Paediatric assessment of toilet training readiness and the issuing of products

An RCN care pathway
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 recent 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 paediatric continence advisors, 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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✦ PromoCon, Disabled Living, Manchester
✦ RCN Continence Forum

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Paediatric assessment of toilet training readiness and the issuing of products

An RCN care pathway

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Paediatric 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 paediatric 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 paediatric continence advisor.

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: 
  \[ 3 + 1 \times 30 = 120 \text{mls}. \]
- 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 – 250 mls – 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 for 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 paediatric continence advisor 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 paediatric continence advisor.
✦ 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 paediatric continence service at least every six months, as a record that the child’s needs had 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 paediatric 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 paediatric continence promotion service forms.

**Criteria for paediatric 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 paediatric 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 paediatric 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 paediatric continence advisor.
- The child’s family should be informed about any changes to product supply.
Supply of paediatric continence products

Child referred to service

Child undergoes baseline assessment

Any underlying problems are identified and addressed – for example, constipation

Most appropriate care pathway discussed with family. This is implemented and written information is provided

Toilet readiness/training programme deemed appropriate

Toilet training trial begins

Progress → Continue with toilet training → Provide ongoing advice and support → Adjust any supplies previously provided → Monitor until trained and discharge

No progress

Six-monthly assessment → Progress

Toilet training deemed inappropriate at this time

Child supplied with products, following policy appropriate to need
The following is an example of a paediatric continence reassessment checklist, based upon that used by Liverpool Primary Care Trust.

### Paediatric continence reassessment checklist

<table>
<thead>
<tr>
<th>Child's name</th>
<th>Date of birth</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assessor's name</td>
<td>Base</td>
</tr>
</tbody>
</table>

**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 advisor 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 less than three per week', contact paediatric continence advisor for further advice.

- Record number of drinks per day

  - NB if less than six, advise accordingly.

**Development update**

- Toilet skills chart reviewed and updated [Yes / No]
- Three-four day input/output chart completed [Yes / No]

If above charts not completed, please document reason:

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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?
   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? Stock levels 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 used by 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.

<table>
<thead>
<tr>
<th>Date</th>
<th>Day 1</th>
<th>Day 2</th>
<th>Day 3</th>
<th>Day 4</th>
<th>Day 5</th>
<th>Day 6</th>
<th>Day 7</th>
</tr>
</thead>
<tbody>
<tr>
<td>Time</td>
<td>Toilet</td>
<td>Nappy</td>
<td>Drink</td>
<td>Toilet</td>
<td>Nappy</td>
<td>Drink</td>
<td>Toilet</td>
</tr>
</tbody>
</table>
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 paediatric continence promotion service.
Appendix 1

Assessment for provision of paediatric continence products care pathway

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


Primary continence problem: toilet training never really achieved? Yes No Secondary continence problem: Yes No Age child first trained Age problem began

Acknowledgement to care pathway development group. Care pathway reviewed, Jan 2006.
# Appendix 2

## Toilet skills assessment

<table>
<thead>
<tr>
<th>Child’s name:</th>
<th>Date of birth:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initial assessment completed by:</td>
<td>Date of first assessment:</td>
</tr>
</tbody>
</table>

### (a) Bladder function – if bladder emptied

<table>
<thead>
<tr>
<th>Date</th>
<th>Date</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 More than once per hour, shade in area 1</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>2 Between one-two hourly, shade in areas 1 and 2</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>3 More than two hourly, shade in areas 1, 2 and 3</td>
<td>3</td>
<td></td>
</tr>
</tbody>
</table>

### (b) Bowel function, if

<table>
<thead>
<tr>
<th>Date</th>
<th>Date</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Has frequent daily soiling, shade in area 1</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>2 Does not always have normally formed bowel movements – is subject to constipation or diarrhoea – shade in area 2</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>3 Has regular normally formed bowel movements – shade in areas 1, 2 and 3</td>
<td>3</td>
<td></td>
</tr>
</tbody>
</table>

### (c) If night time wetting occurs

<table>
<thead>
<tr>
<th>Date</th>
<th>Date</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Frequently – every night – shade in area 1</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>2 Occasionally – odd dry night – shade in areas 1 and 2</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>3 Never, shade in areas 1, 2 and 3</td>
<td>3</td>
<td></td>
</tr>
</tbody>
</table>

### (d) If night time bowel movements

<table>
<thead>
<tr>
<th>Date</th>
<th>Date</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Occur frequently – every night – shade in area 1</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>2 Occur occasionally – some clean nights – shade in areas 1 and 2</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>3 Never occurs, shade in areas 1, 2 and 3</td>
<td>3</td>
<td></td>
</tr>
</tbody>
</table>

### Independence

### (e) Sitting on the toilet, if

<table>
<thead>
<tr>
<th>Date</th>
<th>Date</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Afraid or refuses to sit, shade area 1</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>2 Sits with help, shade in areas 1 and 2</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>3 Sits briefly without help, shade in areas 1, 2 and 3</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>4 Sits without help for long enough to complete voiding, shade in areas 1, 2, 3 and 4</td>
<td>4</td>
<td></td>
</tr>
</tbody>
</table>
### (f) Going to the toilet, if

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Gives no indication of need to go to the toilet, shade area 1</td>
<td>1</td>
</tr>
<tr>
<td>2</td>
<td>Gives some indication of need to go to the toilet, shade areas 1 and 2</td>
<td>2</td>
</tr>
<tr>
<td>3</td>
<td>Sometimes goes to toilet of own accord, shade in areas 1, 2 and 3</td>
<td>3</td>
</tr>
</tbody>
</table>

### (g) Handling clothes at toilet, if

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<thead>
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<tbody>
<tr>
<td>1</td>
<td>Cannot handle clothes at all, shade 1</td>
<td>1</td>
</tr>
<tr>
<td>2</td>
<td>Attempts or helps to pull pants down, shade areas 1 and 2</td>
<td>2</td>
</tr>
<tr>
<td>3</td>
<td>Pulls pants down by self, shade areas 1, 2 and 3</td>
<td>3</td>
</tr>
<tr>
<td>4</td>
<td>Pulls clothes up and down without help, shade in areas 1, 2, 3 and 4</td>
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### Other components

#### (h) Bladder control, if

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<tbody>
<tr>
<td>1</td>
<td>Never or rarely passes urine on toilet/potty, shade area 1</td>
<td>1</td>
</tr>
<tr>
<td>2</td>
<td>Passes urine on toilet sometimes, shade areas 1 and 2</td>
<td>2</td>
</tr>
<tr>
<td>3</td>
<td>Passes urine on toilet every time, shade in 1, 2 and 3</td>
<td>3</td>
</tr>
<tr>
<td>4</td>
<td>Can initiate a void on request, shade areas 1, 2, 3 and 4</td>
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#### (i) Bowel control, if

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<tbody>
<tr>
<td>1</td>
<td>Never or rarely opens bowels on toilet/potty, shade in area 1</td>
<td>1</td>
</tr>
<tr>
<td>2</td>
<td>Opens bowels on toilet sometimes, shade areas 1 and 2</td>
<td>2</td>
</tr>
<tr>
<td>3</td>
<td>Opens bowels on toilet every time, shade areas 1, 2 and 3</td>
<td>3</td>
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#### (j) Behaviour problem, that interferes with toileting process – for example, screams when toileted, faecal smears, if

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<tbody>
<tr>
<td>1</td>
<td>Occurs frequently – once a day or more – shade in area 1</td>
<td>1</td>
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<tr>
<td>2</td>
<td>Occurs occasionally – less than once a day – shade areas 1 and 2</td>
<td>2</td>
</tr>
<tr>
<td>3</td>
<td>Never occurs, shade in area 1, 2 and 3</td>
<td>3</td>
</tr>
</tbody>
</table>
### Paediatric Assessment of Toilet Training

<table>
<thead>
<tr>
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<th>Date</th>
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<tbody>
<tr>
<td>(k) Wears nappies, ‘pull ups’ or similar, if</td>
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<td></td>
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<tr>
<td>1</td>
<td>Yes, shade area 1</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>No, shade areas 1 and 2</td>
<td>2</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| (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-five drinks, shade in area 2 | 2    |      |      |
| 3 | Drinks 80ml/kg per day – six+ drinks, shade in area 3 | 3    |      |      |

References and further reading


