

Managing Bowel and Bladder Problems in Schools and Early Years Settings

Guidelines for good practice



PromoCon

promoting continence and product awareness

Author Foreword

Managing children with bladder and bowel problems in schools has been written to help local authorities, schools, early years settings and health providers develop policies and procedures specific to local circumstances and children's individual needs in relation to bladder and bowel problems and other toileting issues.

This work was funded by a Section 64 Grant from the Department of Health and I would like to take this opportunity to thank both Noel Durkin (DH) and Kevin Odell (DfES) for their support and helpful comments in getting this project started and reviewing, with others, the final draft.

The background to the project was the result of a 2 year study looking at the views and teacher experiences of managing children with bowel and bladder problems within the classroom setting and it was the response of the teachers that was the driving force in the development of this work. The role of the health professional as part of a multi-disciplinary approach, when necessary, is vital in joint care planning. It is hoped that by providing a structured approach within a holistic framework the school entry of a child with a bowel /bladder/toileting problem will be smooth and stress free for all concerned.

June Rogers MBE, June 2006

Further information regarding this document can be obtained by contacting PromoCon, Disabled Living, Manchester

Foreword

" Encouraged by the government's recent focus on schoolchildren's health and wellbeing, it is a particular pleasure to welcome a publication that addresses the needs of an often neglected group of children - those with bladder and bowel difficulties.

These Guidelines are intended to stimulate discussion amongst colleagues who are planning school-based services, as well as those providing the direct care. They provide a template that enables policies and procedures to be set up in a way that meet local requirements - as well as to provide a framework for the training of those supporting children.

All children - and particularly those with bladder and bowel difficulties - need access to good quality water and toilet facilities. ERIC (Education and Resources for Improving Childhood Continence), has stimulated positive changes through its two school - based Campaigns, "Water is Cool in School" and "Bog Standard". Adequate water and toilet facilities provide an essential "backcloth" to enable the standards set in these Guidelines to be positively addressed. I commend them to you."

*Penny Dobson MSc, RGN,CQSW
Director, ERIC (Education and Resources for
Improving Childhood Continence)*



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Introduction

Managing children with bladder and bowel problems in schools relates very closely to other documentation already produced including the handbook 'Including me' and 'Managing Medicines in Schools and Early Years Settings'

'Including me' is about managing complex health needs in schools and early years settings. It sets out guidance to enable children and young people who have complex health needs, and as a consequence require additional support and / or care within school or early years setting, to enable them to maintain optimal health during the day and access the curriculum to the maximum extent.

This document is available from:
The Council for Disabled Children
E mail: cdc@ncb.org.uk

Managing Medicines in Schools and Early Years Settings sets out a clear framework within which local authorities, health trusts, schools and early years settings can work together to develop policies to ensure that children requiring medicines receive appropriate support. It updates, and extends to early years settings, the 1996 DfEE/DH guidance on supporting pupils with medical needs in school.

It explains the roles and responsibilities of employers, parents and carers, governing bodies and management groups, head teachers and heads of settings, teachers and other staff, and of local health services. It considers staffing issues including employment of staff, insurance and training. Other issues covered include drawing up a health care plan for a pupil, confidentiality, record keeping, the storage, access and disposal of medicines, home to school transport, and on-site and off-site activities. The document also contains a set of forms which can be photocopied by users.



It takes account of the recommendations from the National Service Framework on Medicines for Children (2004) to ensure safe practice in the management of medicines for children, the new duties on local education authorities, schools and early years settings under the Disability Discrimination Act, and latest medical advice.

The document is available on-line at:
<http://www.teachernet.gov.uk/>

Bladder and bowel problems

For a number of reasons children may enter the school population either not toilet trained or have specific bowel and bladder needs that require intervention during the school day. Schools need to develop policies and guidelines regarding good practice for the safety and well being of both staff and children when dealing with children with such toileting problems. In order to make sure that children's individual needs are met and also to ensure staff are appropriately trained schools need to ensure that individual health care plans are drawn up for each child and any staff involved with the care of the child undergoes child specific training.

Suggested topics for inclusion in guideline documentation include:

- Overview of common problems such as daytime wetting and soiling due to constipation
- Examples of management plans and toileting charts
- Useful contacts

Policy guidelines from Lancashire Education Authority can be downloaded from - www.promocon.co.uk

Steps in Child-specific Training

It is always necessary for individualised child-specific training to be undertaken to enable school staff to carry out specific health care procedures, even if school personnel have provided similar care to other children. Although published guidelines and protocols describing general procedures may exist, individual children may require or prefer variations that school staff must become familiar with to ensure each child's comfort and to maintain consistency with home regimens.

Individualised child-specific training is divided into three components:

- 1) An overview of the child's health condition so staff have an understanding regarding the rationale of the procedure
- 2) The specific health care procedures
- 3) A plan to cover unexpected happens and what to do in an emergency.

School staff who are directly responsible for providing health care services to the child need

comprehensive training (including for example what the procedure is, why it needs to be undertaken and a step by step teaching plan) with opportunity to update as necessary. Likewise health care professionals, such as school nurses, who are involved with the training of school staff must themselves have access to training and regular updates regarding specific procedures. The person responsible for the training will be someone who has a direct link to the care of the child, if not the school nurse then for example a paediatric continence nurse specialist.

Examples of teaching plans are included in the appendix. The time taken to complete the training will depend on the procedure to be undertaken and the underpinning skills and knowledge base the person being taught already has. It is important that the child's home carer, for example the mother, is also involved in the training process so that the procedure is carried out in a way that the child is familiar with.

The person will be deemed competent when they can carry out the procedure confidently and safely. The persons competency and understanding of the procedure will need to be reviewed periodically, how often may be determined by how often the procedure is to be carried out. For example procedures that are carried out routinely on a regular basis, such as changing a nappy, may not need to be reviewed as often as procedures that may occur infrequently, for example changing a stoma bag

1. An overview of the training should be provided.

The following is a brief list of the suggested topics to discuss in child-specific training:

- a. Description of the health issues or condition and required procedures.
- b. Universal precautions (infection control).
- c. Psychosocial implications, including privacy, confidentiality, and dignity; maximum involvement of child in self-care; and attitudes and preferences of the child and family.
- d. Pertinent information from the Individual Health Care Plan (IHCP).
- e. Communication network within school and between school, home, and health care providers.

2. Discuss health care procedures.

The following are suggested topics on health care procedures to discuss

- a. Basic anatomy and body mechanics.
- b. Name and purpose of the procedure.
- c. A plan to address untoward and / or unexpected occurrences, and what to do in an emergency
- d. Time(s) to be performed and length of time involved.
- e. Teaching methods, such as trainer demonstration of the procedure (e.g. using a doll, viewing videotapes or slides); trainee demonstration of the procedure on a doll; trainee observation of the parent or trainer performing the procedure on the child; and documentation using skills checklists.
- f. Location where child's care will take place.
- g. Hygienic practices, including health and safety and infection control (universal precaution).
- h. Equipment and supplies required.
- i. Lifting and positioning of the child.
- j. Level of child's involvement in self-care.
- k. Precautions.
- l. Signs and symptoms requiring attention.
- m. Documentation of the procedure.
- n. Scheduled supervision and follow-up.

3. Review emergency plan.

It is important to review the following steps and responsibilities in an emergency plan.

- a. Signs of possible problems.
- b. Recognition of and response to problems and emergency situations.
- c. Individual responsibilities in an emergency situation.
- d. Location of the emergency plan.
- e. List of people to contact in case of an emergency.
- f. Mock emergency plan drill

Child specific training

The ability of children to provide their own health care can provide them greater freedom in school and in the community. It will promote the goal of independent living in their adult years. Children can improve their self-care skills by improving their tolerance, direction, and/or independent completion of health care (Caldwell, Todaro, & Gates, 1989a).

1. Increase tolerance for care.

Children achieve independence in self-care at varying levels depending on cognitive, physical, emotional, social, and cultural factors. Appropriate goals should be developed to increase their tolerance of care. For instance, a child who is reluctant to sit on the toilet may tolerate the procedure if it is paired with listening to a favorite piece of music.

2. Involving the child.

Many children with physical disabilities learn to direct the care provider and assist during aspects of the procedure. For example, a child who has cerebral palsy and has difficulties with mobility may be able to inform the care provider when they need to go to the toilet. The use of 'smart cards' may be helpful (as mentioned in 'Including me' page 86) These are held by the child and includes their name and other information they may wish to disclose quickly or discretely to teachers about their condition.

3. Achieve Independence.

Other children will be able to learn to perform procedures independently. The degree of supervision needed may vary depending on the complexity of the care and the developmental level of the child. Depending on the preference of the child and family, procedures -can be carried out to facilitate inclusion with peers, (e.g. toileting at break times)



Implementation, Monitoring and Evaluation

The following list provides steps for families, health care professionals and school staff to assist in the implementation, monitoring, and evaluation of a child with special health care needs in school:



1. Provide direct care as appropriate or supervise child's health care provider(s).

In the majority of cases individual child specific care is delegated to school staff, usually nursery nurse or class room assistant, the school nurse or nurse specialist will usually be involved only in the supervision and/or training (if appropriate) of the child's carer(s). When a health professional, such as a school nurse, is not based in the school it needs to be clear in an emergency who to contact and what action is to be taken.

2. Update assessment of the child's health status annually.

Health care procedures to be carried out in the school should be reviewed at least annually; some may need reviewing every term. Any change in the health status of a child and/or health care procedures should be reported to the appropriate staff member and school nurse. Any major changes will require revision of the health care plan (IHCP) and review of procedure, any additional training required should be carried out as necessary.

3. Document, review, and update skills training.

Documentation provides a clear understanding of required health care needs of individual children. Included in that documentation should be a list of potential problems that may occur and what action would need to be taken. The documentation also provides evidence of risk management, and information to educational authorities as to number of children needing health care procedures in schools.

It may be prudent to record every time an invasive procedure, such as catheterization is carried out. Particularly when a problem occurs during a procedure, precise documentation, that indicates the time and date that the health care was carried out, and the problems observed, will assist in answering questions or concerns of both parents and health care providers.

Adapted by permission from Children and Youth Assisted by Medical Technology in Educational Settings: Guidelines for care, Second Edition (1997), Chapter 3 page 57-59. S Porter, M Haynie, T Bierle et al. Paul H Brookes Publishing Co.

Helping pupils with bladder and bowel problems

Clean Intermittent Catheterisation

1. Introduction

Definition

1.1 For some children whose bladder does not function properly e.g. in children with spina bifida, a procedure called clean intermittent catheterization (CIC) may need to be undertaken to enable the child's bladder to be emptied. This procedure involves inserting a catheter (a narrow tube like a straw with a rounded end) into the child's bladder via the urethra (passage through which urine leaves the bladder) or a catheterisable stoma (opening) on the child's abdomen called a 'Mitrofanoff', which allows the urine to drain out and the bladder to empty.

Rationale

1.2 Clean intermittent catheterization (CIC) can be considered as normal routine as part of the daily living activity for some children with a bladder problem. This procedure has a considerable positive impact upon pupil's well being and personal dignity by helping to keep the child dry and reduce adverse health problems such as urine infections

1.3 Procedures such as CIC are successful in a school situation if

- carried out on a routine regular basis
- there is sensitivity to and acceptance and understanding of the individual needs of the pupil
- developing organizational arrangements are responsive to the individual needs of the pupil
- ongoing communication with parents in respect of such needs are maintained

1.4 With CIC the aim is to achieve as much independent functioning as possible and the majority of children are ultimately expected to be able to carry out the procedure independently without any help or supervision

2. Organisation of Programme

2.1 The level of assistance and supervision required by each child in developing independence may vary in accordance with their individual ability to complete intermittent catheterization. The length of time to achieve independence will also vary and for a small number of children ongoing assistance or supervision may always be required.

Care Staff

2.2 If possible the child's preference must be considered in the selection of appropriate staff to help with the procedure

Staff assisting or supervising CIC must:

- agree to assist or supervise CIC with the pupil
- be approved by the child's family, head teacher and the specialist health professional involved to assist or supervise the procedure
- understand the specific procedure needs of individual pupils

2.3 CIC does not require formal nursing qualifications to be able to carry out the procedure. However a nurse or other health professional teaching this does require to be

qualified and if a registered nurse is delegating this task then they will need to ensure that the person being trained can recognize their limitations and that they can recognize abnormal from normal.

It can be carried out by any appropriate individual who has agreed to be involved and undergone child specific training in relation to the procedure. If any another child required the same procedure the carer would need to undergo further training in respect of the needs of that individual child.

It must be remembered however that any nurse that delegates a task to a non-registered person remains accountable for that task being undertaken – even if not present. The nurse needs to ensure therefore that the person is competent to carry out the task and follows NMC code of professional conduct

2.4 The multi-disciplinary health professional team involved with the child must provide written information regarding the procedure

2.5 Personnel agreeing to carryout or supervise the procedure should have the necessary training and supervision to be competent in the procedure. Ideally both the parent and health care professional (e.g. paediatric continence advisor or school nurse) should be involved with any training.

2.6 There is a need to underline good practice, with children having a same sex member of staff to assist them. This is especially important with older children who will develop greater self consciousness with increasing age.



Image supplied by kind permission of Astra Tech Ltd

3. Responsibilities

School

3.1 Head teachers need to ensure that the conditions referred to in paragraph 2.2 to 2.5 have been met

3.2 School staff must keep records including:

- a) formal parental request for clean intermittent catheterisation for the child in school with written authorisation
- b) written authorization and any specific information from the child's health care professional
- c) individual written health care plan with negotiated arrangements recorded
- d) training schedule of care staff involved with procedure

3.3 The Head teacher must disseminate policy information relating to hygiene and infection control to personnel involved with or supervising CIC

Parents

3.4 parents should ensure that they:

- a) provide the school with all the necessary clinical equipment such as catheters to be used by the child
- b) inform the school of any changes in the child's condition or the procedure to be carried out
- c) advise the school of names and contact numbers of who to contact in case of a problem

Developing an Individualized Health Care Plan (IHCP)

Each child's IHCP must be tailored to the individual's needs. The following section covers the procedure for CIC and possible problems and emergencies that may arise. It is essential to review it before writing the IHCP.

For a child who requires catheterization, the following points should be considered

- Medications that would affect urine colour,

- amount and odour
- Flexible timing of catheterization to accommodate classroom timetable, field trips, and other school events
- An extra set of clothing in school in case of 'accidents'
- Individual baseline status, including urine colour, amount, and pattern of continence.
- Position of child during catheterization.
- Type of catheter and manufacturers instruction for usage
- Child's history of urinary tract infections and typical signs and symptoms
- Child's ability to self-catheterize (The child who is capable of self-care should have ready access to his or her equipment and a clean, private toilet with a sink).
- Fostering independence in performing the procedure, depending on the child's developmental ability.
- Child's need of assistance with clothing and leg splints etc
- Potential problems that may arise
- Latex allergy alert.
- Universal precautions (Anticipating the tasks to be done, the risk involved, and the personal protective equipment needed will enhance protection of both the caregiver and child.)

Adapted by permission from Children and Youth Assisted by Medical Technology in Educational Settings: Guidelines for care, Second Edition (1997), Chapter 11 page 219. S Porter, M Haynie, T Bierle et al. Paul H Brookes Publishing Co.

Appendix 1

Example of training schedule for Intermittent Catheterisation.

The child with a stoma in school

What is a stoma?

A stoma is an artificial opening in the body. The name comes from the Greek word which means mouth or opening. The opening can be made for urine, although more commonly it is made to allow for the emptying of waste matter (faeces). There are three types of output stomas.

Ileostomy

This is a stoma made from the ileum or small intestine. As this is higher up in the bowel, the waste matter will be liquid or semi-solid.

Urostomy

This is the name given to all stomas involving the urinary tract and involves directing the urine away from the bladder.

Types

- **Nephrostomy** - when urine is diverted directly from the kidney
- **Ureterostomy** - when urine is diverted via the ureter (the tube from the kidney to bladder)
- **Vesicostomy** - when the bladder opens directly onto the abdominal wall
- **Ileal or colonic conduit** - the ureters are detached from the bladder and re-implanted into a small piece of intestine which forms the stoma.
- **'Mitrofanoff'** – a catheterisable channel from the bladder opening on the abdominal wall via which urine is drained out

Colostomy

This is an opening made near the end of the colon so the waste matter will be fairly solid.

- **A.C.E. (Antegrade Continence Enema)** This is an opening on the abdominal wall to allow the lower bowel to be washed out on a regular basis to enable the bowels to be emptied and continence maintained. There are a number of reasons why children have this performed including congenital abnormalities of the anus and rectum. Some children have a catheter or 'button' permanently in situ

Reasons why a child may require stoma

Congenital Abnormalities

Imperforate anus (VATER Syndrome)

This is a congenital abnormality in which the anal opening in the baby's bottom is not formed so there is no exit for faeces. The baby has to have a temporary colostomy until surgery can take place to repair the defect. This condition has varying degrees and may be accompanied by other abnormalities. In severe cases the stoma may still be in place when the child starts school.

Hirschsprung's Disease

This is a condition in which the nerve supply to parts of the colon, which stimulates peristalsis, is absent or incomplete. This results in constipation which can be so severe as to cause intestinal obstruction. Surgery usually involves removing the parts of the colon that do not work. The baby normally has a temporary stoma until all the surgery has been completed. Again the stoma may still be present in the older child.

Cloacal Exstrophy

This is a congenital abnormality which results in the abdomen failing to develop properly and the baby can be born with the intestines and other organs (depending on the severity of the condition) exposed. This can result in the child sometimes requiring two stomas one for the bladder and one for the bowel.

Ectopic Bladder

In this condition the baby's bladder is exposed on the outside of the abdominal wall. The child may require a urostomy.

Eagle-Barrett Syndrome (Prune Belly)

This condition results in the absence of stomach muscles and the baby's tummy looks like a shriveled prune. It can result in problems with the urinary tract with a resultant need for a urostomy.

Bowel disease / Injury

Crohn's Disease

This is a chronic inflammatory condition which can occur at any point throughout the gastrointestinal tract. The disease can cause the formation of deep ulcers resulting in abscess and fistula formation. The cause is unknown.

Ulcerative Colitis

This is a more common inflammatory condition with again an unknown cause. This condition however tends to effect only the large bowel (colon) and rectum.

These two conditions tend to occur more commonly in the teenage and young adult population.

The first treatment of choice is medical with surgical intervention to remove the affected bowel, which may be accompanied by a temporary or permanent stoma.



Image supplied by kind permission of Coloplast

Tumours

Although rare malignant tumours do occur in childhood those affecting the bladder usually result in the necessity for its removal and the formation of a urostomy.

Accident / Injury

Injury to the pelvic area as a result of a road traffic accident for example, can result in the child requiring a temporary or permanent stoma.

Caring for a Stoma

The aim is to keep the stoma and surrounding skin clean and healthy. The skin should be washed with warm water only. If soap is used, it should be rinsed off thoroughly. The skin should then be patted dry gently. Do not rub too hard.

Most skin problems are caused by the appliance leaking. If the bag leaks-change it!

Changing an Appliance

Disposal of a used appliance – the following procedure is suggested

- empty used appliance
- wrap in newspaper
- place in plastic bag and seal
- dispose with normal rubbish
- never flush used appliance down toilet

Your health care professional /local authority will advise you regarding local policies.

Information for Carers

Although the school staff will not be directly involved with managing the child's stoma it is important that they have an awareness and understanding of any possible problems that occur so that they can take appropriate action

Possible Skin Problems

Redness around stoma

This could be caused by:

- allergic reaction to adhesive or plastic
- allergy to creams or lotions
- using harsh soaps or rubbing too hard when cleaning the skin
- too frequent changing of appliance

Sore / Broken Skin

This could be the result of:

- any of the above problems not being treated
- leakage of stoma contents onto skin
- pre-existing condition such as eczema

Rash

This caused by:

- excessive sweating under the pouch
- fungal infection such as thrush

Using a skin barrier wipe or a small amount of prescribed powder or paste can help to protect the skin, however, if any of the above problems occur they should be reported and further advice sought from the child's stoma nurse or doctor if necessary.

Other possible problems

Odour

Modern appliances are designed to be odour proof when worn and many have charcoal filters to remove the odour of escaping wind.

Deodorising sprays and drops can be used if necessary to reduce unwanted odours during appliance changes.

Some foods are known to cause excess odour and wind, and the family will find through trial and error which ones to avoid.

Leakage

Leakage usually occurs due to ill fitting of an appliance or an appliance that has been left on too long. Problems can also occur with stomas that are very flush with the skin or have uneven edges. These can usually be corrected with the use of paste. If problems persist, advice should be sought from the health care professional involved with the child, who may suggest a change of type of stoma appliance .

Bleeding from Stoma

Slight bleeding may occur from the surface of the stoma if it is rubbed too hard during cleaning and is of no real significance. However, if the bleeding appears to be coming from inside the stoma, medical advice should always be sought.

'Ballooning' of Appliance

This occurs when excess wind is produced which cannot escape from the appliance. This can be released by undoing the clip on the pouch (drainable only) or releasing the pouch from the flange on a two piece appliance. If this continues to be a problem, advice should be sought from the health care professional.

Pancaking of Appliance

This results in a vacuum developing in the pouch, when faeces 'pancakes' around the top of the

pouch and blocks the opening. If this is a persistent problem, a little baby oil placed in the pouch may help the faeces slide down the pouch. Alternatively a tissue screwed up and placed in the top of the pouch may help the appliance from sticking to the stoma. Partially blocking the filter may also help.

Change in Stool Pattern

Constipation

Constipation (delay in passage of stool or difficulty in passing thick stool) may occur as a result of too high a fibre diet or medication. The family should be advised to ensure the child has an adequate fluid intake and avoid known dietary 'culprits'. If the problem persists, the family should contact their stoma nurse.

Diarrhoea

Diarrhoea (excess passage of watery stool) may occur, again as a result of diet or medication – with antibiotics the most common culprit, or from an infection. As diarrhoea causes fluid loss, extra drinks should always be given. Babies and young children are very vulnerable to dehydration and medical advice should always be sought.

Possible problems that may occur with a stoma. These problems occur only rarely but are included so carers are aware of all possible problems.

Retraction

This results in the stoma becoming recessed causing problems with fitting and maintaining a leakfree, secure appliance.

A change to an appliance may help in some cases. In more severe cases , surgical refashioning may be necessary.

Herniation

Herniation can sometimes occur around the stoma and appears as a protruding swelling (not unlike an umbilical hernia). In mild cases particularly if the stoma is temporary, any problems with leakage can usually be corrected by changing the size or type of appliance. If the hernia is large and causing problems, it may require surgical correction

Prolapse

When this occurs , a length of bowel prolapses out from the stoma and can be quite alarming when first seen. The stoma suddenly takes on the appearance of a long pinky red sausage! If the child has a temporary stoma and the prolapse is uncomplicated then the family will be instructed how to carefully reduce the prolapse. The main complications of prolapse are trauma to the prolapsed bowel and a reduction in the blood supply. Immediate medical advice should always be sought if the stoma prolapses and changes colour to blue / black which indicates an impaired blood supply. If the child has persistant problems then surgical correction may be required.

Stenosis

This is a condition when the stoma outlet becomes narrowed and usually happens over a period of time. It can result in difficulty in passing stools, abdominal discomfort and in severe cases, intestinal obstruction. Mild cases may respond to gentle dilation, severe cases of stenosis however, may require surgical intervention.

Bathing

Unless otherwise contradicted there is no reason why a child with a stoma cannot go swimming. The appliance should be emptied prior to entering the pool and it may be useful to take a spare appliance in case it needs to be changed afterwards.

When a child is having a shower or bathing the appliance can be left on or off depending on personal choice. However those children with a urostomy should consult with their stoma nurse to check whether it is alright to leave the appliance off.

Appendix 2

Example of training schedule for stoma care

The Child with soiling problems in school

Soiling

This is most commonly related to constipation when the resultant soiling is due to 'overflow' and is therefore outside the child's voluntary control. The child is often unaware that the soiling has taken place and also of the associated smell. Children need to be treated sympathetically when this occurs. Many children suffer from low self-esteem and shame because of the soiling and the often long protracted course of treatment can evoke apathy and behavioural problems. Schools need to understand that treatment of this problem involves an holistic team approach often involving the prolonged use of laxatives. Children with a soiling problem may well need help and support in getting changed and appropriate care staff need to be identified as part of an Individual Health Care Plan.

Many children are reluctant to use the school toilets to open their bowels. This may be due to lack of privacy school toilets afford and also some children are worried about the smell they may leave behind. However, as most of the children are on large doses of laxatives and are told not to 'hold on' easy access to a toilet is an important part of the treatment programme.

Teachers need to find a way of ensuring the child has access to a 'user friendly' toilet that affords privacy and has good ventilation and a generous supply of soft toilet paper! Some schools have made use of redundant staff toilets for such children or allowed them to use the 'Disabled' toilet. Schools also need to safeguard children from bullying which often takes place around the toilet area.

Achieving continence is a developmental milestone that children achieve at varying rates and while some children appear to struggle initially the majority of children will be toilet trained by the age of 4 years. However for a small number of children their problems will be ongoing and school need to put strategies in place to provide for the needs of those children.

Appendix 3

Example of training schedule for changing a child's nappy



References

Children and Youth Assisted by Medical Technology in Educational Settings: Guidelines for care, Second Edition (1997), S Porter, M Haynie, T Bierle et al. Paul H Brookes Publishing Co. www.brookespublishing.com/store/books/porter-2363/index.htm

“Including me”

Managing complex health needs in schools and early years settings Jeanne Carlin, Published November 2005 by the Council for Disabled Children and Department for Education and Skills

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Paul Poycott	County Adviser
Michael Collins	Head Teacher
Mary Crawford	Health and Safety Team Leader
Jan Holliday	SEN Assessment Officer
David Parkes	County Advisor
Gill Pearl	Project lead PromoCon
Barbara Riley	Headteacher
Jayne Wilson	School Nurse Team Leader
Carole Wolstenholme	Parent
David Wood	Senior Educational Psychologist

Chaired by Ian Southern Policy Officer,
Inclusion Strategy Team

Also all the health professionals who suggested additions including Pam Brookfield, Continence Service Manager Central Cheshire Primary Care Trust for the ‘Changing a Nappy’ teaching plan

Further information / resources:

PromoCon

Disabled Living

Red bank House
4 St Chad's street
Manchester M8 8QA

Tel: **0870 7774714**

Email: promocon@disabledliving.co.uk

Website: www.promocon.co.uk

(Promoting Continence and Product awareness)

PromoCon, working as part of Disabled Living Manchester provides impartial advice and information regarding products and services for children and adults with toileting, bowel and/ or bladder problems.

“Good Practice in intimate care”

Oxford City PCT

karen.brombley@nhs.net

Lead nurse for children with complex health needs

Tel: **01865 747692 / 07775 800988**

“Guide to Intermittent Catheterisation in schools.” 2003 Astra Tech Ltd

“Constipation”

Information for families and carers regarding constipation can be downloaded at

www.childhoodconstipation.org.uk

“Collaborate Agreement Document”

for children requiring catheterization in schools
This is an example of a consent document and teaching framework which would be drawn up in collaboration between health, school and the family.

Further information from Janet Fishwick / Alison Gormley at Royal Manchester Children's Hospital

Tel: **0161 794 4696**

“Lancashire Guidance Notes for Schools”

can be downloaded from www.promocon.co.uk.

Click on 'working with schools' menu button.

Education and Resources for Improving Childhood Continence (ERIC)

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Tel: **0117 9603060**

Helpline:

0845 370 8008 (Mon-Fri, 10.00am-4.00pm)

Email: info@eric.org.uk

Websites: www.eric.org.uk

www.trusteric.org (young people's website)

ERIC is a national registered charity which provides information and support to children and young people, parents and professionals on childhood bedwetting, daytime wetting, constipation and soiling and incontinence in children with special needs. It also provides resources such as books, bedding protection and enuresis alarms

ERIC runs conferences and seminars for professionals and can provide cost effective bespoke seminars tailored to suit in-house needs. For further details contact training@eric.org.uk

ERIC School Campaign websites:

www.wateriscoolinschool.org.uk

This is a national campaign to improve water facilities and access to fresh drinking water for children in schools.

www.bog-standard.org

Bog Standard is a national campaign to improve the standard of school toilets and pupils access to better quality facilities.

Appendix 1

Example : Training Schedule intermittent catheterization (CIC)

Clean Intermittent

Catheterization Boys Skills Checklist

Child's Name.....

Person trained.....

Position..... Instructor.....

Explanation/Return Demonstration	Expl./ Demo Date	Explanation (E) /Return Demonstration (D)					
		Date	Date	Date	Date	Date	Date
A. States name and purpose of procedure							
B. Preparation:							
1. Identifies child's ability to participate in procedure							
2. Reviews universal precautions (infection control)							
3. Completes at _____time(s) (in emergency complete earlier rather than later)							
4. Completes where _____ (consider privacy and access to bathroom)							
5. Position for catheterization _____							
6. Identifies body parts:							
a. Scrotum							
b. Foreskin							
c. Meatus							
d. Glans							
7. Identifies possible problems and appropriate actions to take							
C. Identifies supplies:							
1. Water-soluble lubricant (if used)							
2. Type of Catheter							
3. Wet wipes / Cleansing supplies							
4. Container for urine (if used)							
5. Gloves							
D. Procedure:							
1. Washes hands							
2. Gathers equipment							
3. Arranges equipment for procedure							
4. Positions child and explains procedure							
5. Washes hands, puts on gloves							
6. Opens /prepares catheter following manufacturer's instructions							
7. Cleans:							
a. Prepares cleaning materials							
b. Retracts foreskin (if needed)							

Clean Intermittent

Catheterization Boys Skills Checklist

Child's Name.....

Person trained.....

Position..... Instructor.....

Explanation/Return Demonstration	Expl./ Demo Date	Explanation (E) /Return Demonstration (D)					
		Date	Date	Date	Date	Date	Date
c. Holds penis at 45 degree – 90 degree angle from the abdomen							
d. Pulls penis straight							
e. Cleans meatus and glans							
f. Uses swab only once							
g. Wipes a minimum of three times							
8. Grasps catheter about 4 inches from tip							
9. Inserts well-lubricated catheter into penis with consistent pressure (if muscle spasm occurs, stop momentarily and then again use slow even pressure) never force catheter							
10. When urine flow stops, inserts slightly more and withdraws a little							
11. Rotates catheter so all catheter openings reach all bladder areas							
12. Allows urine to flow by gravity into the shallow pan or toilet							
Child-specific (steps 13-15 need to be Individualized for each student)							
13. If ordered, gently press bladder to help empty							
14. Pinches catheter and withdraws slowly when urine stops flowing							
15. If not circumcised, pulls foreskin over glans							
16. Removes gloves and washes hands							
17. Assists child in dressing if necessary Measures and records urine volume (if asked), disposes of urine, and cleans equipment and stores in home container (if necessary)							
19. Washes hands							
20. Documents procedure and observations							
21. Reports any changes to family							

Checklist content approved by:

Parent/Guardian signature.....

Date.....

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Clean Intermittent

Catheterization Girls Skills Checklist

Child's Name.....

Person trained.....

Position..... Instructor.....

Explanation/Return Demonstration	Expl./ Demo Date	Explanation (E) /Return Demonstration (D)					
		Date	Date	Date	Date	Date	Date
A. States name and purpose of procedure							
B. Preparation:							
1. Identifies child's ability to participate in procedure							
2. Reviews universal precautions (infection control)							
3. Completes at.....time(s) (in emergency, complete earlier rather than later)							
4. Completes where (consider privacy and access to bathroom)							
5. Position for catheterization:							
6. Identifies body parts:							
a. Labia majora							
b. Labia minora							
c. Meatus							
d. Urethra							
Identifies possible problems and appropriate actions to take.							
C. Identifies supplies:-							
1. Type of catheter							
2. Wet wipes/wipes							
3. Cleansing supplies							
4. Container for urine (if used)							
5. Gloves							
6. Mirror (if used)							
D. Procedure:							
1. Washes hands							
2. Gathers equipment							
3. Arranges equipment for procedure							
4. Positions child and explains procedure							
5. Washes hands, puts on gloves							
6. Opens/prepares catheter for use accordingly to manufacturer's instructions							

Clean Intermittent

Child's Name.....

Person trained.....

Position..... Instructor.....

Explanation/Return Demonstration	Expl./ Demo Date	Explanation (E) /Return Demonstration (D)					
		Date	Date	Date	Date	Date	Date
7. Cleans:							
a. Prepares cleaning materials							
b. Opens labia minora and majora							
c. Cleans from front of folds to back of meatus							
d. Uses swab only once/repeat as necessary							
8. Grasps catheter about 3 inches from the tip							
9. Inserts into urethra until urine begins to flow							
10. Advances ? inch more							
11. Rotates catheter so all catheter openings reach all bladder areas							
12. Allows urine to flow by gravity into container or toilet							
Child-specific (steps 13-18 need to be individualized for each child)							
13. If ordered, gently press bladder to help empty							
14. Pinches catheter and withdraws slowly when urine stops flowing							
15. Stops and waits until all urine has drained if urine begins to flow again during removal							
16. Remove gloves and washes hands							
17. Assists child in dressing							
18. Puts on gloves, measures and records urine volume if necessary, disposes of urine, and cleans equipment and stores in home container							
19. Washes hands							
20. Documents any problems							
21. Reports any changes to family							

Checklist content approved by:

Parent/Guardian signature.....

Date.....

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Appendix 2

Example : Training Schedule for stoma care

Colostomy Pouch Change

Skills Checklist

Child's Name.....

Person trained.....

Position..... Instructor.....

Explanation/Return Demonstration	Expl./ Demo Date	Explanation (E) /Return Demonstration (D)					
		Date	Date	Date	Date	Date	Date
A. States name and purpose of procedure							
B. Preparation:							
1. Identifies child's ability to participate in procedure							
2. Reviews universal precautions (infection control)							
3. Completes at _____time(s)							
4. Identifies where procedure is done (consider privacy and access to bathroom)							
5. Position for ostomy care: _____							
6. Identifies possible problems and appropriate actions to take							
C. Identifies supplies:							
1. Cleanser and water							
2. Skin preparation							
3. Soft cloth or gauze							
4. Clean pouch							
5. Belt, if needed							
6. Measuring guide (if necessary)							
7. Gloves							
8. Protective powder and paste (if used)							
9. Scissors (if necessary)							
D. Procedure:							
1. Washes hands							
2. Assembles equipment							
3. Positions child and explains procedure							
4. Washes hands, puts on gloves							
5. Empties contents of pouch before removal, if ordered							
6. Removes used pouch and skin barrier							
7. Washes the stoma and skin area and disposes of gauze or wipe							
8. Dries stoma and skin; applies protective Powder/paste – if necessary							

Colostomy Pouch Change Skills Checklist

Child's Name.....

Person trained.....

Position..... Instructor.....

Explanation/Return Demonstration	Expl./ Demo Date	Explanation (E) /Return Demonstration (D)					
		Date	Date	Date	Date	Date	Date
Child-specific (steps 10-14 need to be individualized for each child)							
9. Places skin barrier around stoma (if 2 piece system)							
10. Applies paste to pouch or removes backing from adhesive							
11. Applies pouch closure							
12. Centres new pouch over stoma							
13. Presses pouch firmly against skin barrier to prevent leaks							
14. Disposes of used pouch in appropriate receptacle							
15. Removes gloves and washes hands							
16. Documents procedure and observations							
17. Reports any changes to family							

Checklist content approved by:

Parent/Guardian signature.....

Date.....

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Continent Urostomy/ Mitrofanoff Catheterization

Child's Skills Checklist

Child's Name.....

Person trained.....

Position..... Instructor.....

Explanation/Return Demonstration	Expl./ Demo Date	Explanation (E) /Return Demonstration (D)					
		Date	Date	Date	Date	Date	Date
A. States name and purpose of procedure							
B. Preparation:							
1. Identifies child's ability to participate in procedure							
2. Reviews universal precautions (infection control)							
3. Completes at _____ time(s) in emergency, complete earlier rather than later)							
4. Completes where _____ (consider privacy and access to bathroom)							
5. Position for catheterization _____							
6. Identifies possible problems and appropriate actions to take							
C. Identifies supplies:							
1. Cleanser and water or wipes							
2. Disposable gloves							
3. Type of catheter							
4. Lubricant if used (water soluble)							
5. Container for urine							
6. Storage receptacle for catheter							
D. Procedure:							
1. Washes hands							
2. Assembles equipment							
3. Positions child and explains procedure							
4. Washes hands, puts on disposable gloves							
5. Opens/prepares catheter following manufacturer's instructions							
Child-specific (steps 6-11 need to be Individualized for each child)							
6. Washes stoma using cleansing supplies							

Continent Urostomy/ Mitrofanoff Catheterization

Child's Skills Checklist

Child's Name.....

Person trained.....

Position..... Instructor.....

Explanation/Return Demonstration	Expl./ Demo Date	Explanation (E) /Return Demonstration (D)					
		Date	Date	Date	Date	Date	Date
7. Inserts catheter into stoma until urine begins to flow							
8. Advances ? inch-1 inch further							
9. Allows urine to flow by gravity into container or toilet							
10. Leaves catheter in until urine flow stops 11. Pinches catheter and withdraws slowly							
12. Removes gloves and washes hands 13. Reapplies stoma covering if used							
14. Assists child in dressing if necessary							
15 Measures and records urine volume (if asked to do); disposes of urine if necessary, and cleans equipment and stores in home container							
16. Washes hands							
17. Documents procedure and observations							
18. Reports any changes to family							

Checklist content approved by:

Parent/Guardian signature.....

Date.....

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Appendix 3

Changing a child's nappy

Changing a Nappy in School/ early years setting for infants and older children Skills Checklist

Child's Name.....

Person trained.....

Position.....

Instructor.....

Explanation/Return Demonstration	Expl./ Demo Date	Explanation (E) /Return Demonstration (D)					
		Date	Date	Date	Date	Date	Date
A. State purpose of the procedure.							
B. Preparation:							
1 Identifies carer's ability to participate in procedure.							
2 Reviews universal precautions.							
3 Completes at _____ time(s).							
4 Designated ventilated bathroom. Consider privacy. (Must be away from food preparation and other children's activities.)							
C. Identifies:							
1 Suitable constructed washable nappy changing area. (for infants/non mobile children) The changing area must be covered with a smooth moisture resistant cover. (Torn plastic covers must be discarded.)							
2 Storage of clean nappies.							
3 Disposable wipes or cotton wool. (Flannels should not be used.)							
4 Individual labelled nappy creams/lotions.							
5 Disposable gloves.							
6 Disposal receptacle.							
D. Procedure:							
1 Wash hands.							
2 Assemble equipment.							
3 Place infant/child upon changing mat.							
4 Put on gloves.							
5 Remove wet/soiled nappy. Fold the nappy inwards to cover faecal material and place into designated covered container. Used wipes and gloves are to be placed into designated covered container. Container should have a disposable liner. The container should be emptied at least once a day and the liner replaced.							
6 Once the child has been changed and returned safely to the, e.g. nursery area, clean the changing area with a detergent spray or soap and water.							
7 Hands should be washed thoroughly whether gloves have been used or not.							

*Childcare placements that produce a substantial quantity of used nappies, arrangements should be made for appropriate disposal, e.g. a contract with a Waste Disposal Company.

Checklist content approved by:

Parent/Guardian signature.....

Date.....



PROCEDURE FOR CHANGING A CHILD'S NAPPY

State purpose of the procedure.

Designated ventilated room should be provided for nappy/pad changing. (Must be away from food preparation and other children's activities.)

If at all possible if / once a child is able to stand independently they should be changed standing up.

Suitably constructed washable nappy/pad changing area should be available for infants and those children in wheelchairs unable to stand. It is important that all parts are readily cleanable. The changing area must be covered with a smooth moisture resistant cover. (Torn plastic covers must be discarded immediately.)

Clean nappies should be stored at a convenient distance from the nappy changing area.

The child's skin should be cleaned with a disposable wipe or cotton wool. (Flannels should not be used to clean bottoms.)

Nappy creams/lotions should be labelled with the child's name and only if prescribed for that child - they must NOT BE SHARED.

Any creams should be used sparingly as if applied too thickly they can reduce the absorbency of the nappy

Disposable gloves should be worn when changing nappies. The nappy should be folded inward to cover faecal material and placed in a covered container.

Soiled nappies should be disposed of into a tightly covered receptacle, lined with a disposable liner and operated with a foot pedal. The disposal bin should be emptied daily and the used liner replaced. These bins should be stored away from the reach of children.

Once the child has been changed and removed from the changing area, the surface should be cleaned with a detergent spray or soap and water and left to dry.

Hands should be thoroughly washed whether gloves have been used or not.

Childcare placements that produce a substantial quantity of used nappies, arrangements should be made for appropriate disposal, e.g. a contract with a Waste Disposal Company.

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