Bladder & Bowel UK
Supporting people with bladder and bowel problems
part of Disabled Living

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The Children's Bowel & Bladder Charity

Managing Bladder and Bowel Issues in Nurseries, Schools and Colleges

Guidance for school leaders, proprietors, governors, staff and practitioners

October 2019

Title	**Managing Bladder and Bowel Issues in Nurseries, Schools and Colleges** Guidance for school leaders, proprietors, governors, staff and practitioners.
Document purpose	To provide information for education settings on managing issues related to continence (bladder and bowel health) and toileting in schools.
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Target audience	Nursery, school and college governors, leaders and proprietors, SENCos/ALNCOs, school staff, early learning practitioners, parents and carers, children and young people.
Description	This guidance document provides a framework to help educational settings understand bladder and bowel difficulties and issues faced by children and young people. It outlines the measures that should reasonably be taken to support them, so that they have a positive experience of education and attain their potential.
Action required	For dissemination, discussion and implementation across educational settings in the UK, including nurseries, schools and colleges.
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A word from the authors

Continence conditions are among the most common health issues affecting children and young people. The impact can be profound on a child or young person's life. However, they are poorly understood and supported. Bladder and bowel difficulties are associated with stigma, embarrassment and shame; they cause avoidance of school trips and sleepovers; they impact social interactions, wellbeing, educational attainment and progress.

"I can't remember a time I wasn't bullied because of my wetting problem. At junior school I would have regular accidents and be taunted constantly in the playground for 'smelling like fish'. I didn't have any friends. I always wanted to sit inside at break to avoid the bullies".
Beccie

Many people incorrectly believe that issues are the result of poor parenting or delayed development. The Bladder & Bowel UK and ERIC helplines hear daily from families who are left with feelings of despair due to struggling alone with the burdens of disturbed sleep, constant washing and having to take unplanned time off work due to the unpredictability of soiling and/or wetting 'accidents'.

Against this background, many families find it difficult to ask for help. If they are met with an inappropriate response or lack of understanding from health services, nursery, school or college their problems are compounded. Motivated by this and because we know that educational settings aim to provide the best learning environment for their pupils, the charities, Bladder & Bowel UK and ERIC have teamed up to provide comprehensive, clear, concise and practical information to nurseries, schools and colleges about continence issues.

We hope this guidance will raise awareness of the prevalence and range of different continence conditions, encourage positive action between school and home whilst providing information and strategies for preventing and managing bladder and bowel conditions in educational settings. If implemented, we feel confident that in the future no young person will express their continence difficulties as "*not life threatening, but life ruining*" and will be able to fully engage with education, so they reach their full potential.

Juliette Rayner
CEO
ERIC

Davina Richardson
Specialist Children's Nurse
Bladder & Bowel

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Foreword

I am delighted to welcome this comprehensive guidance for the management of continence conditions in children and young people in education. In considering the societal, environmental, developmental and cultural changes that, in a fast-changing world, both they and we are facing, it provides a much-needed resource.

We are all aware that bladder and bowel difficulties can and do create many challenges for pupils and staff alike, and many of us can likely recall knowing of the 'smelly' one in our own classrooms! So, it is of paramount importance that those working with children and young people fully understand the causes, the effect and what we can do to help.

Educational attendance, attainment and health are intrinsically linked. Therefore, the more we can do to minimise the negative impact on a pupil's health and well-being, the more likely they are to flourish and grow.

This guidance not only helps us better understand the key and far-reaching role that education has to play in better managing continence issues, but also highlights the critical interface and role of health such as school nurses, paediatricians, continence services, and other agencies, including the children and young people themselves. In doing so, we learn how to best utilise one-another's expertise and co-produce meaningful individual care plans. Those care plans that are tailored and sensitive to individual need are the ones that are much more likely to succeed!

In busy, pressured establishments, this guidance, once implemented, will also serve to save valuable time, resources and, in turn, help create an educational environment of inclusivity, tolerance and positivity.

The experience that children and young people have during their time in education lasts throughout life. Using this guidance gives you the opportunity to ensure that for those suffering from bladder and bowel issues, this does not define who or what they are. Rather, with the right management and support, its impact is minimised and they can go on to positively learn alongside their peers.

Sharon White
CEO
School and Public Health Nurses Association www.saphna.co

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Glossary of common terms

Bladder and bowel: The terms 'bladder and bowel issues', 'bladder and bowel problems', 'bladder and bowel dysfunction', 'bladder and bowel conditions' are often used interchangeably. They all relate to conditions that have an impact on the way the bladder and/or bowel function. For some individuals, but not all, this may result in incontinence of urine (wetting) and/or incontinence of faeces (soiling).

Children: This document refers to all children and young people as 'children'. It is written to be relevant to those who work with children and young people up to the age of 19 years who attend nursery, school or college.

Continence containment products: The term used to describe protective clothing that is designed to prevent urine or faeces leaking into outer garments. Disposable continence containment products is the term used to describe nappies, pant-style products ('pull ups'), and pads that are designed to be discarded when at least two–thirds full of urine or soiled. Washable continence containment products are usually shaped like boxer shorts or standard pants, but contain extra padding and/or waterproofing.

Parents: The term parent(s) also refers to carer(s)

Pupil and student: This document refers to all children and young people who attend a nursery, school or college as 'learners'.

Schools: This document will refer to all education settings (nurseries, schools and colleges) that cater mainly for children and young people under the age of 19 years as schools.

For a full glossary of terms used to describe bladder or bowel problems see Appendix Two.

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1.1 Introduction

This guide is designed to help school, college and nursery leaders, governors, proprietors and staff understand the issues around bladder and bowel health (toileting difficulties/continence issues). It outlines how to promote good bladder and bowel health, as well as what should be done to support affected children. Wherever possible, the guide will refer to appropriate legislation, guidance and resources.

In excess of 900,000 children in the UK have continence difficulties. Not only are increasing numbers of children starting school each year without having fully mastered bladder and bowel control (continence), but many children continue to have issues with continence in the long term. Some have difficulties into adulthood. Continence difficulties in childhood are sometimes assumed to be as a result of disability, behavioural issues, or ineffective parenting. This is rarely the case and if not managed appropriately these issues can cause unnecessary stress for the child, their parents, family and for school staff.

The United Nations Convention on the Rights of a Child (UNCRC) sets out the civil, political, economic, social and cultural rights of all children and young people and was ratified by the UK in 1991. Some of the articles of the UNCRC relate directly to the management of bladder and bowel issues in schools including: Article 3, the best interests of the child should be the primary consideration; Article 6, the rights to healthy development; Article 12, the right to participate in decision making; Article 16, the right to privacy; Article 23, the right to special care, support and access to education for those with a disability; Article 24, the right to good quality healthcare; and Article 28, the right to education.

Each of the countries of the United Kingdom have differing legislation, guidelines and policy. These are available in Appendix Four.

1.2 Key recommendations

1. Education settings should be aware of bladder and bowel conditions and their role in supporting affected children
2. Education settings should be aware of how to promote healthy bladder and bowels by:
    - Encouraging learners to remain hydrated throughout the hours they are on the school site – they should have half of their daily fluid requirement in core school hours
    - Ensuring learners have access to clean, well-stocked toilets at intervals appropriate to the needs of the individual child

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3. Children must not be refused admission to school due to continence difficulties
4. Learners who are known to have continence difficulties should be offered a care plan, to ensure their individual needs are met in school
5. Parents should not be expected to come to school to change their children

1.3 Scale of the problem

It is thought that about 900,000 children are affected by continence difficulties[1], although this is considered to be an under-estimate.

Estimates of how many children have issues with day and night time wetting, constipation and soiling vary, but it is thought that constipation affects up to 29.6% of children[2], becomes chronic (lasts more than eight weeks) in up to a third of these and results in soiling (faecal incontinence) in 0.8 – 7.8% of children[3]. Daytime wetting affects about 2.8% of 6 – 14 year olds; bedwetting is a problem for up to 15.5 % of 7 ½ year olds[4]. Those who continue to have problems with bladder control when they are 4 - 9 years old are at increased risk of ongoing continence problems in adolescence[5]. Children with additional needs are more likely to have continence difficulties than their typically developing peers[6].

There is evidence that toilet training is happening at a later age and developmental stage than in previous generations[7] due to environmental, cultural and social changes. Assumptions based on new norms, that children will not toilet train until they are about 2 ½ - 3 years old or older, may result in children with disabilities[8] not being offered support to toilet train at an early stage[9].

1.4 The impact of continence issues on children

Bladder and bowel issues such as daytime bladder problems, bedwetting, constipation and soiling can have a devastating impact on a child's learning, development and quality of life,

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[1] Paediatric Continence Forum Commissioning Guide (2014)
[2] Koppen et al (2015)
[3] Ambartsumyan & Nuurko (2013)
[4] Butler et al (2005)
[5] Heron J et al (2017)
[6] von Gontard et al (2016)
[7] Kaerts et al (2012)
[8] In this document the terms disabilities, additional needs and special educational needs are used interchangeably
[9] Richardson (2016); Rogers (2010),

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as well as causing increased stress to their families. A lack of awareness amongst health and education professionals, along with concern that their peers will discover their difficulty, negatively affects many learners' experience of school.

Children with continence issues are at high risk of bullying and withdrawing from social situations. Most suffer embarrassment and stigma. Furthermore, continence difficulties may also be associated with behavioural or psychological problems, poor self-image and peer victimisation. Recent research has also found that teenagers with incontinence are at greater risk of underachieving academically and need more support to remove barriers so they can reach their academic potential[10].

1.5 Development of continence

1.5.1 Continence development in children

In previous generations most children were toilet trained by the time they were two years old. Currently, most are toilet trained by the time they are 3 – 4 years old. Young children have small bladders: they hold about 120mls of urine at age three years and increase in capacity by about 30mls a year. However, their kidneys produce urine at the same rate as older children's kidneys (about 60mls an hour). Additionally, they normally get the message that the bladder needs emptying at a later stage. Therefore, young children will need to use the toilet frequently and at short notice. As children get older, if their bladder is working well, they become aware of the need to pass urine before the bladder is full, giving them the time and notice to use the toilet at convenient intervals; such as at break time. If children are drinking adequately, their urine should be pale in colour, they should be passing urine 5 – 7 times a day and the bladder should be empty when they have finished passing urine.

By the age of three years old, children should be opening their bowels three times a day to three times a week. If they do not respond to the need to open their bowels in a timely manner they are at increased risk of developing constipation. It is normal to have the urge to open the bowels after a meal or warm drink.

1.5.2 Why some children have difficulty toilet training

Not all children become toilet trained at the same age. It is usually considered that continence will be acquired when the child becomes aware of their bladder and bowel and of social expectations around toileting. Therefore, most parents wait until their child is

[10] Whale et al (2017)

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showing signs of awareness of passing urine or opening their bowels before starting toilet training. However, not all children will display these signs and there is evidence that bladder maturation is promoted by toilet training[11].

If a child has a bladder or bowel health problem, toilet training may be delayed[12]. If the child has a disability or chronic illness, toilet training may have been delayed in favour of other treatments, or because assumptions may have been made about the child's abilities in this area.

1.5.3 The causes of continence problems in childhood

Bladder and/or bowel difficulties may delay acquisition of continence or may result in incontinence at any age or developmental stage. The most common cause of wetting and soiling is constipation[13]. Daytime wetting may occur as a result of constipation or bladder difficulties, including urinary tract infection[14]. Bladder difficulties may develop if children are regularly expected to hold on for too long, or not given time to fully empty their bladder. Equally sending children to the toilet too often may cause problems in the long term, because the bladder will become used to emptying more frequently than is typical.

Encouraging children to hold on when they need a bowel action or giving them insufficient time to complete a bowel motion, may cause constipation.

If schools have concerns about bladder or bowel issues in any child, they should discuss this with the child's parents and the school nurse (or health visitor for children in nursery) if appropriate.

1.5.4 Children with Special Educational Needs and Disabilities (SEND)

Children with disabilities may experience the same bladder and/or bowel issues as their typically developing peers. However, they are more likely to develop lower urinary tract symptoms and/or constipation. Furthermore, they may face additional obstacles to achieving and maintaining continence. Restricted mobility may make getting to the toilet more challenging; communication difficulties can hamper requests for help; reduced social awareness may impact on their desire to learn to use the toilet, sensory issues may make them unwilling to use school toilets.

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[11] Joinson C et al (2009)

[12] For details of different bladder and bowel difficulties see Appendix Two

[13] For a definition of constipation see Appendix Two

[14] For more information on urinary tract infection see Appendix Two

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Some children with disabilities will require adaptations to promote toileting. Liaising with their family and health care professionals is important to ensure that individual needs are understood and met. Some children with disabilities may already have a care plan in school. If so, any continence needs should be included in these. Learners without a care plan may benefit from one[15].

Children and young people with disabilities or medical conditions may face even greater challenges in maximising a fulfilling and full education if personal care needs are not fully supported. (Scottish Government[16])

1.6 How schools can promote good bladder and bowel health

1.6.1 Access to drinks

Children should be drinking 6 – 8 water-based drinks each day. Thirst should not be relied on as an indicator of the need for a drink in children, as this cue may not be well developed, or children may have reduced awareness of it. The total volume that a child needs varies according to age, size, activity levels and environment, with more required for children who are overweight, when the environment is hot, or when children are exercising. The latter includes playing outside at break times.

As well as preventing dehydration, which is detrimental to learning and wellbeing, good drinking habits promote good bladder health, help to prevent urinary tract infections (UTI) and constipation. The table below outlines suggested total intake for most children, during waking hours.

Age	Sex	Total drinks per day
1 – 3 years	Female	900 – 1000 ml
	Male	900 – 1000ml
4 – 8 years	Female	1000 – 1400ml
	Male	1000 – 1400ml
9 – 13 years	Female	1200 – 2100 ml
	Male	1400 – 2300 ml
14 – 18 years	Female	1400 – 2500 ml
	Male	2100 – 3200ml

Suggested intake of water-based drinks per 24 hours by age and sex

(Adapted from CG 111 Nocturnal Enuresis NICE 2010 and American dietary requirements, cited in CG 99 Constipation in Children and Young People, NICE 2010)

[15] For more information on care plans see section 1.10. A sample care plan is available in Appendix Six

[16] Updating of the School Premises (General Requirements and Standards) (Scotland) Regulations 1967: consultation response analysis

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Good practice requires the following to be implemented:

- Ensuring children have a good fluid intake. The majority need encouragement with this
- Children should be having half their daily water-based fluid intake in school hours
- If children will not drink water, they should be allowed to have diluted fruit squashes, preferably sugar-free. These should be provided by parents and brought to school ready to drink in a sports-style water bottle that is opaque, so other children do not realise they are having something different
- Children should avoid fluids that contain caffeine (tea, coffee, hot chocolate, cola and many energy drinks) as these irritate the bladder
- Fizzy drinks should be an occasional treat only, as they may irritate the bladder
- When children increase their fluid intake they may require more frequent access to the toilet. However, as their bodies adjust, so long as they are drinking within normal limits, their bladder capacity should improve and the need for extra toilet visits should reduce

Schools should consider how they could facilitate good drinking habits among all their leaners. This may include:

- Open access to drinks unless this is clearly inappropriate; for example, in science or computer laboratories
- Provision of easily accessible water fountains or taps to top-up water bottles
- Encouraging learners to bring their own water bottles in from home, or providing water bottles in school

1.6.2 Access to the toilet

Schools should be aware that some learners avoid eating and/or drinking in school so that they can avoid using the toilet. This is more likely if they feel that toilet access is restricted, or they feel the need for additional privacy, or school toilets are poorly maintained and stocked[17].

Learners should have open access to clean, safe, well-stocked toilets throughout their hours at school. This is particularly important for younger children, those who have difficulties with their bladder and/or bowel and for girls who are menstruating. Some learners will need prompting to use the toilet; it may be appropriate to do this after breaks, meals and snacks.

[17] Bottom of the Class: are falling standards failing primary school children Essity

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As children mature their ability to use the toilet opportunistically increases. For most this means they will go at break time. However, all learners should be allowed open access to the toilet. This is particularly important for those learners known to have an issue. A system should be provided to allow them to have open access as soon as they need it. For primary school children this may be a non-verbal sign that they are going to the toilet, as many are too embarrassed to put their hand up and ask. For those at secondary school or college it might be more appropriate to issue them with a 'medical' or 'time out' pass, which grants them liberty to leave the classroom as they require. Learners may be reluctant to use a pass that states it is for toileting.

'Each child's bladder and bowels are individual and their bladder and bowel capacity are very variable, function to their own timetable and will differ according to a multitude of variable factors. A child's timetable is therefore unlikely to conform to the school's timetable.' (Welsh Government 2012[18])

Although schools can take action to minimise disruption to teaching, policies or procedures in schools that restrict access to the toilet, or to drinking water may be in breach of legislation[19]. This is because they may have a disproportionate negative effect on learners with disabilities or health conditions. If access to toilets and drinks is not granted universally, the affected young people are likely to have increased anxiety about their condition, associated with the embarrassment and stigma of such personal health problems.

1.6.3 Hygiene standards in school toilets[20]

Many surveys have been undertaken about the state of school toilets. While some schools have toilets of a high standard, too often learners report dirty, poorly stocked toilets, where negative behaviour is not uncommon.

'We try to teach our pupils to respect the adults around them. To do this we believe we need to show them respect. How will our pupils know we respect them if we don't provide them with a suitable environment? That is why we refitted our school toilets' (Head teacher in Gloucestershire, 2018)

It is important that school toilets are cleaned and restocked as required during the day, so that learners have access to suitable facilities, appropriately heated, ventilated and lit, with toilet paper, soap and paper towels or hand driers. Floor to ceiling doors ensure privacy.

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[18] School toilets: Good practice guidance for schools in Wales (2012)

[19] See Appendix Four for relevant national legislation

[20] Also see section 1.6.4 and Appendix Seven, School Toilet Charter

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Movement sensors are not recommended for school toilet lighting as they may switch lights off while a learner is still using the toilet.

Waste bins should be provided in all cubicles for both sexes. The bins should have an attached lid, be lined with a disposable rubbish bag and have an opening of sufficient size to easily accept large pads, catheters etc, as well as sanitary protection. All learners using such equipment should have disposal bags provided by home for these items. This allows discrete and hygienic disposal and ensures double bagging.

Girls who have reached puberty require appropriate provision for sanitary wear, but any learner may need to dispose of catheters, stoma bags or continence containment products. Waste bins should be emptied as required during the school day to ensure they are not overfilled.

Learners with additional needs or those with continence difficulties may require extra space and privacy than is afforded by most school toilets and provision should therefore be made for them to use the disabled toilet. Those with sensory issues may also need special provision, such as access to a toilet that does not have hand driers. Consideration should be given to a discrete location for learners to store spare clothes or accessories required for toileting or changing, including items such as catheters and wipes. Soiled items to go home for laundering should be returned discreetly.

1.6.4 School toilet provision[21]

Schools must meet the minimum standards required by legislation. Requirements for the provision of school toilets vary in the different countries of the United Kingdom[22].

Good facilities reduce health issues, prevent toilet phobia and promote respect:

'The lack of priority given to these amenities, is seen by many children as an indication of the lack or priority – and respect – given to them by society at large.' (Children's Commissioner for Wales, 2004)

It is good practice for schools to consider:

- Provision of sufficient toilets to cover peak use in break times
- Whether toilets should be provided separately for girls and boys

[21] Also see section 1.6.3 and Appendix Seven, School Toilet Charter

[22] For legislation relevant to the different countries of the UK see Appendix Four

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- Whether there should be gender neutral toilets. If these are single cubicles, they should ensure the privacy of the occupant, by having full height walls and doors. Gender neutral cubicles offer choice to learners, increase accessibility, meet legislative requirements for schools to provide for learners who are taking steps to live in the opposite gender and are what learners are used to using at home
- That single cubicles with washbasins provide privacy for learners who need to clean themselves after an episode of incontinence. They usually have bins and these should be provided for those who need to dispose of accessories, such as wipes or catheters
- Many learners do not like having toilets that open directly onto a school corridor, as they do not like feeling they are being observed going into the toilet
- That behaviour generally in the toileting area may improve when all learners are using enclosed toilet cubicles, in a single area
- Involving the learners in decisions about school toilet provision

1.6.5 Managing episodes of incontinence in school

Episodes of incontinence may occur for a variety of reasons. If it is known that a child may have bladder and/or bowel difficulties their parents should ensure that sufficient clothes/equipment for individual requirements are available in school at all times.

It is not acceptable for school to suggest that a learner goes back into disposable continence containment products (nappies or disposable pants) as a means of managing incontinence. Washable 'protective' or 'padded' continence pants are acceptable. Disposable continence containment products reduce the sensation of wetting and soiling and may give the learner the impression that it does not matter where they pass urine or open their bowels. Disposable continence containment products should only be used to manage incontinence in school if recommended by a healthcare professional who is involved in treating the learner's bladder/bowel issue.

If a learner is incontinent frequently and this is causing concern either for the learner's wellbeing or in terms of management, parents and an appropriate healthcare professional should be consulted. Parents may be asked to provide washable pants as an alternative to disposables, although each case should be assessed individually.

Schools should consider that time spent assisting a learner to change is an opportunity for a positive learning experience. It may take ten minutes or more to support an individual with changing, but this time should be used to assist them to become as independent as they are able and is not dissimilar to the time allocated to working with a learner towards an individual learning target.

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1.7 Health and Safety

Schools are expected to take care of a learner in the way that a responsible parent would. Staff should receive training in order to maintain safety and manage risks. Training to support children with continence issues can be obtained from guidance such as this or from relevant healthcare professionals[23].

For specific concerns related to individual learners it is usually appropriate to discuss the child's needs with their parents and health care professionals. The school nurse is in a unique position to be able to support and coordinate this. An appropriate care plan is appropriate for many children with individual care needs related to their continence[24].

1.8 Safeguarding

Knowingly leaving a child in soiled or wet clothing is neglectful and could be seen as abuse. The priority is for the learner to be appropriately supported and for school to ensure that their needs are met. Children who are left in a soiled state are at increased risk of sore skin and urinary tract infections. There is also likely to be a significant impact on their psychological wellbeing and an increased risk of name-calling or bullying.

All staff who work in school will have had relevant pre-employment screening to help prevent unsuitable people from working with children. Therefore, there are no regulations requiring more than one person employed by a school to be present to support a learner with changing, or to assist them with continence. Furthermore, having more than one person is unlikely to promote continuity, dignity or privacy for the child.

There will be some circumstances where an individual learner will require two people to support them with changing. For example, if a hoist is used or if two are required for safe handling. Rarely the head teacher may decide that, for an individual learner, it is appropriate for two members of staff to be present for changing.

It is good practice that, as far as possible, the same person assists a learner each time they need support, but there may need to be two or three people trained to cover absences, school trips etc. Another member of staff should be aware when the care is being undertaken. Where possible, staff of the same gender as the learner should be supporting

[23] This may be the school nurse, or if involved the specialist nurse, learning disabilities nurse or children's continence nurse. Further advice may be sought from the Bladder & Bowel UK or ERIC helplines – see Appendix Eight

[24] A sample form for a care plan can be found in Appendix Six

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them with intimate care. If this is not possible, it should be discussed with the parents and learner. The priority is to provide the required support for the learner.

A signed record should be kept of all personal care given, including times that the learner and carer left and returned[25]. If there is any variation from the usual routine this should be recorded and the parent notified. Consent from a parent should be obtained, if a person other than those trained and named on the care plan is required to support a learner with intimate care, due to exceptional circumstances. However, if there are any concerns for the wellbeing of the child, the school's safeguarding policy and procedures must be followed[26].

Schools should work with parents to ensure that children understand appropriate and inappropriate touching and that children understand that they should tell a trusted adult if they feel uncomfortable[27].

1.9 Continence policies for schools

A clear intimate or personal care policy in schools will not only help to safeguard both learners and staff but will ensure that arrangements and expectations are clear. It will ensure that learners' independence and welfare is promoted, their dignity and privacy is respected. It will also promote confidence in the child and family that school is supportive of their needs.

Learners with bladder and bowel issues who receive support from school are more likely to achieve their full potential[28]. Personal care is usually included in job descriptions for school support staff. Assisting a child in such a way that they learn the skills needed for independence with their personal care, as far as their medical condition and level of ability allows, may form part of their one-to-one education.

The policy should outline the circumstances when it is appropriate for a child to have a care plan[29].

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[25] There is more information on intimate care and safeguarding in Guidance for safer working practice for those working with children and young people in education settings

[26] Schools should follow statutory guidance Keeping Children Safe in Education (DfE 2018)

[27] Pants resources for schools and teachers

[28] Whale et al (2017)

[29] A sample policy is available in Appendix Five

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1.10 Care plans to meet individual needs

All learners who require support with management of their bladder and/or bowel care or personal hygiene in school should have a care plan. Alternatively, for learners who have more than one support need in school, bladder and/or bowel care may be addressed within an existing care plan. School staff should agree the care plan with the parents, and the learner, where they are able to participate. Healthcare professionals may be involved in the plan[30], particularly if there are specific issues, such as catheterisation or changing of stoma devices, or disagreement about the level of support required[31].

All care plans should be reviewed at least annually or sooner if needs change.

1.11 Communication between home and school

Parents should provide school with sufficient information for them to meet the child's medical or health needs. Similarly, school should keep parents informed about their child's progress and any concerns. They should work together alongside the learner, where their age and developmental stage allows, to develop an appropriate care plan to meet the learner's needs. Additionally, parents should provide any portable items of equipment required to attend to the learner's continence needs throughout the school day. This might include, but is not restricted to, catheters, urinals, stoma bags, spare clothes, wipes, plastic bags, continence containment products if used[32]. Discussion should be had about who is responsible for larger items such as specialised toilet seats, hoist slings etc in conjunction with the child's occupational therapist.

Parents should not be asked to come into school to assist with changing their child or be expected to take them home to change them[34].

1.12 School attendance

It is not acceptable to refuse admission or exclude a child who has not achieved continence or continues to need support with this area of care. Some children may be missing significant amounts of school due to their incontinence or related symptoms. These should be addressed with the family and a healthcare professional.

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[30] In Northern Ireland care plans should be completed in collaboration between health and education

[31] See Appendix Six for a sample care plan

[32] See Department of Education guidance: Supporting pupils at schools with medical conditions (2015) for more information on working with parents

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It is recommended that schools do not penalise a learner for their attendance record if the absence is related to their healthcare needs. Absences for healthcare appointments, time to travel to those appointments, and recovery time from treatment or illness should not be used to penalise a learner.

Parents should make every effort to facilitate school attendance including booking appointments outside school hours wherever possible. Where this is not possible, parents should minimise time out of school by ensuring their child attends before and/or after an appointment, as appropriate.

1.13 Medication

It should be the exception that medications to treat continence conditions are administered at school. However, the advice of the child's healthcare professional should be followed. Where medications are required to be given in school hours this should be reflected in the child's care plan and the school's medical policy must be followed.

1.14 Unacceptable practice

It is unacceptable practice to:

- Prevent learners from attending an education setting due to their continence needs
- Prevent learners from accessing the toilet or drinks as they need
- Assume every learner with a bladder or bowel condition requires the same support
- Ignore the views of the learner or their parents, or evidence or opinions provided by healthcare professionals. These views may be queried with additional opinions sought promptly as required
- Send learners with continence needs home frequently or prevent them from staying for normal activities, including lunch, unless this is specified as part of their care plan
- Send a learner who requires support with their continence to the toilet without someone who can provided the required assistance
- Not apply in good time for adjustments, including access to drinks and the toilet, for a learner with continence needs during examinations or tests including mocks
- Prevent learners from drinking, eating or taking toilet or other breaks whenever needed in order to manage their healthcare needs effectively
- Require parents, or otherwise make them feel obliged, to attend the education setting, or off-site activity to provide support to the learner for issues related to their continence needs
- Expect or cause a parent to give up work or other commitments because the education setting is failing to support a learner's continence needs
- Create unnecessary barriers to a learner's participation in any aspect of their education, including trips, e.g. by requiring a parent to accompany the learner

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Appendix One

Understanding bladder and bowel conditions

Bladder and bowel difficulties can occur in childhood for the following reasons:

- Functional bladder and bowel conditions are the most common cause of bladder and bowel difficulties. They occur without any underlying damage to the child's anatomy, physiology, or nervous system and where there is no diagnosable underlying condition.

- Structural bladder and/or bowel conditions occur as a result of anatomical differences. Children may be born with these (e.g. spina bifida), they may occur due to an issue around the time of birth (e.g. cerebral palsy) or they may develop later, as a result of disease or injury (e.g. spinal cord injury due to an accident or tumour). Structural conditions may need corrective surgery, which might involve several procedures during childhood. However, despite surgery, many children with this group of conditions may continue to have challenges managing their continence throughout their childhood, or throughout life.

Incontinence is nearly always beyond the child's control. It is highly unlikely a child will wet or soil deliberately. Wetting and soiling are not a result of naughtiness or laziness. Most children with wetting or soiling have an underlying condition. Diagnosis is not always easy. Furthermore, some parents may not seek early help. This may be due to the embarrassment and stigma associated with these issues, or due to the mistaken belief that their child will grow out of it, or to a lack of understanding of what is typical with this area of development. For those who do have a diagnosis, treatment is often complex and protracted.

Many children with bladder and bowel difficulties will have an associated issue with behaviour due to the psychological impact of their symptoms. These often resolve with successful treatment of the underlying condition. Conversely, children with psychological problems may be more at risk of continence problems. School staff should be aware that bladder and/or bowel symptoms rarely occur solely as a result of failure of parenting, or disability. Therefore, assumptions should not be made without the child undergoing a full assessment of their bladder or bowel health from an appropriately trained healthcare professional[33].

[33] For further information on different bladder and bowel diagnoses and managements see Appendix Two

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Appendix Two

Index of continence symptoms and conditions

The same problem may affect different children in different ways. It is important for schools to ensure that they receive information from parents and healthcare professionals. It is recommended that learners have a care plan in school to ensure their needs are met.

Children with uncommon conditions may also experience one or more of the common bladder and/or bowel conditions.

Common bladder and bowel issues

Bedwetting
See Enuresis

Chronic constipation
Constipation (see below) is described as chronic if it lasts for more than eight weeks. Chronic constipation may require long-term treatment.

Constipation
Children with constipation may open their bowels less than once every three days; pass occasional very large motions, or have more frequent small motions; stools may be different textures and may be offensive smelling; they may withhold or strain to prevent themselves from passing large painful stools and may have problems with abdominal pain and distension, or soiling (see below). Children with constipation often have reduced appetite, are unhappy, irritable or moody and may have reduced energy levels. All of the latter symptoms may improve for a time after a large bowel motion.

Faecal Impaction
The term used to describe a situation where constipation is so bad that the child is unlikely to be able to pass all the stools retained in the large bowel without medical intervention. Soiling is usually associated with faecal impaction and is outside the child's control. The child is often unaware they have soiled (see soiling below). Treatment is usually called disimpaction and involves giving increasing doses of laxatives over a period of days to enable the child to pass the stools. Children undergoing disimpaction usually require several days off school, as the treatment causes an initial deterioration in soiling.

Enuresis
Also known as bedwetting or nocturnal enuresis, this is the condition of wetting during sleep. It may be accompanied by daytime symptoms, or there may be no daytime bladder

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problems. Affected children often sleep less well than their peers, which may affect school performance and behaviour. It may affect socialisation and willingness to take part in school trips that involve nights away.

Faecal incontinence
Also known as soiling (see below) is leakage of stools from the child's bottom.

Frequency
Passing urine more than seven times a day. In extreme cases children may need to use the toilet every few minutes.

Overactive bladder
A common condition where the bladder muscle 'twitches' during bladder filling, resulting in children experiencing urgency (sudden, desperate need to use the toilet) and frequency (needing the toilet more often than would normally be expected). It may be associated with wetting if the child cannot get to the toilet quickly enough. If adults are unaware of the condition, they may assume that the child is delaying toileting too long or is avoiding using the toilet at appropriate times.

Retentive faecal incontinence
Soiling as a result of chronic constipation. It is usually associated with faecal impaction and requires treatment with laxatives. (See definitions of chronic constipation and soiling.)

Soiling
Soiling is uncontrolled leakage of stools into the underwear. This is normally associated with chronic constipation and is usually totally outside the child's control. Often the child is unaware that they have soiled, even though stools may smell offensive to others. Lack of awareness is due to changes to the anatomy of the large bowel as the result of constipation and is not due to behavioural or psychological issues.
Rarely soiling is not caused by constipation. Any child who is soiling should be assessed by a healthcare professional. Treatment is usually with laxatives, which may initially make the problem worse. The laxatives may be required for months.

Stool withholding
This describes avoiding using the toilet to open the bowels. This is usually as a result of fear of pain, following a large hard bowel motion, but may also occur when a child wants to avoid using the toilet due to lack of privacy or concerns about their environment.

Urgency
The sudden and overwhelmingly urgent need to get to the toilet. It may be preceded or accompanied by positional changes (crouching or holding the groin), or by fidgeting (the 'wee dance'). Urgency may be accompanied by frequency and urinary incontinence.

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Urinary incontinence
This describes wetting, due to uncontrolled leakage of urine.

Urinary tract infection
An infection in the bladder, or kidneys, also known as UTI, urinary tract infections are more common in girls than boys. They may result in a child being acutely unwell, having urgency, frequency, or pain when they pass urine, or they may have few symptoms. Wetting may be associated with urinary tract infection.

Voiding postponement
Habitually delaying passing urine is known as voiding postponement. Some children will restrict fluid intake to avoid having to go to the toilet. Others may use the toilet infrequently but have a feeling of urgency and possible wetting as the bladder is overfull. This may be associated with not wanting to use school toilets. If voiding postponement becomes habitual it may result in further bladder problems.

More complex and/or less frequently occurring bladder and bowel issues

Anal Atresia/imperforate anus
This is where the anus is not open to the skin. The condition requires surgical correction soon after birth and may result in long-term problems with bowel control.

Anorectal malformation/ anorectal anomaly
These are a group of rare disorders affecting the anus and/or rectum. They arise as a result of a problem that occurs when the baby is developing during pregnancy. They include the anus not being open (anal atresia/imperforate anus), or the anus being in a different position or being narrower than usual (anal stenosis). There may be a different passage connecting the rectum to the skin (a fistula). The rectum may be closed inside the bottom, so that it does not connect with the anus, or the rectum may connect with the bladder, urethra or vagina through a fistula. Girls may have a malformation where there is only one opening for the bladder, bowel and vagina, called cloaca (see below).

Anal Stenosis
A narrowing of the anal opening, which makes it difficult for the affected baby to open their bowels. Treatment is usually with surgery soon after birth.

Bladder outlet obstruction
A problem with urine flow when using the toilet. Urine flow is slow and the child may struggle to empty their bladder.

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Bladder Extrophy
A condition where the lower abdomen does not form properly during pregnancy, so the child is born with the bladder open and exposed on the outer surface of the abdomen. Some children may have related problems with the urinary system and lower bowel. Bladder extrophy is usually treated surgically in the first few years of life.

Cloaca
A complex anorectal malformation in girls, where there is only one opening for the bladder, bowel and vagina. This requires complex surgery to correct the problem and may result in long-term continence problems.

Dysfunctional voiding
The child habitually contracts their pelvic floor or external urethral sphincter (the muscle at the base of the bladder) when they are passing urine. This results in difficulty emptying the bladder.

Encopresis
This term is now obsolete. Despite this, it is still sometimes used to describe the passage of normal stools in inappropriate places. It was used to distinguish children who were soiling due to mental health, behavioural or psychological problems from those who were soiling due to chronic constipation. The term has been replaced by non-retentive faecal incontinence.

Epispadias
The urethra does not form properly causing an abnormality of the opening and may result in incontinence.

Giggle incontinence
This is a rare condition where the bladder empties fully during or immediately after laughter. There are no other bladder symptoms.

Imperforate anus/ anal atresia
The anus is not open to the skin so that stools cannot be passed. This is treated with surgery shortly after birth, but may result in long-term problems with bowel control.

Inflammatory bowel disease
Crohn's disease and ulcerative colitis are inflammatory bowel diseases – they cause swelling and pain in the bowel. Crohn's disease can affect any part of the bowel from mouth to anus. It usually occurs in patches, with sections of normal bowel between. Ulcerative colitis affects the colon and rectum, producing tiny ulcers on the bowel lining. Both conditions have a range of symptoms including diarrhoea. Severity of symptoms varies and children may experience periods of active inflammation and times when they are in remission.

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Irritable bowel syndrome
Also known as IBS this is a group of symptoms that include abdominal pain, diarrhoea and/or constipation.

Hirschsprung's Disease
A rare congenital problem where the nerves to parts of the large bowel have not developed, so the bowel muscles cannot move in the normal way and stools are not moved through the large bowel. Severity varies from having a short section of bowel affected near the bottom to having no nerve input to any of the large bowel. Treatment is with surgery, usually soon after birth. Affected children may have long-term problems with constipation and bowel control.

Neuropathic/neurogenic bladder
The term used to describe a lack of bladder control due to problems with the nerve supply to the bladder, for example spina bifida.

Neuropathic/neurogenic bowel
This describes the inability to control bowel movements due to a problem with the nerve supply to the bowel, for example spina bifida.

Non-retentive faecal incontinence
The passage of normal stools in inappropriate places. It is usually associated with mental health, behavioural or psychological problems and differs from soiling due to chronic constipation. It was previously known as encopresis, although this term is now obsolete.

Sacral agenesis
This is the absence of the lower sacral vertebrae. This may be associated with difficulties of bladder and bowel control due to differences in development of the lower spine and associated impact on the nerves that are responsible for controlling the bladder and bowel.

Short bowel syndrome
A complex problem that is caused by the loss of function or physical loss of a portion of the small and/or large bowel. Symptoms and severity vary, but it is often associated with diarrhoea as well as problems with absorption of nutrients, which may result in malnutrition, weight loss and symptoms related to lack of essential vitamins and minerals.

Stress incontinence
Involuntary leakage of urine associated with increased intra-abdominal pressure, such as when coughing, exercising or sneezing. This condition is rare in children.

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Underactive bladder
A rare condition where intra-abdominal pressure has to be raised to start, maintain or finish passing urine. Affected children may use the toilet less often than expected, or they may have frequency as their bladder does not empty properly when they go to the toilet.

Urethrovaginal reflux
Urine pools in the vagina during voiding and then leaks when the child leaves the toilet, resulting in wetting after passing urine.

Appendix three

Aids and treatments to support management of bowel and bladder conditions

Antegrade Colonic or Continence Enema (ACE)
Also known as a MACE (Malone antegrade colonic enema). A special channel is created surgically, that allows a catheter to be passed into the large bowel. Fluid (usually water) is administered through the catheter to wash out the bowel. This is used for children who are unable to maintain bowel continence in the usual way or with other treatments. Washouts are usually performed at home once a day or on alternate days.

Bladder training /urotherapy
Bladder training involves children having regular drinks and toilet visits throughout their waking hours. The precise timing of these will vary according to individual need. However, children are often advised to have a drink followed by a toilet visit every two hours. Some children may use vibrating watches to remind them when to drink and use the toilet. This treatment usually needs to be continued for a number of weeks or months. For children undergoing bladder training schools should support the programme by allowing open access to drinks and the toilet.

Button devices (micky/mini buttons)
A device used as a means of accessing the bladder to drain urine, as an alternative to a vesicostomy or suprapubic catheter; or the bowel to administer washout fluid, as an alternative to an ACE.

Catheters
Urinary catheters are small tubes that are inserted into the bladder to drain urine. They may be inserted via the urethra, a Mitrofanoff (see below) or through the abdominal wall (suprapubic catheter). Catheters can be indwelling (they remain in the bladder for days or

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weeks at a time), or intermittent (they are inserted and then removed as soon as the bladder is empty).

Cystostomy (Vesicostomy)
A surgical procedure that allows connection between the bladder and abdominal wall to drain urine from the bladder.

Enema
A liquid that is inserted into the rectum to help a child empty their bowels to treat constipation and prevent soiling. They are not usually first-line treatment and should only be used on advice of a specialist healthcare professional.

Laxatives – see medications
A group of medications used to treat constipation. Children with chronic constipation may need laxatives for long periods of time, often months or years. When children first start to take laxatives, or doses are adjusted they may have loose stools or deterioration in soiling. This is not the same as gastroenteritis. Children do not normally need to have time off school, unless clearly unwell or they are being treated for faecal impaction (see Appendix Two). Laxatives only rarely need to be administered during school hours.

Medications
Many children are prescribed medication to help with the symptoms of their bladder or bowel condition. It is important that children are given medication as prescribed. Any concerns or questions about medication in schools should be referred to the parent in the first instance. Schools must act in accordance with their medical policy[34].

Antibiotics: A group of medicines used to treat bacterial infections, including urinary tract infections.

Anticholinergics: a group of medicines that may be used to treat bladder problems, including frequency, urgency and wetting.

Desmopressin: a medication given at bedtime to treat night time wetting.

Mitrofanoff
A surgical procedure that creates a special channel from the abdominal wall into the bladder. Children with a Mitrofanoff usually need to catheterise to empty their bladder several times a day.

Stoma
A stoma is an opening onto the surface of the body. It includes where the bowel or part of the urinary tract is opened onto the abdominal wall. The name of the stoma will vary according to which part of the urinary tract or bowel is involved: a colostomy is where the

[34] Advice on administration of medicines in school is available for schools from DfE guidance: Supporting pupils at school with medical conditions

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colon is brought to the abdominal wall; an ileostomy, is where the ileum (part of the small bowel) is brought to the abdominal wall. A bag is attached to the surface of the abdominal wall to collect faeces and may need to be emptied or changed during school hours.

A urostomy is when one or both ureters (the tubes from the kidneys to the bladder) are brought to the abdominal wall. A cystostomy, also called a vesicostomy, is when the bladder opens directly onto the lower abdominal wall. The urine is collected into either a bag attached to the abdominal wall or a disposable pad. In these cases, the bag will need to be emptied or the pad changed as frequently as necessary during the school day.

Suppositories

A small solid means of giving medication directly into the rectum, suppositories may be used as a means of helping a child empty their rectum and therefore prevent soiling. They are not usually given in school, are not usually first-line treatment for constipation and should only be used in children as advised by a specialist healthcare professional.

Transanal irrigation

Transanal irrigation is a specialist treatment that involves inserting water, usually via a cone or catheter, into the rectum via the anus to washout the bowels. This is usually done at home daily or on alternate days and is used to help a child gain or maintain bowel continence, when other treatments have not been successful.

Vesicostomy

A surgical opening between the bladder and the lower abdominal wall, that allows urine to drain. It is usually a temporary treatment in babies and younger children to allow urine to drain and to protect the kidneys from possible damage.

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Appendix Four

Legislation relevant to bladder and bowel care in nurseries, schools and colleges

The legislation which impacts on bladder and bowel care in nurseries, school and colleges varies between the devolved nations of the United Kingdom.

1. ENGLAND

The Equality Act 2010: The Department for Education has produced 'The Equality Act 2010 and schools Departmental advice for school leaders, school staff, governing bodies and local authorities' to guide schools about how to meet the requirements of the Act. Continence difficulties may fit within the definition of disability and they are more common in children who have disabilities. Policies or procedures that restrict access to the toilet, or to drinking water may be in breach of legislation, because they may have a disproportionate negative effect on children with disabilities or health conditions.

The Children and Families Act 2014, places a statutory duty on education settings to support children with medical conditions, so that affected children can access and enjoy the same opportunities at school as any other child. Bladder and bowel difficulties are medical conditions and should therefore be covered by a school's medical policy. The Department for Education has provided guidance for schools: Supporting pupils with medical conditions at school.

It is notable that:

- Schools do not have to wait for a formal diagnosis prior to providing support to pupils
- School's policy should consider having individual healthcare plans to support pupils with medical conditions and that these should be reviewed annually[35]
- The guidance states that it is not generally acceptable to: prevent pupils from drinking, eating or taking toilet breaks whenever they need to in order to manage their medical condition effectively; or to require parents or otherwise make them feel obliged to attend school to…provide medical support to their child, including with toileting issues[36]

Part 3 of The Children and Families Act 2014 relates to those children and young people with special educational needs. Department for Education and Department from Health joint guidance is available: Special educational needs and disability code of practice 0 to 25 years. This includes information about Education Health Care Plans (EHCP). For children with bladder or bowel issues, these should be included in the EHCP, where there is one.

[35] See sections 1.9 and 1.10

[36] DfE Dec 2015 Supporting pupils at school with medical conditions

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The School Premises Regulations 2012 and Part 5 of the revised Education (Independent School Standards) (England) Regulations 2010 The Department for Education has produced DfE Advice on standards for school premises (2015) to help schools understand their duties under the regulations, including with respect to toilet and washing facilities.

2. NORTHERN IRELAND

Special Educational Needs and Disability (Northern Ireland) Order 2005 and the **Special Educational Needs and Disability Act (Northern Ireland) 2016 (SEND Act)** provides for children who have a greater difficulty in learning than the majority of their peers or has a disability that impacts on their ability to use the same facilities as other children.

The Department of Education in Northern Ireland provides a variety of resources to support schools and parents on their website.

3. SCOTLAND

Education (Additional Support for Learning) (Scotland) Act 2004 (as amended by the Education (Additional Support for Learning) (Scotland) Act 2009 is based on the concept that support may be needed for any reason and in the short or long term due to a child's individual learning needs. It provides a legal framework for identifying and addressing those support needs. A Code of Practice 2017 is available.

Education (Scotland) Act 2016 gives children rights to additional support for learning, including asking for assessment of whether a child has additional support needs or requires a coordinated support plan.

Children and Young People (Scotland) Act 2014 is part of the Scottish Government's policy of 'getting it right for every child' and makes provision about the rights of children and young people.

Education (Disability Strategies and Pupils' Educational Records) (Scotland) Act 2002 makes it a legal requirement for schools to prepare and implement an accessibility strategy, to improve disabled learners' participation in the curriculum, to improve the physical environment of the school to enable better access to education and associated services (which will include toilet facilities) and to improve communication with disabled pupils. Guidance for education authorities, independent and grant-aided schools is available

Getting it right for every child (GIRFEC) is about making sure that children receive the 'right help at the right time, from the right people'. It is based on the children's rights and promotes eight factors for wellbeing: safe, healthy, achieving, nurtured, active, respected,

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responsible and included (SHANARRI). Supporting children with bladder and bowel issues in schools is compatible with this as it promotes safety, health, allows children to achieve, to feel nurtured and respected. Involving the child as far as possible in their care and decisions about their care promotes inclusion.

The Standards in Scotland's Schools etc. Act (2000) states that 'Where school education is provided to a child… it shall be the duty of the authority to secure that the education is directed to the development of the personality, talents and mental and physical abilities of the child or young person to their fullest potential.' Guidance about the Act is available.

4. WALES

Education Act (1996) allows statements of special educational needs. As the Act does not include healthcare needs, care plans should be used to set out provision for learners with healthcare needs. There is guidance: Supporting learners with healthcare needs to help local authorities and governing bodies to meet the requirements of section 175 and section 21 (5) of the Education Act 2002. Governing bodies and headteachers should focus on meeting the specific healthcare needs of the learner.

The Equality Act (2010) places a duty on educational settings to make reasonable adjustments for learners who have disabilities.

Social Services and Well-being (Wales) Act 2014 brings together local authorities' duties and functions to improve the well-being of people who need care and support and carers who need support. It seeks to ensure that care and support to children is delivered in line with the principles of the United Nations Convention on the Rights of the Child.

The Welsh government has also produced School toilets: Good practice guidance for schools in Wales (2012).

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Appendix Five

Sample intimate care policy for nurseries, schools and colleges

Introduction

(*name of school*) is aware that some learners may require assistance from members of staff for personal care, including toileting, either due to the age and developmental level of the student, or as a result of disability or medical need. The main aim of the school is to ensure that our learners are safe, secure and protected from harm.

Aim

The intimate care policy aims to provide a clear framework for staff to ensure the safety and dignity of all learners who need support with personal care, including toileting and continence management. It will also clarify for learners and their families the support they can expect from school.

Principles

(*name of school*) respects our learners and encourages them to achieve their potential. This includes encouraging them to be as independent as they are able with their personal care. We will ensure that our learners are:

Treated as individuals
That their right to safety, dignity and privacy is respected
Involved with and consulted about their personal care as far as they are able
Provided with consistency of care as far as possible

School responsibilities

We will work with parents/carers to promote toilet training, unless there are medical reasons why this is not appropriate.

Where learners are not able to be fully continent, we will ensure that an care plan is written to ensure their needs are clarified and met. The learner will be included in discussions about the care plan, unless this is clearly inappropriate, as will their family. Relevant healthcare professionals including the school nurse may also be consulted. The care plan will be reviewed at least annually or sooner if the learner's needs change.

School will ensure that anyone who undertakes intimate care is an employee of the school and has had appropriate safeguarding checks. Only those staff named on the individual care plan will be involved in providing support with intimate care to a learner. School will ensure that sufficient staff are named on care plans and available to provide the required support in all foreseeable circumstances. If, in exceptional circumstances, none of the named staff

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members for an individual are available, school will contact the family for consent to involve a different member of staff.

Only in an emergency would staff undertake intimate care that has not been agreed with the parents/carers. This act of care would be reported to a senior member of school staff and to the parents/carers as soon as possible after the event. The reasons for this and the care undertaken would be documented by the staff member who had delivered the care.

A written record will be kept of all support with intimate care. This will include the date and time of the care, who was present and any care given that has differed from the care plan, together with the reason for this. Any changes in the learner's behaviour or appearance will be documented and reported to a senior member of staff, in line with the safeguarding policy.

Staff will communicate carefully with learners, using their usual communication method, to discuss their needs and preferences. Wherever possible the learner's wishes and preferences will be taken into account.

School will take into account the religious views, beliefs and cultural values of the learner and their family as far as possible when undertaking personal care.

School will work with the learner to promote positive self-esteem and body image and independence with self-care as far as is appropriate and practical.

School will ensure that all staff are aware of the need for confidentiality. Personal and sensitive information will only be shared with those who need to know.

School will act according to their safeguarding policy and procedures if there are any concerns for the learner's wellbeing.

Governors responsibilities

To ensure that sufficient staff are trained to meet the needs of their learners.

The governing body will ensure that this policy is monitored and reviewed at least every three years.

Parent/carer responsibilities

Parents/carers must ensure that they provide all relevant information to school, as soon as possible, so that the needs of their child can be met. This includes the nature of their child's needs, details of any healthcare professionals involved including specialist nurses, as well as any changes in their medication, care or condition.

Parents/carers must ensure that they work towards their child achieving the maximum possible level of independence at home.

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Parents/carers should work with school to develop and agree a care plan.

Parents/carers must make sure that school always has required equipment available for their child's intimate care or toileting needs.

Parents/carers must ensure that school always has their emergency contact details.

Learner responsibilities

To be as involved as possible in their intimate care and with their care plan.

To let school staff know when they are aware that they need assistance.

To let their parent/carer or a trusted member of school staff know if they have any concerns or feel uncomfortable at any time.

Related documentation

When reading this policy please be aware of and refer to the following related documents:

- The safeguarding policy
- Confidential reporting policy
- Managing medical needs in school policy
- First aid policy
- Health and safety policy
- Inclusion policy

(add other policies/documents as appropriate to school)

Appendix Six

Sample care plan

It is advised that a care plan is completed for all learners who have continence difficulties that affect their school day. As the care plan is a working document designed to assist school in their care for a learner, this should include all the information they require. It should be completed by school with the parents/carers and involve the child as far as their age and development allows. If school have any concerns, if the child's condition or treatment is complex, or if there are any disagreements, schools may consult the school nurse, or the relevant healthcare professional.

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Bladder & Bowel UK
Supporting people with bladder and bowel problems
part of Disabled Living

eric
The Children's Bowel & Bladder Charity

CARE PLAN

Name of School: ……

Child's/young person's details

Child's name	
Date of Birth	
Year group	
Home address	
School name	
School address	

Date of plan: …….

Planned review date: ……
(The plan should be reviewed at least annually or more frequently if the child's situation changes)

Name of person(s) completing plan and their role:

…….

…….

…….

<u>Family contact information</u>

Name		
Relationship to child		
Telephone number	Home: Work: Mobile:	
Email		
Address if different to child		
Name		
Relationship to child		

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Telephone number	Home: Work: Mobile:	
Email		
Address if different to child		
Siblings' names		

Health contacts

Specialist nurse	
Consultant	
General Practitioner	
Health Visitor/School nurse	

Education contacts

Class teacher	
Special Needs coordinator (if relevant)	
Other support staff in school	

Description of child

Give brief details of child's interests, behaviour and relevant conditions, e.g. speech and language, mobility .

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Description of continence difficulty

Goals for continence management

Describe how the child's bladder and bowel health is going to be promoted and maintained and how potential and independence are going to be appropriately promoted. You may include goals for parents, child and /or school staff depending on individual needs.

Medication

Details of medication. If any medication needs to be taken in school refer to the school's medical policy and follow school procedures.

Management and description of routine

e.g. details of drinking, toileting and changing routines, aides used and any reward schemes

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Details of help required for personal care, who will provide this, where and how

Arrangements for sporting activities, school visits/trips etc

Details of staff training needed/undertaken

Include who has been trained, the training given, by whom with dates and signatures of trainer and staff member

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Use and disposal of continence products and aids

Include arrangement for soiled clothes and underwear, provision or new/spare equipment eg catheters).

Emergency situations

Describe what would constitute an emergency for the child and what action should be taken. Schools should always act in line with their safeguarding, medical and first aid policies.

Name of parent/carer .....

Signature of parent/carer ..... **Date** .....

Name of school representative .....

Role/job title of school representative .....

Signature of school representative ..... **Date** .....

Name of child/young person .....

Signature of child/young person ..... **Date** .....

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Appendix Seven

School Toilet Charter

Access to clean, appropriately stocked toilets whenever the need arises, is a fundamental human right and necessary for good health and wellbeing. This reflects the United Nations Convention on the Rights of the Child (UNCRC), which upholds all children's rights to their best interests being of primary consideration, to healthy development, to participation in decision making, to privacy, to special care and support if they have a disability and to education.

This School Toilet Charter is designed to assist schools in meeting these rights.

All schools should provide:

1. Unrestricted access to a toilet, whenever the need arises. This means no school should have a policy of not allowing learners to use the toilet during lesson times.
2. Adequate numbers of facilities for all, which ensure privacy.
3. Dedicated gender-neutral toilets, or female and male toilet cubicles, properly equipped, for users with additional needs. This includes provision of appropriate waste bins and integral washbasins.
4. Properly designed toilet and washroom facilities, suitable for the range of anticipated users, with adequate lighting, ventilation, fixtures and fittings.
5. Hot water, ideally from mixer taps, with adequate provision of soap and hand drying facilities.
6. Toilet tissue dispensers provided at a convenient height, replenished as needed throughout the day.
7. An effective toilet cleaning/inspection regime to ensure adequate standards of hygiene, behaviour and cleanliness, throughout hours of usage.
8. A published school toilet management policy approved by school governors and learners and communicated to all learners, parents/carers and staff.
9. A child friendly comments/complaints/suggestions procedure, for learners, parents/carers and staff to communicate toilet concerns or grievances to the head teacher and/or school governors.

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Appendix Eight

Sources of help for schools and families

Bladder & Bowel UK

Working under the umbrella of Disabled Living, Bladder & Bowel UK is a national charity that offers advice and information on all bladder and bowel issues for all age groups and abilities, including children and young people. Staffed by specialist nurses they provide a range of free online resources and bespoke training to help children and young people, their parents, carers and professionals to promote continence and manage incontinence. They also offer an annual education days and symposia for professionals. Bladder & Bowel UK have a confidential helpline to provide professional advice and support families and professionals.

Address: Burrow's House, Priestley Road, Worsley, Manchester M28 2LY
Helpline: 0161 607 8219
Email: bbuk@disabledliving.co.uk
Website: https://www.bbuk.org.uk

ERIC, The Children's Bowel & Bladder Charity

ERIC is dedicated to helping all children and teenagers manage and overcome distressing continence conditions. Whether it is a toilet-training issue, bedwetting, constipation or soiling problem, ERIC provides expert support, information and understanding to children and young people and enables parents, carers and professionals to help them establish good bowel and bladder health. ERIC's family support includes a free confidential helpline, parent and family workshops, online resources and information. Support for professionals includes training targeted at the needs of the health, education, early years and social care sectors working with children and families. Professionals can also access ERIC's free confidential helpline, online tools, resources and information.

Address: 36 Old School House, Britannia Road, Kingswood, Bristol BS158DB
Helpline: 0808 169 9949
Email: web@eric.org.uk
Website: www.eric.org.uk

Colostomy UK

Colostomy UK provide support and information for people living with stomas.

Address: Colostomy UK, Enterprise House, 95 London Street, Reading, Berkshire RG1 4QA
Helpline: 0800 328 4257
Email: info@colostomyuk.org
Website: http://www.colostomyuk.org

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Down's Syndrome Association

The Down's Syndrome Association is a UK charity dealing with all aspects of Down's syndrome. They provide information, advice, training and support so that people with Down's syndrome can live full and active lives.

Address: Langdon Down Centre, 2a Langdon Park, Teddington, Middlesex TW11 9PS
Helpline: 0333 1212 300
Email: info@downs-syndrome.org.uk
Website: https://www.downs-syndrome.org.uk

Mencap

A charity that supports people with learning disability and works to improve their quality of life.

Address: Royal Mencap Society, 123 Golden Lane, London, EC1Y 0RT
Helpline: 0808 808 1111
Website: https://www.mencap.org.uk

Mitrofanoff Support

This charity provides information, reassurance, emotional support and networking for people who have a Mitrofanoff.

Address: Mitrofanoff Support, PO Box 3690, Wokingham, RG40 9QH
Helpline: 07903 382013
Email: info@mitrofanoffsupport.org.uk
Website: http://www.mitrofanoffsupport.org.uk

National Autistic Society

The National Autistic Society provides information, advice to support people with autism and their families and is working to change society for the better for those on the autistic spectrum. Their website includes useful information on social stories and on toilet training for children with autism.

Address: 393 City Road, London EC1V 1NG
Helpline: 0808 800 4104
Email: supportercare@nas.org.uk
Website: https://www.autism.org.uk

Scope

Scope provides practical information and support to people affected by disability and campaigns for a fairer society.

Address: Here East Press Centre, 14 East Bay Lane, E15 2GW
Helpline: 0808 800 3333
Email: helpline@scope.org.uk
Website: https://www.scope.org.uk

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Appendix Nine

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NICE Quality Standard: QS62 Constipation in Children and Young People (May 2014)

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