladder maturity	
3 more than 2 hourly	0	maturing bladder – consider toilet training readiness	
(b) Bowel function, if:			
1 has frequently daily soiling	3	exclude underlying constipation	
2 does not always have normally formed bowel movements i.e. is subjected to constipation or diarrhoea	2	address underlying bowel problem before commencing toilet training (check Bristol Stool Form score)	
3 has regular normally formed bowel movements	1	mature bowel – consider toilet training readiness	
(c) If night-time wetting occurs:			
1 frequently, i.e. every night	3	if over the age of five years and dry in the day consider referral to the enuresis service	
2 occasionally i.e. has odd dry night	2	indication of developing bladder maturity	
3 rarely/never	0	mature bladder – consider toilet training	
(d) If night-time bowel movements:			
1 occurs more than once per week	3	assess for underlying constipation – treat as appropriate	
2 never occurs	1	mature bowel	
Independence/awareness			
(e) Sitting on the toilet, if:			
1 afraid or refuses to sit	4	consider behaviour modification programme	
2 sits with help	2	liaise with O.T if necessary re toilet adaptation/equipment	
4 sits without help for long enough to complete voiding	1	check for bladder/bowel maturity and consider toilet training readiness	
(f) Going to the toilet, if:			
1 gives no indication of need to go to the toilet	4	consider introducing strategies to raise awareness of wet/dry/soiled	
2 gives some indication of need to go to the toilet	2	introduce positive reinforcement for target behaviour	
3 sometimes goes to toilet of own accord	0	consider formal toilet training programme	
(g) Handling clothes at toilet, if:			
1 cannot handle clothes at all	3	if child physically able introduce programme to encourage child to pull pants up/down independently	
2 attempts or helps to pull pants up/down	2	introduce positive reinforcement for target behaviour	
3 pulls clothes up and down without help	1	consider toilet training readiness	

Behaviour			Score
(h) Bladder control, if:			
1 never or rarely passes urine on toilet/potty	4	complete baseline wetting/soiling chart to identify voiding interval -to time toilet sitting when bladder more likely to be full	
2 passes urine on toilet sometimes	2	consider removal of nappy (if worn) and introduction of formal toilet training programme	
3 can initiate a void on request	0	good evidence of bladder maturity commence on toilet training programme	
(i) Bowel control, if:			
1 never or rarely opens bowels on toilet/potty	4	complete baseline wetting/soiling chart to identify frequency of bowel movements to time toilet sitting when bowel more likely to empty e.g. after meals	
2 opens bowels on toilet sometimes	2	consider toilet training readiness	
3 opens bowels on toilet every time	0	evidence of bowel control consider formal toilet training	
(j) Behaviour problem, that interferes with toileting process e.g. screams when toileted, if:			
1 occurs frequently, i.e. once a day or more	4	consider liaison with LD team/CAHMS re behaviour modification programme	
2 occurs occasionally, i.e. less than once a day	2	consider assessment to identify 'trigger' factors for behaviour e.g. sound of hand dryer	
3 never occurs	1	check bladder/bowel maturity and consider toilet training readiness	
(k) Response to basic commands, e.g. "sit down", if:			
1 never/ Occasionally responds to commands	4	consider introducing 'routine/social stories' to gain co-operation	
2 usually responds	1	consider toilet training readiness	

References and further reading

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