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Handy guide

Promoting healthy bladder and bowels in children.

Guide for assessing bladder and bowel function, identifying common childhood continence issues and who or when to refer.

For parents, carers, health visitors, public health nurses and community nursery nurses.

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Actions for Public Health Nurses

To support the management of common childhood continence including toilet training or improving bladder and bowel function.

Children with additional needs may take longer to become toilet trained or may never achieve full continence. However we will work to help promote healthy bladder and bowel functioning to support health and dignity.

To do this we will:

- undertake an assessment of bladder and bowel function, using the tools on page 3
- advise on fluid intake, avoidance of bladder irritants, diet, establish individual toilet training routines and contribute to the 'My Plan for Toilet Training'
- refer child to their GP to confirm constipation or soiling and to advise and support parent and carers in treating constipation
- refer to OT for toilet adaptations for children with a physical disability
- refer to the Paediatric Bladder and Bowel team for further assessment, treatments or interventions as identified during assessment and following the SOP on the 'N drive'
- call **0300 4225308** or email: **ghn-tr.paediatricbladder-bowelcareteam@nhs.net** for general enquiries and referrals

Charts and assessments

Follow the continence SOP on the N drive: N:\Children Young People and Maternity\Health Visiting\Standard Operating Procedures\SOPS

The following charts should be completed by the PHN, parents or carers to enable the practitioner to record a clinical baseline assessment of a child's bladder and bowel function:

- **Bristol Stool Chart** 14 days in a row*
- **Frequency and volume chart** 4 days (which can be random) Measure input and output*
- **The Stool and Frequency Volume Charts** Post or email to parent or carer two weeks before the proposed assessment visit with letter of explanation of how to complete and the expectation that charts need to have been completed and available for staff to analyse at initial visit home visit.
- **NICE History taking questionnaire for Constipation** If child suspected of having constipation and soiling - please complete with parent
- **Toilet Skills Assessment for children with additional needs** Complete with the parent or carer on 3-6 separate occasions which are at least 1 month apart.

These charts should be uploaded as attachments to the child's S1 records and will need to be uploaded if a referral is indicated to Paediatric Bladder and Bowel service via E-RS.

*These charts can be found on the N drive.

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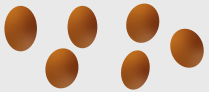
Bowels What is normal?

Normal is type 4, 3 times a day to 4 times a week

- **Refer to Bristol Stool Scale** (see image) to identify stool type.
- **Check how often stools are passed per day/week.**
- **Consider size:** large, med, small?
- **Does child experience pain** or distress on passing stool?
- **Record where stool is passed** toilet, nappy, pants?
- **Are the pants clean or soiled?** If soiled how often?
- **Note** any current medication.

Reference		Description
Type 1		Separate hard lumps, like nuts (hard to pass)
Type 2		Sausage shaped but lumpy
Type 3		Like a sausage but with cracks on the surface
Type 4		Like a sausage or snake, smooth and soft
Type 5		Soft blobs with clear cut edges (passed easily)
Type 6		Fluffy pieces with ragged edges, a mushy stool
Type 7		Watery, no solid pieces, entirely liquid

Symptoms constipation in children

NICE History-taking: Childhood constipation – 1 year and older

Two or more of the following, resulting in 'yes' answers, indicates constipation:

- **Does the child have a bowel movement fewer than 3 times a week?**
- **Does the child pass large, hard stools?**
- **Does the child pass rabbit droppings?** Type 1?
- **Have you noticed any soiling?**
- **Does the child have a poor appetite** that improves after passing a stool?
- **Does the child experience abdominal pain** that comes and goes with the passage of stool?
- **Is there evidence of retentive posturing?** Straight-legged, tiptoed, back arched?
- **Does the child have anal pain?** Bleeding? Cracks or tears?

Soiling

Soiling is when a toilet-trained child regularly passes stools in their pants - always suspect constipation! A child who has faecal impaction can develop soiling or overflow. This is when small bits of poo break off into the child's pants or soft, sometimes runny, poo leaks around the large blocked mass in the rectum.

Soiling is often mistaken by parents for diarrhoea Soiling stool can be described as: Runny, liquid poo, soft 'cow pat' type poo, sticky, tar-like poo which can be hard to wipe and very smelly, hard pellets or rabbit droppings which can be crumbly and dry or smudges of poo in their pants

If soiling is present then refer to GP for disimpaction Refer to NICE guidance - Constipation in children and young people

Disimpaction therapy:

Start with polyethylene glycol 3350 + electrolytes (Movicol Paediatric Plain) < 1 yr: ½-1 sachet daily

- 1-5yrs: 2 sachets day 1, increase by 2 sachets/ day to max 8
- 5-12 yrs: 4 sachets day 1, incr by 2 sachets/day to max 12

Review within 1 week Add a stimulant laxative, e.g. senna, if no effect after 2 weeks

After disimpaction, the child will need to continue on a maintenance dose of Macrogols whilst their bowel function returns to normal.

The child may require ongoing support from PHNs to address issues that may have led to stool withholding.

Causes of daytime wetting

Overactive Bladder and small bladder capacity are amongst the commonest causes of daytime bladder problems, including wetting.

Constipation. If present, this will squash against the bladder, giving the bladder less space and making it less able to hold on to wee. It may also lead to frequency, urgency or day or night time wetting.

Drinks Wee that is dark yellow in colour and very strong means the child is not drinking enough. This can irritate the lining of the bladder and make the overactive bladder worse. Fizzy drinks and drinks with caffeine in them also irritate the lining of the bladder.

Not getting to the toilet in time. If a child 'holds on' for too long instead of going to the toilet when needed, they may not make it in time and are more likely to wet

Infections. Urinary Tract Infection (UTI) can cause frequency and urgency - refer to GP.

Interventions:

- **Review Fluid Volume Chart** and advise on fluid type quantity. Review after 4-6 weeks.
- **Revisit adult-led toilet training with parents** prompting toilet sits every 1 ½ to 2 hours.
- **Encourage child to sit on the toilet after wetting** to reinforce that wees need to go in toilet and to ensure that the bladder has been completely emptied.

What is a healthy bladder capacity?

Working out a child's Expected Bladder Capacity (EBC)

For example: (4yrs + 1) x 30 = 150mls. This means the 4yr old's bladder should be able to hold approximately 150mls of urine.

- Up to age 12yrs (+ 1) x 30=390 ml
- Adult capacity 400+ ml

If the child is voiding more than once an hour check for constipation or a UTI. Review fluid intake.

Dehydration Urine Colour Chart

The following Dehydration Urine Colour Chart will help you use your urine colour as an indicator of your level of dehydration and what actions you should take to help return your body back to a normal level of hydration.

	Doing ok. You're probably well hydrated. Drink water as normal.
	You're just fine. You could stand to drink a little water now, maybe a small glass of water.
	Drink about 1/2 bottle of water (1/4 litre) within the hour, or drink a whole bottle (1/2 litre) of water if you're outside and / or sweating.
	Drink about 1/2 bottle of water (1/4 litre) right now, or drink a whole bottle (1/2 litre) of water if you're outside and / or sweating.
	Drink 2 bottles of water right now (1 litre). If your urine is darker than this and / or red or brown, then dehydration may not be your problem. **See a doctor**.

The correct way to sit on the toilet

- Children need to feel secure when they are sat on the toilet.
- Their feet need to be secure on the ground or step.
- Their knees need to be higher than hips or semi-squat.
- They should lean forward with their elbows resting on their knees.

Things to watch out for If a child is leaning back, they could be stool-withholding.

The healthier way to sit on the toilet

Intestine is pinched and blocked

When to refer

GP

Sometimes, when things don't go to plan with toilet training there can be a medical reason. It is always good practice to refer to the GP for ongoing issues. The GP can then assess for underlying organic cause of:

- **Constipation and soiling**
- **Suspected Urinary Tract Infection** Urine needs to be tested and if infection is detected then medication will need to be prescribed by the GP.
- **Stool withholding** if ongoing, this could lead to constipation and impaction. This will also need to be assessed by GP to ensure there is no physical or medical reason for this.

Paediatric Bladder & Bowel service

- At least 3 months for constipation
- At least 6 months for toilet training and aged 4+
- At least 3 months for bedwetting
- At least 6 weeks for severe daytime wetting (or bedwetting)

The eligibility for continence products is now 5 years+ but the service offers support from 4 years.

For advice and queries contact the team:

ghn-tr.paediatricbladder-bowelcareteam@nhs.net

0300 422 5308