Great Horwood Church of England School

Personal and Intimate Care Policy September 2019

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Reviewed: September 2019

Date of next review: September 2022

Signed:……………………………………

Great Horwood CE Combined School

At Great Horwood Church of England Combined School, the interests of the children are at the heart of all that we do. As a Christian School, rooted in the teachings, values and spiritual life of the Church of England we believe that the opportunities we provide for children promote a love of learning, and a thirst for knowledge and exploration of the world around them.

Inspired by Christian faith, and embracing the core value of love, perseverance and respect, Great Horwood Church of England Combined School is committed to providing a safe, caring and challenging learning environment in which all individuals are able to realise their full potential and grow in confidence, learning to value themselves and others in preparation for their future.

Great Horwood Mission Statement:

'Where children learn and grow together'

Great Horwood core values:

Love Perseverance Respect

PERSONAL AND INTIMATE CARE POLICY

Aims

The aim of this policy is to:

- Safeguard the dignity, privacy, rights, safety and well-being of children
- Ensure that children are treated consistently when they experience intimate personal care
- Provide guidance and reassurance for staff to ensure safe practice
- Ensure that parents are involved in planning the intimate care of their child and are confident that their concerns and the individual needs of the child are taken into account
- Reassure parents that staff are knowledgeable about intimate care

Introduction

- All staff at Great Horwood School realise that the issue of personal care is a difficult one and will be respectful of individual's needs.
- Intimate care can be defined as care tasks of an intimate nature, associated with bodily functions, body products and personal hygiene which demands direct or indirect contact with or exposure of the genitals. Examples include care associated with continence, changing a child who has been sick as well as more ordinary tasks such as help with washing.
- Where possible all children will be encouraged to take responsibility for their own personal and intimate care, however in circumstances where this is not possible, staff will support them in line with this policy.

- Children's dignity will be preserved and a high level of privacy, choice and control will be provided to them. Staff who provide personal care to children have a high awareness of child protection issues.
- Great Horwood School is committed to ensuring that all staff responsible for the personal care of children will undertake their duties in a professional manner at all times. We recognise there is a need to treat all children with respect when personal care is given. No child should be deliberately attended to in a way that causes distress or pain.

Principles

- All children who require personal care are treated respectfully at all times; the child's welfare and dignity is of paramount importance.
- There is careful communication with each child who needs help with personal care to discuss the child's needs and preferences. The child is made aware of each procedure that is carried out and the reasons for it.
- Staff will use the opportunities during intimate personal care to teach children and young people about the value of their own bodies, to develop their personal safety skills and to enhance their self-esteem.
- As a basic principle children will be supported to achieve the highest level of autonomy that is possible given their age and abilities. Staff will support each child to do as much for themselves as they can by encouraging independence and encouraging him/her to carry out aspects of intimate care as part of his/her personal and social development. This may mean, for example, giving the child responsibility for washing themselves.
- Individual personal care plans will be drawn up for particular children as appropriate to suit the circumstances of the child. These plans include a full risk assessment to address issues such as moving and handling, personal safety of the child and the carer and any health issues.
- Each child's right to privacy and dignity will be respected. Careful consideration will be given to each child's situation to determine how many carers might need to be present when a child requires help with personal care.
- Each child's needs will be assessed on an individual basis. Guidelines recommend that where possible, two adults are present when a child needs help with personal care. However, this is not always possible.
- Careful consideration is given to each child's situation to determine how many carers might need to be present when a child needs help with intimate care.
- Wherever possible the same child is not cared for by the same adult on a regular basis; best practice indicates that there should be a rota of carers known to the child who will take turns in providing care. This will ensure, as far as possible, that over-familiar relationships are discouraged from developing, while at the same time guarding against the care being carried out by a succession of completely different carers.
- Where possible, a child in Foundation Stage will be supported with personal care by their key worker.
- Parents/carers will be consulted regularly regarding the particular needs of their child in relation to personal care; a clear account of the agreed arrangements will be recorded on the child's care plan. The needs and wishes of children and

parents will be carefully considered alongside any possible constraints; e.g. staffing and equal opportunities legislation.

The Protection of Children

- This policy should be read and applied in conjunction with the school's Safeguarding Pupils Policy.
- All staff receive safeguarding training which is updated every two or three years depending on the level of training.
- The Headteacher – Mrs P. Shaw is the designated staff member for Child Protection.
- Permission must be sought from the parent before any regular intimate care can be undertaken if there is a known underlying physical or developmental issue which prevents the child from attending to their own needs. (see Appendix 1)
- For occasional and unpredictable occurrences of wetting and soiling, parents must be notified at the end of the school day. (Appendix 2)
- If a member of staff has any concerns about physical changes in a child's presentation, e.g. marks, bruises, soreness etc. information must be recorded as quickly as possible and passed to a designated teacher for child protection. Full details can be found in the schools Safeguarding Policy.
- The school curriculum, in particular through PSHE, aims to encourage children's self-confidence, self-esteem and self-awareness – all important elements in enabling children to protect themselves. All children receive support in developing assertiveness and personal safety skills carefully matched to their level of development and understanding.
- Each child will have an assigned senior member of staff (the headteacher or SENDCo) to act as an advocate to whom they are able to communicate any issues or concerns that they may have about the quality of care they receive.
- Allegations made against staff or volunteers at the school will be handled in line with the procedures set out in the Complaints and Safeguarding Policies and may be referred to the Local Authority Designated Officer.
- If a child becomes distressed or unhappy about being cared for by a particular member of staff, the matter will be looked into and outcomes recorded. Parents are contacted at the earliest opportunity as part of this process in order to reach a resolution. Staffing may be altered until the issue is resolved so that the child's needs remain paramount. Further advice may be sought from Buckinghamshire County Council or the NHS if necessary.

Guidance and Procedure

- This policy should be read in conjunction with the Guidance on Managing Continent Needs in Schools – Buckinghamshire Children and Young People's Trust (April 2010). This guidance is in the appendix of this policy.

- All children for whom wetting and soiling are a regular occurrence must have at least one spare set of dry clothes in school at all times.
- Staff must aim to retain the privacy and modesty of the child at all times.
- Before attending to an individual's personal needs, staff must inform another member of staff.
- All pupils who are wet or soiled should be attended to in the toilet area they normally use.
- Staff must wear protective clothing such as disposable gloves and aprons when dealing with body fluids, which are readily available in the Acorns cloakroom.
- Non-allergic wet-wipes should be used, which should be provided by parents. A small stock of these are kept in school.
- All wet and soiled clothing should be placed in two plastic bags.
- Supplies of suitable cleaning materials will be provided for cleaning and disinfecting areas.
- Staff who provide intimate care are provided with training when appropriate. Apparatus is provided to assist with children who need special arrangements following assessment from the physiotherapist/occupational therapist/specialist teaching service as required.
- All gloves and aprons must be disposed of safely immediately after use.
- Staff and pupils must hand-wash thoroughly after intimate care.
- A record of the incident should be logged on the child's personal record sheet stating who attended to the child's needs. (see Appendix 3)
- A note should be sent home to parents. (see Appendix 2)

Role of the Governing Body

- This policy will be reviewed by the Senior Management Team and Governing Body every three years.

Monitoring

- This policy is a working document. Therefore, it is open to change and restructure as and when appropriate.
- Regular monitoring of personal care plans and their implementation is ongoing by those staff involved in their administration. Any issues raised through this monitoring process that may require policy adjustments will be brought to the attention of the Headteacher as they arise.

The notes below should be put onto the school letter head before being sent to parents

Appendix 1

Consent for staff to cater for Personal or Intimate Care

Name of child ______________ Year ___________

I give my consent for my child to be changed by staff in the event of wetting, soiling or any other eventuality that may require clothing to be changed.

I understand that the privacy and dignity of my child will be respected at all times and have read the school policy for Personal and Intimate Care.

Parent/carer's name _____________

Parent/carer's signature ______________ Date ____________

Appendix 2

Oops – I had a little accident!

_______________ wet / soiled themselves today at school.

They changed their clothes independently

They changed their clothes with adult support

They were changed by an adult

In accordance with our Personal and Intimate Care Policy the incident has been recorded.

Yours sincerely,

Class teacher

Appendix 3

Record of Personal or Intimate Care

Child's name ____________________ Year ______________

Date	Wet/soiled	Notes	Staff initials

Intimate/Personal Care Plan

Child's Name	Date:
Main areas of need:	
Toileting (including moving and handling) plan:	
Dressing/undressing plan:	
Medical plan:	
Personal safety of member of staff	
This plan was written by on **Agreed with parents/carers on** **Child's views were sought for this plan on (if not, why not)** **Parent ………………………………… Date………………………** **Class teacher ……………………….. Date………………………** **HT/SENDCo ……………………….. Date………………………**	

Guidance on Managing Continence Needs in Schools

Buckinghamshire Children and Young People's Trust

April 2010

Vision Statement for Children and Young People's Trust in Buckinghamshire

"In Buckinghamshire we want all our children and young people to have the best start in life and to be able to lead safe, healthy and fulfilling lives and to be able to make a positive contribution to their communities and to society. Our aim is to ensure access to a range of universal services as well as developing more targeted services to meet their specialist needs."

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PART ONE – Background Information

Preface and Acknowledgements

The Working Group was convened following a request from the SEN Team for guidance for schools regarding the management of continence needs in children and young people.

Members of the Working Group

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Andrea West, Operational Lead Children's Complex Care

Acknowledgements

These guidelines on managing continence have been developed with thanks from guidance already in existence and produced by the following sources:

Southwark NHS Primary Care Trust and Southwark Council

ERIC website www.eric.org.uk

BCC Early Years and Childcare Service Inclusion Team

IMPACT II Paediatric Bowel Care Pathway

Leicester City LEA

UNISON

Hertfordshire County Council

Oxfordshire County Council

Produced April 2010

1. INTRODUCTION

1.1 Schools are increasingly admitting onto their rolls children and young people (CYP) with continence problems. Problems include bedwetting, daytime wetting and soiling and are common in childhood. It is estimated that one in twelve children in the UK between the ages of five and twelve experience problems, however, accurate figures are difficult to come by due to the stigma attached to incontinence[1]. Research has also shown that children with continence problems experience more emotional problems and have lower self-esteem than children without continence problems. Incontinence can also impact on a child's ability to access education. Therefore, it is very important that schools have policies and practices in place to ensure that they can respond to a child's continence needs, should they arise.

[1] *For further information, see www.eric.org.uk/whyme/index.html*

1.2 This guidance is relevant to all staff working in Buckinghamshire maintained schools and lays out Buckinghamshire Children and Young People's Trust (Trust) advice to schools in meeting the needs of children and young people with continence problems, with particular regard to the Children Act (2004).

1.3 To ensure that the guidance is in line with current government policy, it references the key legal frameworks of:

- Disability Discrimination
- Special Educational Needs (SEN)
- Safeguarding
- Health and Safety.

1.4 The Trust recognises the benefits of a planned approach to removing or reducing barriers in all schools and educational settings.

1.5 The Trust is supplying this practical advice in order to support schools to make informed decisions about managing continence concerns.

1.6 <u>Children Covered by this Guidance</u>

1.6.1 An increasing number of children with physical disabilities and/or long-term medical conditions are attending mainstream schools. This does not necessarily mean however, that schools are able to identify potential difficulties and respond effectively to them. In the first instance, it is important to understand how continence issues can arise.

1.6.2 Some of the conditions, which can have an effect on bowel or bladder control, include the following:

Autistic Spectrum Disorder: a lifelong, non-progressive neurological disorder characterised by language and communication deficits, withdrawal from social contacts and extreme reactions to changes in the immediate environment.

Crohn's Disease: an inflammatory bowel disease characterised by severe chronic inflammation of the intestinal wall or any portion of the gastrointestinal tract.

Hirschsprung's Disease: a rare disorder of the bowel, the symptoms of which can include constipation, distension of the bowel and vomiting.

Imperforate Anus: a congenital abnormality in which the anus is not fully formed.

Irritable Bowel Syndrome: a bowel condition characterised by abdominal pain and by wide variations in the frequency and predictability of bowel movements.

Spina bifida: the incomplete development of the spinal column which can cause difficulties with bladder and bowel control.

It is worth noting that incontinence may be just one of a range of problems affecting a child – if this is the case and the child also has a Statement of Special Educational Needs, further information on incontinence as it affects the child may be included in the Statement itself. Therefore, it is important that schools work out a planned programme of support with the child's parents[2] to ensure that the child's needs are provided for.

2. DESCRIBING COMMON SYMPTOMS

2.1 Daytime Wetting

2.1.1 *Frequency*

The child may feel the need to pass urine at frequent intervals, which can be as often as every fifteen minutes or so. This can be distressing for the child and also disruptive if the child has to leave class frequently to go to the toilet. However, it is wise to check with the parents as to whether or not the child may have an infection which is causing these symptoms.

Children with these needs will normally require a more formal type of intervention, which could include medication in some cases in order to help achieve normal bladder control. Treatment usually involves a bladder re-training programme, necessitating ready access to a toilet and to drinks. A typical programme may involve the child going to the toilet 'by the clock' at 1-2 hourly intervals initially. The child will also require extra drinks during the school day.

2.1.2 *Urgency*

The child may also feel the need to pass urine straight away, without the ability to 'hold on'. Urgency is commonly seen in conjunction with frequency although it can occur on its own or as a result of an infection. Unless the child has immediate access to a toilet there will be a problem of continence. A child with urgency problems will require prompting to go to the toilet, for example at the end of a lesson, to ensure that the bladder is emptied regularly. The child will also need to undergo a training programme established in collaboration with parents and the School Health Service in order to learn to recognise and respond appropriately to signals from their bladder.

2.2 Encopresis

2.2.1 Encopresis is nowadays generally used as a term to describe the passing of normally formed stools in a socially unacceptable place and is thought to be behavioural in origin. Children with encopresis normally do not have underlying constipation which causes the soiling.

2.3 Overflow Soiling

Overflow soiling, by contrast, is the uncontrolled passing of faecal matter as a direct result of chronic constipation, all of which remains totally outside the child's voluntary control. Faecal matter may be liquid or solid. The child may be unaware that soiling has taken place and of the associated smell. Many children suffer from feelings of low self-esteem and shame because of the condition and treatment

[2] *The term parents is used throughout the document to refer to those with parental responsibility.*

programmes can become protracted if no early solution is found. Easy access to appropriate toileting, changing and washing facilities is an essential part of any treatment programme.

3. CONTEXT, PRINCIPLES AND VISION

3.1 Context

3.1.1 This advice must be read within the wider national context of the five key outcomes of: *Being Healthy*, *Staying Safe*, *Enjoying and Achieving*, *Making a Positive Contribution* and *Economic Well-being* from the Children Act (2004) and associated guidance Every Child Matters.

3.1.2 This policy must also be read in conjunction with the school and Local Authority Safeguarding and Health and Safety Policies. Please note that it does not supersede the Local Authority's duties under relevant legislation.

3.2 Vision and Principles

3.2.1 The key principle of this guidance is that children should not be excluded from access to and participation in any school *solely because of incontinence*. A related principle is for the Local Authority to support schools in meeting their obligations under the Disability Discrimination Act (1995) and to be conscious not to treat a disabled child 'less favourably' than someone else for a reason related to their disability.

3.2.2 Other core principles in this guidance include:

- treating children or young people who require assistance with toilet training or who require special personal care arrangements with dignity, respect and sensitivity
- recognising that related issues include the child's and family's perception of themselves and how they value themselves, the need for privacy and confidentiality, the potential for bullying and the fact that incontinence is often not the only issue for such children
- planning to work towards the earliest and most independent possible toileting arrangements
- highlighting the central role of parents, including the need for consistency in approach between home and school
- providing all school staff with access to appropriate resources, training and facilities and for these to be supported by clear plans and policy guidelines
- valuing and promoting multi-agency working across Education, Health, Social Care and the voluntary sector.

4. LEGAL IMPLICATIONS FOR SCHOOLS

This section sets out a summary of the legal frameworks relevant for schools in the management of continence needs. This guidance does not constitute an authoritative legal interpretation of the provisions of any enactments or regulations or the common law: that is exclusively a matter for the courts.

4.1 Health and Safety Legislation

4.1.1 Local Authorities, school Governing Bodies and Headteachers are responsible for the health and safety of children and young people in their care. Schools must therefore have regard to health and safety legislation, which requires them to:

- assess the risks of supporting a child with continence needs
- introduce measures to control identified risks
- inform their employees about the measures taken to address any risks
- ensure that employees support children with continence needs in accordance with training and instruction.

4.1.2 Children with complex health needs may be more at risk than their peers. Staff may need to take additional steps to safeguard the health and safety of such children. Individual procedures may be required to ensure that those children who are at risk are supported. The employer is responsible for making sure that all relevant staff know about and are, if necessary, trained to provide any additional support these children may require.

4.2 Staff Duty of Care

4.2.1 Anyone caring for children, including teachers and other staff in charge of children, has a duty of care to act like any reasonably prudent parent. Staff need to make sure that children are healthy and safe. In exceptional circumstances, the duty of care could extend to taking action in an emergency. This duty also extends to staff facilitating activities taking place off site, (e.g. visits, outings, field trips, etc.). Although there is no legal or contractual duty on staff to administer medicine or supervise a child taking it, some support staff may have specific duties to provide medical assistance as part of their contract of employment or agree to additional training from a suitable health professional to meet such duties. Further information about the administration of medicines in schools is available separately[3].

4.3 The Disability Discrimination Act 1995 (as amended by the Special Educational Needs and Disability Act (SENDA) 2001)

4.3.1 The Disability Discrimination Act applies to all maintained schools, to maintained nurseries, to independent schools, to special schools not maintained by the Local Authority and to private, voluntary and statutory providers of early years services

[3] *Section 8.5 Managing Medicines in Schools and Early Years Settings, Buckinghamshire County Council Health and Safety Handbook for Schools (Issue 2, September 2008)*

that are not constituted as schools.

4.3.2 The Disability Discrimination Act (DDA) defines a disabled person as *"…someone who has a physical or mental impairment that has a substantial and long-term adverse effect on his or her ability to carry out normal day-to-day activities..."*

4.3.3 Protection against discrimination is provided under the act for any child who meets this definition. A number of CYP with disabilities are delayed in reaching continence and some never attain it. However, it should be noted that not all children with continence difficulties will meet the definition of disability as provided by the DDA.

4.3.4 Where the DDA applies, schools are required to take *reasonable steps* to ensure that children with disabilities are not treated less favourably than non-disabled children in relation to admissions, exclusion from school and education-related activities[4],[5].

4.3.5 **It is unacceptable to refuse admission to any child who is delayed in reaching continence, whether or not they fall into the definition as provided by the Act**.

4.3.6 Any admissions policy for a school ***that sets a blanket standard of continence (or indeed any other area of development) for all children and young people*** is likely to be discriminatory and therefore unlawful under the DDA. Each child needs to be dealt with on an individual basis, and where he/she is disabled there is a duty on the school to make reasonable adjustments to ensure that the child is included in the school.

4.3.7 Furthermore, asking the parents of a child to come and change a child is likely to be a direct contravention of the DDA, and leaving a child in a soiled nappy or unchanged for any length of time pending the return of the parent may constitute a form of abuse.

4.3.8 See Appendix E for an example of discrimination.

4.4 Duties under the Disability Discrimination Act 1995

4.4.1 The Disability Discrimination Act 1995 further extends schools' duties to promote equality in accessing education. The Act places a duty on Governing Bodies to:

- promote equality of opportunity between disabled persons and other persons
- eliminate discrimination that is unlawful under the Act
- eliminate harassment of disabled persons that is related to their disabilities
- promote positive attitudes towards disabled persons
- encourage participation by disabled persons in public life; and

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[4] *Disability Rights Commission - Code of Practice for Schools (2002)*

[5] *DfES - Inclusive Schooling (2001)*

- take steps to take account of disabled persons' disabilities, even where that involves treating disabled persons more favourably than other persons.

For CYP with incontinence, particular care is needed with respect to planning for trips and their social provision, including potential bullying.

4.5 Accessibility Planning

4.5.1 Under the DDA, Governing Bodies are under a duty to draw up accessibility plans to improve access to education for disabled children. The strategies and plans have to address three distinct elements of planned improvements in access for disabled pupils:

- improvements in access to the curriculum
- physical improvements to increase access to education and associated services
- improvements in the provision of information in a range of formats for disabled pupils.

Accessibility plans could include facilities for changing CYP with continence needs.

4.6 Safeguarding

4.6.1 Everyone working with children and young people is aware that those with additional needs may be particularly vulnerable to abuse. It is essential that all staff are familiar with their school Safeguarding Policy, which should make reference to the relevant procedures on recording and reporting in *What To Do If You are Worried a Child is Being Abused* (DoH, 2003).

4.6.2 Under Section 175 of the Education Act 2002, the governing body of a school is under a duty to make arrangements for ensuring that their functions relating to the conduct of the school are exercised with a view to safeguarding and promoting the welfare of children who are pupils at the school. The DfES has issued Guidance on this - *Safeguarding Children and Safer Recruitment in Education (2007)*, which outlines how this objective can be achieved.

PART TWO – Practical Issues for Schools

5. SUPPORTING CONTINENCE NEEDS IN SCHOOL

5.1 Working at the Whole School Level

5.1.1 It is recommended that all schools should have clear written guidelines for staff to follow when changing a child. This will support the induction and supervision of all staff, ensure consistency in following the correct procedures and protect them from false allegations of abuse (see also **Safeguarding** below). It will also clarify for parents what procedures the school follows when supporting personal care.

5.1.2 Written guidance should include:

- a core vision/mission statement (this may include reference to inclusion, anti-discriminatory practice, etc.)

- approaches to parent partnership in personal care, including feedback mechanisms

- specific processes engaged in when a child transfers to the setting (e.g. the planning meeting, management plans, monitoring and review arrangements, etc.)

- who changes nappies/soiled clothing

- where changing takes place

- resources that are used

- disposal of soiled items

- infection control measures in place

- procedures for staff members when they notice that a child is unduly distressed and/or has unexplained marks or injuries

- how children and young people are included, including feedback mechanisms

- how staff incorporate cultural, religious or ethnic values into their practice

- training and professional development activities

- monitoring and review arrangements.

5.1.3 Schools may also consider including in their written policy the possibility of special circumstances arising should a child with complex continence needs be admitted into the school. In such circumstances the appropriate health care professional will need to be closely involved in forward planning.

5.2 Working with Individual Children

5.2.1 There are a number of sensitivities with regard to children who have toileting/continence difficulties, not the least of which concern the child's self-esteem, the need for privacy and confidentiality, and the potential for name-calling/bullying owing to body odour, etc. The potential vulnerability of members of staff who are likely to be involved in assisting children with continence problems also needs to be acknowledged.

5.3 Planning Support

5.3.1 Where a school is aware that a child will be starting with a continence difficulty, Headteachers should check that the facilities they have available are adequate in supporting the child's needs and take appropriate action if they are inadequate.

5.3.2 It is good practice for the school to arrange a meeting before the child starts at the school with the parent, previous setting (if applicable), any other agencies involved (if applicable) and the child him/herself. The purpose of the meeting will be to develop an individual plan for the child and to discuss the arrangements for supporting the child's continence needs. A suggested agenda for this meeting is

appended [Appendix B]. If the continence problem develops while the child is attending the school such a meeting should also be arranged.

5.4 Developing the Individual Plan

5.4.1 The meeting should discuss the need for an assessment of the child's difficulties, a monitoring process to support progress, an individual plan to develop continence (if required[6]) and a review date for such a plan. A suggested format for such a plan is appended [Appendix D].

5.4.2 As part of the individual plan, the school should consider:

- the extent of the child's continence needs, including the child's toileting routines
- the facilities/resources available to support the child
- the training needs of any relevant adults who will be involved with the child.

5.4.3 When developing the individual plan it is important that schools discuss the child's continence needs with the child's parents. Schools may wish to develop a joint toilet training programme with parents as is suggested in the NHS Guidance on Continence. The aim of such a programme would be to establish a pattern of regularity for the child that covers both the home and school.

5.4.4 Regardless of how the school decides to develop the plan, it is useful to ask the child's parents words/symbols/signs/etc. which the child uses and understands in relation to toileting (e.g. for faeces, does the child say 'poo'? For urine, does the child say 'pee', 'wee', etc.?). The plan should also record a procedure for managing the child when on trips or any other visits away from the setting premises.

5.4.5 The individual plan should be shared with all adults working with the child and a copy retained on the child's school file.

5.4.6 For medical toileting advice, e.g. catheterisation, stoma, etc., the school should seek specialist advice from the Health Visitor or school nurse in the first instance. These professionals should also be invited to attend the individual planning meeting as they are in an excellent position to answer any questions that staff or parents may have regarding continence problems and how schools can effectively respond to them.

5.4.7 It is important that the individual plan takes into account:

- the possibility of teasing/bullying
- seating arrangements in class
- the implications for learning (e.g. sitting still, tummy pain/discomfort, etc.)
- the child's access to specific locations, etc.

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[6] A child may have complex medical needs, including continence needs, and already have a plan for meeting those needs that has been developed by health professionals. If possible, this plan can be incorporated by the school for supporting the child's needs. In such circumstances, the school should liaise with the relevant health professionals who have prepared the plan so that it can be adapted for use in the school.

- implications for Physical Education (e.g. some children with kidney disease have a ‘line’ for dialysis and care needs to be taken that this is not knocked. Medical advice is necessary to ensure management is appropriate)

- ensuring that the child has a spare set of clothes in school.

5.5 Working with the Child’s Parents

5.5.1 Schools have an important role to play in establishing effective working relationships with parents, building up parental confidence in supporting the child and in providing additional strategies/sources of information.

5.5.2 Parents have a key role to play in effective toilet training. Many parents feel especially anxious and stressed when their child has not reached this significant stage in his/her development by the time they are in school.

5.5.3 It is not helpful to assume that the child has failed to achieve full continence because the parent has failed to support the child.

5.5.4 Parents are more likely to be open about their concerns about their child’s learning and development and seek help, if they are confident that they and their child are not going to be judged for the child’s delayed learning. Sharing information between home and the school is important to secure the best care for the child.

5.5.5 It is especially useful to gather as much background information from parents before the child begins attending the school. For example, staff can follow up on:

- whether toilet-training has been introduced at home (and the outcomes of this)
- what currently happens at home
- regular routines/daily patterns that the child has at home which may be possible to incorporate into the school routine
- what suggestions/ideas the family have to support the child.

5.5.6 Some schools may like to set up a home–school agreement that lays out the expectations and responsibilities that each party has in relation to supporting the child’s continence needs. This might include:

(a) *The Parent(s)*

- agreeing to ensure that the child is changed at the latest possible time before being brought to the school

- providing the school with spare nappies, disposable wipes and a change of clothing

- understanding and agreeing the procedures that will be followed when their child is changed at school – including the use of any cleanser or the application of any cream

- agreeing to inform the school should the child have any marks/rash

- agreeing to review the arrangements should this be necessary.

(b) *The School*

- agreeing to change the child during a single session should the child soil themselves or become uncomfortably wet

- agreeing how often the child will be changed should the child be staying for the full day

- agreeing to report should the child become distressed or if marks/rashes are seen

- agreeing to review the arrangements should this be necessary.

5.5.7 This kind of agreement should help to avoid misunderstandings that might otherwise arise, and help parents feel confident that the school is supporting the child's needs [template included in Appendix C]. As suggested in **Safeguarding** below, the proactive reporting of accidents (and recording of same) helps support open relationships between the school and the child's family.

5.6 Reviewing the Plan

5.6.1 The child's individual plan should be reviewed regularly, at least on a termly basis. It is suggested that the school, in co-operation with the child's parents and appropriate agencies involved with the child, develop achievable targets as part of the individual plan. Targets for improving continence can include:

- increasing the child's awareness that there is a problem

- going to the toilet at regular intervals or at specific times

- going to the toilet independently

- self care skills (ability to clean him/herself after using the toilet)

- child's ability to tell an adult if he or she needs to go the toilet or has had an 'accident'.

5.7 Supporting the Child

5.7.1 Where an individual plan has been agreed, schools should consider how the plan is to be delivered in relation to the child. In particular, it is important to ensure that staff respect the child's dignity, independence, need for privacy and self-esteem in supporting the child's continence needs.

5.7.2 Appendix F contains other suggestions regarding approaches to personal care that may be useful to the school.

5.7.3 Schools may wish to bear the following in mind when supporting the child:

(a) have a knowledge and understanding of any religious and/or cultural sensitivities concerning aspects of intimate care related to this individual child and take a full account of these

(b) speak to the child personally by name so that he/she is aware of being the focus of the activity

(c) give explanations of what is happening in a straightforward and reassuring way

(d) keep records, which note responses to intimate care

(e) agree appropriate terminology for private parts of the body and functions to be used by staff and encourage children to use these terms as appropriate.

5.8 Restraint

5.8.1 There may be rare occasions where a child needs to be restrained so that they are able to toilet safely. Schools should ensure that they have a policy on restraint and should ensure that any incidents where a child is restrained are properly recorded and parents informed. *However, it is important to bear in mind that restraint should be used as a last resort and only where the child's actions represent a risk to the welfare of the child, staff or other children*[7].

6. SAFEGUARDING

6.1 Minimising Risk

6.1.1 Personal care may involve certain activities that leave staff feeling vulnerable to accusations of abuse. It is unrealistic to expect that all risk will be eliminated, but it is hoped that staff following this guidance will feel less fearful. The normal process of changing a nappy or clothing should not raise child protection concerns, and there are no regulations that mandate that two members of staff should be available.

6.1.2 Schools may wish to consider applying the following approaches to minimise the risk of child protection issues arising:

- all staff members must be vigilant for any indication of inappropriate practice and report such concerns to the designated person as appropriate
- if there is a known risk of false allegation by a child then a single practitioner should not undertake nappy changing. A student on placement should not change a child unsupervised
- all those working with children should have enhanced Criminal Records Bureau (CRB) disclosure and clearance and should still be closely supervised throughout a probationary period and only be allowed unsupervised access to children once this has been completed to their supervisor's satisfaction
- volunteers with enhanced CRB Disclosure and clearance involved in the intimate care of pupils should be appropriately supervised
- although the Government is currently undertaking a review of the criminal records and vetting and barring regime, the safeguarding regulations introduced in October 2009 continue to apply[8]

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[7] *Schools should refer to the 2010 DCSF guidance 'The Use of Force to Control or Restrain Pupils: Guidance for Schools in England' for further information. Available at: www.teachernet.gov.uk*

[8] *For further information on this, please see http://www.isa-gov.org.uk/*

- where possible, staff should work with children (particularly older children) of the same sex and be mindful of and respect the personal dignity of the pupils when supervising, teaching, or reinforcing toileting skills

- proactively informing parents in an appropriate manner of toileting accidents, etc. may go towards alleviating any misunderstandings in these circumstances. Staff should also ensure that they record any accidents (as detailed in their school procedures) so as to be able to share these with parents when necessary.

6.2 Ensuring Confidentiality

6.2.1 Confidentiality is an important issue. All schools should have, as part of their safeguarding policy, a confidentiality section which is shared with all staff, parents and wherever possible, children and young people.

6.2.2 Sensitive information about a child should be shared only with those who need to know, such as parents or other members of staff who are specifically involved with that child. Escorts and others should only be told what is necessary for them to know in order to keep the child safe.

6.2.3 Parents and children need to know that, where staff have concerns about a child's well-being or safety arising from something said by the child or through an observation made by staff, the designated child protection person will be informed.

7. HEALTH AND SAFETY CONSIDERATIONS

All schools registered to provide education will have a Health and Safety policy that includes protocols regarding hygiene. This protocol may contain a procedure for managing children who occasionally wet or soil themselves while on the premises, as well as those who are sick. These same procedures should apply to situations where staff change a child. Schools may wish to consider the following areas where health and safety issues might arise and need to be addressed.

7.1 Toilets

7.1.1 Staff should encourage the child's appropriate use of toilets and associated skills in private and public settings. Parents should be encouraged to train their children at home as part of their daily routine and schools should reinforce these routines, whilst avoiding any unnecessary physical contact.

7.1.2 The use of toilets could be introduced as part of the personal and social development programme, emphasising the following points:

- find an empty cubicle

- follow an established sequence

- be aware of hygiene issues

- be aware of personal safety issues

- be aware of personal dignity.

7.1.3 Toilets need to be:

- safe, pleasant and warm
- accessible at all times and easy to reach
- able to provide privacy
- cleaned and flushed regularly
- provided with toilet paper
- provided with adequate hand washing facilities, soap and paper towels/dryer.

7.1.4 Where a child has particular difficulties it is recommended that the school considers the use of disabled toilets.

7.2 Hygiene/Infection Control

7.2.1 In order to prevent the spread of infectious diseases, staff should wear disposable gloves and aprons while managing care and be aware of correct hand-washing techniques. A new pair of gloves and apron is required for each child. No child should be left wet or soiled for a parent to change later and parents cannot be expected to be on stand-by to change a child. Supplies of fresh clothes should be easily to hand so that the child is not left unattended whilst they are found.

7.3 Washing Children/Young People

7.3.1 It is good practice to have an agreed, written and signed procedure with parents with regard to washing. Wherever possible avoid contact with the child especially in intimate areas. Check access to warm water and soap and have a bowl for exclusive use, being aware that staff need to use sensitivity and discretion and wash only as necessary.

7.4 Location

7.4.1 The Department of Health recommends that one extended cubicle with a wash-basin should be provided in each school for children with disabilities. If it is not possible to provide a purpose built area, a setting can purchase a changing mat and change the child on a suitable surface. If possible, use the existing toilet areas (with adaptations as required). If this is not appropriate, a private location that protects child and staff dignity needs to be found. Obviously, children and young people should never be changed in teaching/public areas or in areas where food and drinks are prepared.

7.5 Disposal

7.5.1 The changing area should be cleaned after each use using a strong bleach solution. If it is possible, use the existing toilet facilities to dispose of nappy contents and waste water: a dedicated bin/disposal unit may be required. Dirty clothes can be rinsed if proper facilities are available and placed in a yellow plastic bag with black stripes for parent's collection – such a bag should not be kept in the regular coat area. Disposable nappies should be treated as clinical waste and placed in a sealed yellow plastic bag (unless the risk assessment concludes that there is no

risk of infection). If there is no risk of infection the nappy and other items should be placed in a yellow plastic bag with black stripes and be disposed of as normal waste.

7.6 Dealing with Spillages

7.6.1 Spillages need to be dealt with speedily – good personal hygiene and compliance with the relevant Health and Safety procedures are essential. Mops can be disinfected and other items used to clear spillages should be disposed of as above.

7.7 Risk Assessments

7.7.1 The school must complete a risk assessment and a Control of Substances Hazardous to Health (COSHH) assessment to anticipate in advance any possible Health and Safety issues and prepare an action plan to deal with such a risk. There is a legal requirement to assess all activities undertaken **before they are undertaken** in order to introduce measures to protect staff from the risks involved. Although a child's admission to the school should not be dependent on a risk assessment being prepared, risk assessments must be completed anticipatorily.

7.7.2 Possible risks include trips/falls, health risks from infection, manual handling for children where a table is used, equipment failure, storage of creams, etc., safe disposal of waste, etc. There are, of course, action plans that can be put in place to address all of these risks (e.g. dealing with spillages promptly, adherence to appropriate disposal methods, having a change of clothing available, regular equipment checks / maintenance carried out, etc.).

8. RESOURCE IMPLICATIONS FOR SCHOOLS

The Governing Body of a school is responsible for ensuring that their school is fully accessible for people with disabilities. Through accessibility planning, schools should develop plans to change the physical environment to meet the needs of children with complex health needs, including continence needs. Schools need to ensure that the physical environment and facilities available will be able to meet the needs of this latter group.

8.1 Resources Required

8.1.1 There may be resource implications for schools in certain circumstances. Communication between relevant staff is therefore essential in ensuring that additional resources from the school's delegated SEN budget are allocated to ensure that these needs are met.

8.1.2 The type of facilities and resources which the school may need to provide for children and young people with continence problems include:

- areas of the school that can be maintained as sterile
- vinyl disposable gloves
- disposable gloves
- disposable aprons

- disposable paper roll
- soap/other appropriate cleanser
- bowl
- mat
- towels
- hot air dryer/paper towels for drying hands
- anti-bacterial handwipes
- mops that are specifically maintained for this use.

8.1.3 It is helpful to check with parents whether the child or young person has any allergies to particular resources/materials.

8.2 Support Available for Staff

8.2.1 For schools, the Educational Psychology Service (EPS) is available for consultation in addressing the needs of children with continence issues - including exploring whole school approaches.

8.2.2 Schools may wish to explore what further support is available to the child and family from Community and Specialist Paediatric Health Services, hospital-based Paediatric Services or the child's GP/Health Visitor/School Nurse.

9. STAFF CONSIDERATIONS

Schools should have regard to the following considerations when ensuring that they have staff available to support children with continence needs.

9.1 Job Descriptions

9.1.1 The staff likely to carry out personal care tasks for children are teaching assistants and learning support assistants. However, **no employee is required to provide intimate care.** It is strongly recommended that job descriptions for all staff, regardless of whether children in their specific class or group have toileting needs, specify personal care and toileting tasks. If not, it is recommended that this be included at the next performance review. Any new posts should also have personal care/toileting tasks written into their contracts of employment.

9.2 Insurance

9.2.1 Staff may be anxious about taking responsibility for supporting children with complex health needs because they fear something may 'go wrong'. In the event of a successful claim for alleged negligence, it is the Local Authority or employer, *not the employee*, who is held responsible. This is, of course, unless the member of staff has not followed their employer's policy. To protect against the risk of

litigation, schools must take out employer's liability insurance to provide cover for injury to staff acting within the scope of their employment.

9.3 Staff Training

9.3.1 It is important that all staff involved in supporting children with continence needs have received appropriate training. For example, staff should receive training in good working practices, which comply with health and safety regulations, such as the wearing of rubber gloves for certain procedures and methods for dealing with body fluid spillages and manual handling.

9.3.2 All professional development activities undertaken should be monitored and recorded to reflect the impact such activities have had on the inclusive provision offered.

APPENDICES

Appendix A: Further information and guidance

Schools may find the following resources useful:

Materials:

- **Early Support Programme** materials (available from DfES Publications, PO Box 5050, Sherwood Park, Annesley, Nottingham, NG15 0DJ or on the Early Support website www.earlysupport.org.uk)
- **Sure Start** SEN Training materials (available from DfES Publications [quote SS/SENTR/FS] at DfES Publications, PO Box 5050, Sherwood Park, Annesley, Nottingham, NG15 0DJ)
- **All Equal, All Different** (available from Disability Equality in Education, Unit GL, 436 Essex Road, London N1 3QP, Te: 020 7359 2855 or www.diseed.org.uk)
- **All of Us – An Inclusion Checklist for Settings** (available from KIDSactive National Development Division, 6 Azrtec Row, Berners Road, London N1 0PW, Tel: 020 7359 3073 or www.kidsactive.org.uk)
- **Daytime Wetting in Childhood** - provides parents and carers of children over four with information on what might cause daytime wetting accidents and what can be done about them (available through sending a 55p SAE to ERIC, 34 Old School House, Britannia Road, Bristol, BS15 8DB, or call 0117 301 2101 for bulk purchases)
- **The Journey Food Makes**, a CD-ROM helping children over five and their parents understand the digestive system and its consequences. For more on this and related products, see the ERIC website, www.eric.org.uk

- **Good Practice in Continence Services** (available from Department of Health, PO Box 777, London SE1 6XH or www.doh.gov.uk/continenceservices.htm)

- **Everybody Needs Toilets: An easy guide for people living with a learning disability** (British Institute of Learning Disabilities and can be ordered via their website www.bild.org.uk)

- **Helping People with Learning Disabilities Manage Continence: A workbook for support workers and carers** (British Institute of Learning Disabilities and can be ordered via their website www.bild.org.uk)

- **Supporting Continence Management: A Reader for Managers** (British Institute of Learning Disabilities and can be ordered via their website www.bild.org.uk)

- **Toileting Issues for Schools and Nurseries** (Leicester, Leicestershire and Rutland Specialist Community Child Health Services). This is available from Early Years Co-ordinator (SEN), Early Years Support Team, New Parks House Pindar Road, Leicester, LE3 9RN or email early.yearssuport@leicester.gov.uk.

Websites:

Organization	Website address
Sure Start	www.surestart.gov.uk
Early Support Programme	www.earlysupport.org.uk
Disability Equality in Education	www.diseed.org.uk
Education and Resources for Improving Childhood Continence (ERIC)	www.eric.org.uk
KIDSactive	www.kidsactive.org.uk
Bog Standard	www.bog-standard.org/

Local Contacts:

Encopresis Clinic, Sue Nichols Centre, Aylesbury

Enuretic Clinic, Sue Nichols Centre, Aylesbury

Appendix B:
Suggested Agenda for Individual Planning Meeting

1. Welcome and introductions of all present.

2. Any others invited who could not attend.

3. Clarifying purposes and expectations of all present.

4. Outline strengths and achievements (including interests and rewards if relevant and appropriate).

5. Discussion and clarification of needs and terminology (speech or otherwise) that the child uses in relation to continence.

6. Any assessment required (incl. whether child is allergic to any resources/materials).

7. Any input that is required from relevant agencies not present (e.g. Occupational Therapy, School Nurse, Health Visitor, etc.).

8. Individual plan required to include:

- facilities
- equipment
- staffing
- training
- school trips/home-school transport/sports days/school performances/exams.

9. Targets for improving continence may include:

- increasing the child's awareness of whether he/she is wet or soiled
- going to the toilet at regular intervals and/or at specific times
- going to the toilet independently
- ability to clean him or herself after using the toilet (e.g. wiping bottom, washing hands, drying hands, etc.)
- ability to indicate to an adult if he/she is wet or soiled (this can be through speech, sign, symbol exchange, etc.)
- other self-care skills such as pulling down trousers/pants, sitting on the toilet/potty, disposing of toilet tissue, flushing the toilet, pulling up trousers/pants, etc.).

10. Clothing arrangements (e.g. changes of clothing, child dressed in clothes that are easy to manage, etc.).

11. Monitoring and review processes.

12. Checking actions agreed.

13. Review date.

14. Any other business.

Appendix C:
Suggested Home-School Agreement

The parent will:

- ensure that <<insert child's name>> is changed at the latest possible time before being brought to the setting

- provide the setting with spare nappies, disposable wipes and a change of clothing

- agree the procedures for changing at the setting (including the use of cleanser/cream)

- inform the setting about any marks/rash <<insert child's name>> may have

- participate in reviews of this agreement as necessary.

The school will:

- take into account any specific medical advice available

- change <<insert child’s name>> during a single session should he/she soil and/or wet themselves

- agree with the parent how often <<insert child’s name>> is changed if he/she stays for the full day

- record and report any issues as appropriate (e.g. if <<insert child’s name>> has marks/rash, etc., if he/she becomes unusually distressed, etc.)

These suggestions for inclusion are not exhaustive and parents and schools are free to add and amend to suit the individual circumstances of the child and the unique features of the context. This kind of agreement can help to avoid misunderstandings that might arise when no such agreement exists.

Appendix D: Continence Management Plan

Schools may find it helpful to prepare a Continence Management Plan for those children whose toileting/continence difficulties present particular difficulties. A proposed format for a Continence Management Plan can be found in the following appendix and it is suggested that when completed a copy of the Plan should be placed in the child’s school file and a copy given to the child’s parents. An example of a completed Continence Management Plan is provided too for guidance purposes.

Responsibility for completing the Plan should ultimately rest with the school although advice and guidance from parents and colleagues from various services, particularly those in the School Health Service, are likely to be sought during its preparation. Continence Management Plans should be reviewed at regular agreed intervals and maintained for as long as they are required.

Within the Continence Management Plan itself, it will be helpful to be consistent with terminology used by the child and family for bodily functions so that the child can fully understand any prompts. For example, what does the child call faeces – is it poo, or some other name? Likewise urine – is it wee, pee or whatever?

CONTINENCE MANAGEMENT PLAN

SCHOOL:

NAME OF PUPIL: *DATE OF BIRTH:* *YEAR GROUP:*

PROBLEM AREA	ACTION TO BE TAKEN

MEDICATION	SIDE EFFECTS

Does the pupil require a change of clothing to be kept at school? *YES/NO*
Does the pupil require separate towels to be kept at school? *YES/NO*
Name of GP: ……………………………………………………… *Contact number ………………………*
Name of consultant: …………………………………………… *Contact number ………………………*
Name of School Nurse/Health Visitor: ………………………….. *Contact number ………………………*

ANY ADDITIONAL ISSUES FOR EDUCATIONAL VISITS, e.g. transport, ease of access to public conveniences

Date plan completed: …………………………………………………….. *Review date:* ………………………………………
Completed by: …………………………………………………………..
……………………………………………………………………………
……………………………………………………………………………
Signed: ………………………………………………………………….. *Date:* ……………………………………………….
Headteacher/SENCO/Teacher

Signed: ………………………………………………………………….. *Date:* ……………………………………………….
School Nurse/Health Visitor

Signed: ………………………………………………………………….. *Date:* ……………………………………………….
Parent/Carer

Signed: ………………………………………………………………….. *Date:* ……………………………………………….
Parent/Carer

EXAMPLE CONTINENCE MANAGEMENT PLAN (for guidance purposes only)

SCHOOL: Warrington High

NAME OF PUPIL: John Smith *DATE OF BIRTH:* 01/01/99 *YEAR GROUP:* Year 1

PROBLEM AREA	ACTION TO BE TAKEN
1) Wetting and soiling at various times of the day, but not on a daily basis.	1) Monitoring programme with targets to be put in place and reviewed in four weeks' time. For example, a target may be to toilet the child at agreed times during the day.
2) Occasional smearing on toilet walls at school.	2) Overseeing John's visits to the toilet to be agreed with school staff and parents.
3) No change of clothing available in school.	3) Change of clothing to be provided by parents.
4) John has low self-esteem.	4) Reward John with positive praise when he goes to the toilet.

MEDICATION	SIDE EFFECTS
1) John has 5 ml Lactulose given to him by his parents at night-time.	1) Stools too loose.

Does the pupil require a change of clothing to be kept at school? YES
Does the pupil require separate towels to be kept at school? NO
Name of GP: …………Dr. Stephen Jones..…………………… *Contact number:* …01772 123456….
Name of consultant: …No consultant involved………………… *Contact number:* ………………………
Name of School Nurse/Health Visitor: …Mrs. Mary Ward……. *Contact number:* …01772 456123..…

ANY ADDITIONAL ISSUES FOR EDUCATIONAL VISITS, e.g. transport, ease of access to public conveniences

1) Ease of access to public toilet facilities so that the monitoring programme is not interrupted.

2) Need to stop at public toilet facilities if a long journey is to be undertaken.

3) Additional items of clothing, latex gloves, wipes.

Date plan completed: ………30/09/09……………………………….. *Review date:* ……31/10/09………………………
Completed by: ………Mr. L. Smith – Headteacher...………………..
……………………… Mrs. M. Ward – School Nurse……….………
……………………… Mrs. D. Evans – SENCO..……………………

Signed: ……………………………………………………………….. *Date:* ……………………………………………….
Headteacher/SENCO/Teacher

Signed: ……………………………………………………………….. *Date:* ……………………………………………….
School Nurse/Health Visitor

Signed: ……………………………………………………………….. *Date:* ……………………………………………….
Parent/Carer

Signed: ……………………………………………………………….. *Date:* ……………………………………………….
Parent/Carer

Appendix E:
Toilet Training Programme

In collaboration with a child's parents/carers the school may wish to consider developing a jointly agreed toilet training programme. The following items of information and chart are offered to assist with that process if it is felt that this would be a suitable way forward in developing the child's confidence and regularity.

1. Record all trips to the toilet on the chart outlined on the following page.
2. Look out for gestures which indicate that the child needs the toilet, e.g. grunting, going red in the face, fiddling with pants.
3. Give appropriate praise when the child's prompts are successful.
4. Make visits to the toilet enjoyable – keep the visit to the toilet reasonably short, stay with the child and talk to him/her and maybe tell a short story.
5. Establish a suitable "toilet" language and use it consistently with the child.
6. Make sure the child is wearing clothes which are easy to pull down.
7. Never scold or punish the child.
8. Ensure regular dialogue with the child's parents/carers in order to evaluate progress.
9. The aim must be to establish a pattern of regularity for the child.

TOILETING CHART

CHILD'S NAME: ………………………………

DATE BEGUN: ………………………………..

TIME	Day 1		Day 2		Day 3		Day 4		Day 5		Day 6		Day 7	
	Pants	Toilet	Pants	Toilet	Pants	Toilet	Pants	Toilet	Pants	Toilet	Pants	Toilet	Pants	Toilet
7:00														
8:00														
9:00														
10:00														
11:00														
12:00														
13:00														
14:00														
15:00														
16:00														
17:00														
18:00														
19:00														

Pants:

D =damp (a small volume of urine has leaked out)
W =wet (a larger volume of urine has leaked out)
BO = bowels open
PU = passed urine
S =soiled

Toilet:

BO: bowels open

PU: passed urine

Appendix F:
Suggestions regarding Other Approaches to Personal Care

1. Get to know the child beforehand, especially his/her temperament, methods of communications, likes/dislikes, rewards and motivators, etc. A previous school or parent may develop a passport for the child that will include some of this information – always check if this is available to you.

2. It is useful to find out about any religious, cultural or specific family values in relation to personal care approaches that will make your approach as seamless as possible for the child. Other ways of demonstrating your respect for the child include using the child's name when supporting him/her and seeking his/her permission before doing something that he/she is unable to do alone (e.g. buttoning up trousers, etc.).

3. As previously stated, have agreed terms for parts of the body and bodily functions that are consistent and agreed across the team. Encourage the use of such terminology appropriately during the school day. Obviously, reminders to use the toilet need to be discreet and staff may like to use signs, pictures, etc.

4. Ensure the child is aware of the purpose of the activity and providing a running commentary of what is happening may be very useful for him/her. You can take the opportunity to address many areas of the personal development curriculum during this time, as all children should be encouraged to value their own bodies and understand various bodily functions. Obviously, this needs to be conducted in an age and developmentally appropriate fashion!

5. Using a visual "Do Not Enter" sign may ensure privacy is maintained when changing.

6. Staff in schools report that using objects of reference to support the child in anticipating, preparing and understanding the process can be helpful. For example, holding up a nappy/changing mat might prepare for one stage in the sequence or showing soap/sponge might prepare for another.

7. Other settings have found establishing a strict routine from the start helpful and that shortening the times between visits to the toilet so that the child experiences being dry can be useful.

8. As one of the principles inherent in this guidance is working towards independence and autonomy, always encourage the child to undertake as much of the activity him/herself, including washing and dressing/undressing, etc. If you would like more information about specific strategies (e.g., backward chaining) that may help in developing independence in toileting, contact the Early Intervention Team or Educational Psychology Service.

9. Keep a running record noting responses to intimate care and any changes of behaviour – this is an important part of Safeguarding and Health and Safety procedures.

10. Children may feel ashamed, embarrassed and worried about their toilet-training. It is important to be aware of the potential impact on their self-esteem and consistently build up their self-esteem and self-confidence in all areas of the curriculum.

Appendix G:
Code Of Practice Example

Example of Discrimination

The *Disability Rights Commission – Code of Practice for Schools (2002)* provides an example of discrimination in relation to continence.

Para 5.17 of the Code of Practice

A mother seeks admission to a nursery school for her son who has Hirschsprung's disease. The school explains that they cannot admit him until he is toilet trained. That is their policy for all children.

Q. Is this less favourable treatment for a reason related to the pupil's disability?

A. The child has difficulty in establishing bowel control as a consequence of having Hirschsprung's disease, so the reason given is related to the child's disability.

Q. Is it less favourable treatment than another child receives if the reason (for the treatment) does not apply to the other child?

A. The treatment he receives has to be compared with a child to whom that reason does not apply, that is, the comparison is with a child who is continent. A child who is continent is not asked to delay admission to the school. Therefore, this is less favourable treatment than is given to a child who is continent.

Q. Is it justified?

A. In this case the decision was not based on any assessment of the circumstances of the particular case but on a blanket policy and so there is unlikely to be a material and substantial reason. **It is likely that this is unlawful discrimination.**

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FACTSHEET FOR PARENTS

- Continence problems are a common occurrence in childhood and it is estimated that one in twelve (about 750,000) of all children aged 5 – 16 in the UK will experience these problems at some stage.
- Continence problems include bedwetting, daytime wetting and soiling.
- On average, in a class of thirty 10-year olds, two to three children may be wetting the bed.
- Most teachers will, at some point or another, have at least one child in their class who has a wetting or soiling issue.
- Most children gain night-time and daytime bowel control, as well as night-time dryness by 3 - 4 years of age.
- The majority of children are dry at night by the age of 4, although accidents may still happen for a number of years.
- Children with special needs may take longer to become continent and may need special provision to help them with toileting.

WHAT CAN PARENTS DO TO SUPPORT THEIR CHILD AT HOME?

Parents can support their child with their continence problems in the following ways:

- Provide your child with water-based drinks to have at school (at least 2-3 glasses is recommended for during school-time). Drinking plenty of water is important because we lose fluid through sweating and urinating. Your child will need to drink more when exercising or in hot weather. Dehydration (lack of water) can lead to headaches and constipation.
- Make sure there are plenty of fruit and vegetables in your child's diet (5 portions a day), as well as plenty of fibre. Fibre is found in foods like wholegrain cereals, fruit, vegetables and pulses, for example, baked beans.
- Provide your child with opportunities for regular exercise.

- Try to stay positive. Praise your child for small steps within their control (for example, drinking plenty of water) and try not to make too much of it when accidents happen.
- Work on making toilet times fun and rewarding. For example, you can put up colourful pictures in the bathroom, or introduce activities they can enjoy in the toilet, like a hand-held game, or stories.

WHAT CAN PARENTS DO TO SUPPORT THEIR CHILD IN SCHOOL?

Parents can support their child with their continence problems in the following ways:

- Provide your child with water-based drinks to have at school (at least 2-3 glasses is recommended for during school-time). Drinking plenty of water is important because we lose fluid through sweating and weeing. Your child will need to drink more when exercising or in hot weather. Dehydration (lack of water) can lead to headaches and constipation.
- Share any ideas/suggestions you have about supporting your child with school staff.
- Provide the school with spare nappies/pants and a change of clothing.
- Inform school if your child develops any marks/rash.
-

FREQUENTLY ASKED QUESTIONS FOR PARENTS

At what age do most children become clean or dry?

Most children gain day and night-time bowel control, as well as daytime dryness, by 3-4 years of age. The majority of children are dry at night by 4 years old, although accidents may still happen for a number of years.

Why does my child still wet or soil?

Wetting and soiling are most often outside of a child's control. They are almost never due to poor parenting. Many people think bladder and bowel problems result from stress or anxiety, but in fact, these are not common causes. Some possible causes include an overactive bladder, finding it hard to wake up to the sensation of an overactive bladder and a deficiency in the level of the hormone vasopressin (for further information visit www.eric.org.uk).

What if my child has special needs too?

Parents of children with physical or learning disabilities sometimes think the continence problem is an inevitable part of their child's disability and that it can't ever improve. This is **not** always the case. If you are seeing a health professional about your child's special needs, ask them to assess your child's wetting or soiling as well, or to put you in touch with a childhood continence specialist.

Can school call me and ask me to come in and change my child?

No. It is important that schools take responsibility for caring for pupils in this way. It is neither practical nor fair to expect parents to have to come in for this purpose and is likely to be a direct contravention of the Disability Discrimination Act (1995).

What if my child is on medication for constipation and soiling?

Please seek advice from the health professional treating your child.

Appendix J:
FAQs for Schools

At what age do most children become clean or dry?

Most children gain day and night-time bowel control, as well as daytime dryness, by 3-4 years of age. The majority of children are dry at night by 4 years old, although accidents may still happen for a number of years.

If most children are out of nappies by the time they are four then, why do some children still wet and soil?

Wetting and soiling are most often outside of a child's control. They are almost never due to poor parenting. Many people think bladder and bowel problems result from stress or anxiety, but in fact, these are not common causes. Some possible causes include an overactive bladder, finding it hard to wake up to the sensation of an overactive bladder and a deficiency in the level of the hormone vasopressin (for further information visit www.eric.org.uk).

Also children develop at vastly different rates, especially in this area. Some have an atypical pattern of development which affects toilet training, such as communication impairment.

When a child is soiled or wet, can we call the parents to come and change them?

No. It is important that schools take responsibility for caring for children in this way. It is neither practical nor fair for parents to have to come to the school for this purpose. It is also not appropriate for a child to have to wait for these physical needs to be met. Furthermore, this is likely to be a direct contravention of the Disability Discrimination Act (1995).

We cannot use two members of staff to change a child. Is this a problem?

No. There is no requirement that two members of staff be present when a child is changed. Indeed, this would contravene the child's right to dignity and privacy.

We have no designated changing area. Are we therefore able to exclude these children?

No. You are required to make all reasonable adjustments to include children in your setting.

How do we manage the changing of older children?

Older children vary considerably in their needs and wishes around personal care. At all times settings should liaise with parents and respect their wishes. Dignity and privacy are especially important as children become older.

Some children can become upset when they have accidents. How do we manage this?

It is crucial that all members of staff, following a clear management lead, are positive in their attitude to personal care. As with all emotional experiences, children benefit from acceptance of their feelings and an empathic and solution-focused response.

It is not part of my job description to change nappies or clothes. Do I still have to do this?

All settings have a duty of care to their children. Attending to personal needs falls into this category. Whilst there is no duty on teachers and school support staff to change nappies or clothes you may wish to volunteer.

What if a pupil is on medication for constipation and soiling?

Please speak to parents and ask them to liaise with treating health professionals.

Appendix K: Continence – The Facts

Information on bedwetting, daytime wetting, soiling and constipation[9]

One in twelve (about 750,000) five to sixteen year olds in the UK experience continence problems (bedwetting, daytime wetting, constipation and soiling). About 500,000 suffer from bedwetting, 125,000 have daytime wetting and 100,000 have soiling problems.

Although continence problems are less common in older children, it's estimated that *one in fifty to one in one hundred teenagers* will have a bladder or bowel problem. Around one in one hundred adults suffer from incontinence.

Continence

Continence is the ability to consciously control the discharge of urine or a bowel movement. None of us have this control when we start our lives. Just as children don't learn in the same way or at the same pace, they don't all develop continence at the same age.

Most children gain night-time and daytime bowel control, as well as night-time dryness by three to four years of age. The majority of children are dry at night by the age of 4, although accidents may still happen for a number of years.

Children with special needs may take longer to become continent and need special provision to help them with toileting.

Bedwetting

Bedwetting (nocturnal enuresis) is generally defined by health professionals as an involuntary voiding of urine during sleep, with a severity of at least twice a week, in children over 5 years of age, in the absence of any physical problems. There are different definitions in use, but for the purposes of the **'Why me?'** tool kit, bedwetting will cover any incidence of a child wetting the bed at least once a month.

Bedwetting *affects more boys than girls up to the age of 12.* After that age, it affects about the same number of boys and girls.

On average, bedwetting is an issue for:

- one in six 5-year olds
- one in seven 7-year olds
- one in eleven 9-year olds
- one in fifty teenagers.

There are three main reasons why children may wet the bed:

- they find it hard to wake up to the sensation of a full bladder (this is true of all children who wet the bed)
- they are not producing enough of a hormone called vasopressin which slows

[9] With acknowledgment to ERIC website

down the body's production of urine at night. Low vasopressin means some children continue to make large quantities of urine at night
- they may have an overactive bladder – that is, the bladder needs to empty before it is full. A sign of this during the day is when a child has to rush to the toilet and needs to wee frequently.

Daytime wetting

Daytime wetting is the term used for children over the age of five that regularly (more than once a week) wet their pants during the day. 'Wet' can vary from dampness to substantial leakage. Daytime wetting is more common in girls than boys.

On average, daytime wetting is an issue for:

- one in twenty-five 5-year olds
- one in fifty 7-year olds
- one in one-hundred 11-year olds and upwards.

It can have a number of different causes:

- in younger children four to five years, the problem might be linked to a changing routine, such as moving house or a new baby in the family, or becoming engrossed in play or other activity
- for children of all ages, the problem could be caused by bladder over-activity (when the bladder empties before it is full), constipation or having a urinary tract infection
- some drinks (e.g. fizzy drinks, tea and coffee) can stimulate the kidneys to produce more urine; they can also irritate the bladder. (This is not true for everyone, so it's worth the child experimenting to see if any particular drink makes him or her need to urinate more.)

Constipation

Constipation is when there is difficulty or delay in passing stools. If stools build up in the bowel they can become large, hard and painful and difficult to pass.

Constipation can occur if:

- a child puts off going to the toilet or does not listen to the body's signals and delays emptying the bowels for a few days
- a child does not drink enough
- the diet is not varied enough
- the child has a minor illness which increases the body's need for water.

Soiling

Soiling is involuntarily doing a poo (fluid, semi-solid or solid stools) into clothing rather than the toilet. It is more common in boys than girls.

On average, soiling is an issue for:

- one in thirty 4 to 5-year olds
- one in fifty 5 to 6-year olds
- one in seventy-five 6 to 10-year olds

- one in one-hundred children aged over 10.

There are several reasons why children soil:

- the most common reason is chronic constipation which often results from "holding on". "Holding on" to stools can result from passing painful stools previously or can be related to toilet phobias or other emotional upset. Sometimes constipation can result from illness and poor diet or low fluid intake
- when the bowel becomes blocked with stools, the normal sensation of needing to pass stools is lost. Persistent stools stuck in the lower bowel causes intermittent and involuntary reflex opening of the anus, thus resulting in completely uncontrollable soiling. Soiling occurs without the child having any idea it has happened
- the child is not yet toilet trained for stools. This most often occurs when the child has a specific problem, for example a learning difficulty, or refuses to use the toilet. Some children also experience a big time gap between becoming toilet trained to have a wee and to do a poo.