



Guideline for the Assessment of Toilet Training Readiness and the Issuing of Products

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Adapted from RCN (2013), Assessment of toilet training readiness and the issuing of products - an RCN pathway.

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23/01/14	Addition of chart for fluid requirements for children
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Promoting continence – provision of continence products for children

Children's continence promotion is provided by the Child Health Team in association with other healthcare providers, and allow open access to support, advice and information for all children aged 0-19 years, and their families. Whilst the aim of continence promotion should be to work towards ensuring healthy bladders and bowels and promoting continence, there may be a number of children for whom full continence is not achievable.

There is no statutory requirement to provide continence products to children under the age of five, although most areas, including NHS Shetland, provide products from four years old, based on an assessment of clinical need. Those children with a physical or learning disability that impacts directly on their ability to achieve continence, and whose individual continence needs differ from children of a similar age within the general population, will be considered for provision of products. This will be reviewed at least six monthly.

Early referral to the named Health Visitor, School Nurse or Children's Nurse should be made as soon as either any bowel or bladder problems are identified or anticipated. We would expect most children with anticipated problems to undergo a programme within their second year, in anticipation of a formal structured toilet training programme once full bowel and bladder maturity is reached.

Under normal circumstances, children who have achieved daytime control, regardless of any special need, would not normally be considered for provision for night-time products. This is unless they have received assessment/ treatment for nocturnal enuresis, and had a consultation with the Community Children's Nurse or General Practitioner or Consultant Paediatrician.

All children should have a documented assessment and trial of toilet training, if appropriate, prior to the issue of any product. It could be considered as active discrimination, in relation to the child's disability, if these children are not offered the same continence promotion service as any other child, who presents with a wetting or soiling problem.

When full continence is not achievable, healthy bladders and bowels should be promoted at all times. The child should be kept under review, with the provision of suitable containment products as appropriate. Products are not normally supplied as containment for a treatable condition – for example, soiling in relation to constipation.

What is normal?

Bladder development

Babies' bladders are unstable and, as a result, empty frequently with residual urine.

Between a child's second and third year, their bladders mature, developing a mature filling and emptying cycle.

New born babies' bladders hold about 30mls urine, increasing by 30mls each year.

A child's average bladder capacity can be worked out using this equation:

$(\text{age} + 1) \times 30 = \text{average voided volume.}$

Therefore, the bladder capacity for a three year-old is $(3+1) \times 30 = 120\text{mls.}$

Urine is produced from the kidneys at around 60mls per hour. Therefore a three-year-old should be able to stay dry for up to two hours.

The ability to "hold on" increases with age.

The expected number of voids per day is between six and eight.

Bowel development

Depending on whether bottle or breast fed, the expected number of bowel movements per day can vary from three to five per day at age one-month for a bottle fed baby, to two to three times per week for a breast fed baby.

Most babies stop opening their bowels at night before they become one year old.

Expected bowel movements in a child should range from no more than three times per day to no less than three times per week.

Soiling at night beyond the age of one year may be an indication of constipation.

Fluid intake

Children should be encouraged to drink water-based fluids, if possible.

Children should be discouraged from drinking more than one pint of milk to the exclusion of solid food.

Children should drink between six to eight cups per day.

School age children should have three of those drinks during the school day.

Recommended daily intake of fluid (NICE, 2010) is shown in the table below.

Age	Gender	mls/24hrs
4-8 yrs	female	1000-1400
	male	1000-1400
9-13yrs	female	1200-2100
	male	1400-2300
14-18yrs	female	1400-2500
	male	2100-3200

Care Pathway

Procedure for provision of products

Continence must be promoted at all times.

No child should be issued with continence products without having a prior written assessment and trial of potty/ toilet training, if appropriate (see appendix 2).

All children should have a full continence assessment, including diet/ fluid intake/ output/ bowel actions/ dipstick urine test and physical examination if indicated, and begin the appropriate care pathway.

An assessment form should be completed for each child.

A "New Patient/ Product Change Information Form, requesting the provision of aids should be sent to Coordinator for Community Nursing via the generic email address shet-hb.continence@nhs.net, with a copy to Community Children's Nurse at Child Health Department or via email.

The number of disposable products supplied for 24 hours depends on the child's needs but would not normally exceed seven products per day, without prior consultation with the Community Children's Nurse.

Two weeks following the issuing of products there should be an initial review of the child by the professional who initiated the product request. Regardless of any change in need, a reassessment checklist should be completed at least every six months, as a record that the child's needs have been reassessed.

All professionals- for example, a Health Visitor or School Nurse- who initiated the supply of products, should keep the child on their active caseload with an HPI of "Additional", unless formally transferred to another professional.

Families should be informed that they can request a reassessment for a change in product at any time. They should be provided with appropriate contact numbers for the named healthcare professional and coordination for community nursing.

Use of reusable products

Following assessment, some children may be considered more suitable for the supply of washable products, such as absorbent pants.

The number of washable pants issued will depend on the individual child's needs but would not normally exceed 7.

Following assessment, it may be possible to issue the child with a trial product to ensure its suitability. Once considered suitable, the family can then be provided with details of how to purchase the product.

Outcome

Children with any underlying pathology – for example, constipation – will be identified and referred to their GP or the GP with Special Interest in Paediatrics for treatment and advice.

Continence should be actively promoted for children, achieving a more acceptable level of continence in most cases.

For those children for whom continence is not currently achievable, healthy bladders and bowels will be promoted.

Any products supplied to the child will be appropriate to their needs, as determined by their assessment.

To avoid any problems with products, children will have regular reviews, and contact numbers will be provided.

Tools

Assessment tools

Toilet skills checklist

Symptom profiles

Input/ output charts

Bowel chart

Labstix

Patient information sheets and leaflets

Criteria for product provision

Children should only be supplied with products if their assessment demonstrates that continence cannot be achieved, or they do not have the ability to be toilet trained.

The assessing nurse will determine the most appropriate product from the range available. The nurse should consider the following questions when selecting the most appropriate products.

- Will the child be applying the product themselves or with the help of a carer?
- How wet is the child? To provide the child with the most appropriate product, the nurse should refer to the absorbency levels of different products.
- If reusable products are being considered, do the family have the washing and drying facilities?

- Is the child incontinent of both urine and faeces?
- Do the family and carers know how to fit the product correctly?
- Are the family aware of advice against using talcum powder and creams?

Children should be issued with an appropriate number of products to meet their needs, which would not normally exceed 7.

Procedure for ordering products for new patients

A copy of the completed toilet skills chart- Appendix 1- should be kept in the child's notes.

The child's family should be informed about the process for collection of continence products, including when and how to place their first order and contact details.

Procedure for ordering changes in products for existing children

- Children in receipt of products must be reviewed at least every six months.
- When a child is reviewed, a change to reassessment checklist should be completed, even if there is no change in need. This is retained in the child's record for audit purposes by the healthcare professional undertaking the assessment.
- Changes will only be made for the next scheduled delivery. Requests for continence aids must be undertaken by completing the "New patient/ product change information form" and sending to Community Nursing Services Coordinator with a copy to Community Children's Nurse.
- The child's family must be informed about any changes to product supply.

Supply of children's continence products

Children's continence reassessment checklist

Child's name _____ Date of birth _____

Assessor's name _____ Base _____

Clinical update

Has the child had any changes to his/ her condition or medication that may affect incontinence _____ Yes/ No

If yes, please give details _____

Has the child any clinical signs of a urine infection - for example, pain/ discomfort when passing urine? _____ Yes/ No

If yes, do a dipstick urinalysis.

Result _____

NB: If urine result shows abnormalities, seek advice from GP regarding sending urine sample via GP for culture and sensitivity.

How often does the child open their bowels: per day? _____

per week? _____

Record type and consistency of stool (use Bristol Stool Chart) _____

If outside 'no more than three bowel movements per day to fewer than three per week', give lifestyle advice and if this does not improve matters, contact Community Children's Nurse or GP for advice.

Record number of drinks per day _____

NB: if fewer than six, advise accordingly.

Development update

Toilet skills chart reviewed and updated _____ Yes/ No

Three to four day toileting chart completed _____ Yes/ No

If above charts not completed, please document reason: _____

Date and Time	Toilet	Nappy	Drink
Day 2			

Date and Time	Toilet	Nappy	Drink
Day 3			

Date and Time	Toilet	Nappy	Drink
Day 4			

Date and Time	Toilet	Nappy	Drink
Day 5			

Date and Time	Toilet	Nappy	Drink
Day 6			

Date and Time	Toilet	Nappy	Drink
Day 7			

Toilet training skills checklist

Before beginning a toilet training programme it is important to assess if the child has all the skills needed to enable training to take place. Carrying out an assessment ensures that any skill deficits can be identified, alongside any underlying pathology, such as constipation or an unstable bladder.

Assessment should begin in the child's second year and should be a continuous, dynamic process. In other words, following assessment, a programme should be put in place to address any main issues that are identified. For example, if a child will not sit on the potty or toilet, the family can be advised upon what strategies to use - for example, engaging the child in a pleasurable activity that will encourage them to sit for an increasing length of time. This programme would continue until the child is able to sit for long enough to complete a void or evacuate their bowels. If the child is unable to sit through lack of balance etc, referral to an occupational therapist should be made, so that child's needs can be assessed for a potty chair or other toileting aid.

The child should be reassessed every three months or so, and the family given programmes to follow in the meantime. The amount of support required for each child will depend upon the individual child's needs and the family dynamics. Some families need regular review and support, while others require minimal intervention. As the child achieves each statement on the assessment form, the area is shaded. Work continues until the full skill is achieved.

Before beginning assessment, a baseline record should be taken of the child's bowel and bladder habits. The main aim of the bladder assessment is to identify a bladder that is able to complete a normal micturition cycle. In order for this to be identified, the frequency of the voids needs to be recorded. See the previous section of this publication for toileting chart.

For a three-year-old child, bladder capacity is expected to be around 120mls, with between six and eight voids per day at no less than one to two-hourly intervals. A frequency of more than eight voids per day may indicate an unstable bladder. This may warrant further investigation if it is occurring above the age of five. Any other issues - such as urinary tract infections - would warrant earlier investigations.

Many children with special needs are prone to developing constipation for a variety of reasons. The bowel assessment should help to identify whether this is an underlying problem. The family should identify the type of stool produced using the Bristol stool chart, recording the timing, frequency and bowel action. Normal bowel development follows a pattern of cessation of bowel movements at night at around 18 months to two-and-a-half years. If a child aged two to three years-old is still soiling at night, it may indicate an underlying problem, such as constipation. Any children identified should be referred to the GP.

Assessing a child's cognitive level of awareness is not easy if the child demonstrates poor communication skills and an apparent lack of awareness. When formal assessments take place, it can be difficult to know whether a child is unwilling or unable to complete a specific task. Assessing the child in their own home in an informal way, using unobtrusive observational assessment (UOA), has been found beneficial in ascertaining their level of understanding and co-operation.

A formal toilet training programme will be put in place once the child is achieving the physical skills to enable training to take place. For example:

maturing bladder that can hold urine for around one-and-a-half to two hours.

bowel that is not constipated.

ability to sit on toilet/ potty for sufficient time.

This toilet skills assessment checklist should form part of a holistic assessment, to include urinalysis and a medical check that excludes any underlying pathology.

Any identified problems - such as constipation/ unstable bladder/ nocturnal enuresis - should be addressed. Further advice and support should be sought from the Community Children's Nurse/ GP/ General Practitioner/ GP with Special Interest in Paediatrics.

Assessment for provision of children's continence products care pathway

Child's name:	Parent/ carer's name:	Date of birth:
Address:		Postcode:
School:		Tel:
GP:	Assessor:	HV:
Date of referral:	Date of assessment:	Referred by:
Past medical history, please tick if relevant	Learning disability Physical disability	Congenital abnormality Neurological Other (state)

Primary continence problem: toilet training never really achieved? Yes/ No

Secondary continence problem: Yes/ No Age child first trained__ Age problem began__

Only initial if variance from standard statement

Standard statement	Tick	Variance from standard statement and reasons/ comments	Initial	Date
Child has undergone baseline toilet training readiness assessment				
Child has number of daily voids recorded				
Child has number/ type of bowel movements recorded				
Child has completed fluid intake/ output chart				
If child has mobility/ physical problems affecting ability to be toilet trained, liaise with occupational therapist.				
If child voids outside normal parameters, family given appropriate advice.				
If child drinks volumes outside recommended amount, advise them to drink appropriate amount				
If child has bowel movements outside the expected normal, family given appropriate advice.				

Standard statement	Tick	Variance from standard statement and reasons/ comments	Initial	Date
If encopresis is suspected, liaise with GP regarding appropriate interventions.				
If child has problems with night time wetting only, family given appropriate advice.				
If child has signs of cognitive dysfunction use 'toilet skills assessment chart' to help plan programme.				
Liaise with child's GP regarding any appropriate treatment intervention.				
Child commenced on appropriate care pathway, including obtaining the consent of child/ carer to any liaison, treatment or procedures.				
Child to be considered for continence products only if toilet training not appropriate.				
Child to be considered for reusable continence products first, if appropriate				
Continence products supplied to meet child's need.				
Child to be reassessed no less than six monthly. Review date set.				
Establish follow-up procedure.				

Only initial if variance from standard statement.

Sign to confirm that you have met all standards or recorded variances

Full name	Designation	Initials	Sign	Date

Toilet skills assessment

Child's name:	Date of birth:
Initial assessment completed by:	Date of first assessment:

Bladder/bowel maturity		Date	Date	Date
(a) Bladder function - if bladder emptied:				
1) more than once per hour, shade in area 1	1			
2) between one-two hourly, shade in areas 1 and 2	2			
3) more than two hourly, shade in areas 1, 2 and 3	3			
(b) Bowel function, if:				
1) has frequent daily soiling, shade area 1	1			
2) does not always have normally formed bowel movements- is subject to constipation or diarrhoea, shade area 2	2			
3) has regular normal formed bowel movements, shade areas 1, 2, and 3	3			
(c) If night time wettings occurs:				
1) frequently- every night, shade area 1	1			
2) occasionally- odd dry night, shade areas 1 and 2	2			
3) never, shade areas 1, 2 and 3	3			
(d) If night time bowel movements				
1) occur frequently-every night, shade area 1	1			
2) occur occasionally-some clean nights, shade areas 1, 2	2			
3) never occurs, shade areas 1, 2 and 3	3			

Independence		Date	Date	Date
(e) Sitting on the toilet, if:				
1) afraid or refuses to sit, shade area 1	1			
2) sits with help, shade in areas 1 and 2	2			
3) sits briefly without help, shade areas 1, 2 and 3	3			
4) sits without help for long enough to complete voiding, shade in areas 1, 2, 3 and 4	4			
(f) Going to the toilet, if:				
1) gives no indication of need to go to toilet, shade area 1	1			
2) gives some indication of need to go to the toilet, shade areas 1 and 2	2			
3) sometimes goes to toilet of own accord, shade areas 1, 2 and 3	3			
(g) Handling clothes at toilet, if:				
1) cannot handle clothes at all, shade area 1	1			
2) attempts or helps to pull pants down, shade areas 1 and 2	2			
3) pulls pants down by self, shade areas 1, 2 and 3	3			
4) pulls clothes up and down without help, shade areas 1, 2, 3 and 4	4			
Other components		Date	Date	Date
(h) Bladder control, if:				
1) never or rarely passes urine o toilet/ potty, shade area 1	1			
2) passes urine on toilet sometimes, shade areas 1 and 2	2			
3) passes urine o toilet every time, shade areas 1, 2, and 3	3			
4) can initiate a void on request, shade areas 1, 2, 3, and 4	4			

(i) Bowel control, if:		Date	Date	Date
1) never or rarely opens bowels on toilet/ potty, shade area 1	1			
2) opens bowels on toilet sometimes, shade areas 1 and 2	2			
3) opens bowels on toilet every time, shade areas 1, 2 and 3	3			
(j) Behaviour problem, that interferes with toileting process, for example, screams when toileted, faecal smears, if:				
1) occurs frequently-once a day or more, shade area 1	1			
2) occurs occasionally-less than once a day, shade 1 and 2	2			
3) never occurs, shade areas 1, 2 and 3	3			
(k) Wears nappies, "pull ups" or similar, if:				
1) yes, shade area 1	1			
2) no, shade areas 1 and 2	2			
(l) Toilet if:				
1) requires toileting aids or adaptations, shade area 1	1			
2) uses normal toilet/ potty, shade areas 1 and 2	2			
(m) Response to basic commands- for example "sit down", if:				
1) never responds to commands, shade area 1	1			
2) occasionally responds, shade areas 1 and 2	2			
3) always responds, shade areas 1, 2 and 3	3			
(n) Diet, if:				
1) refuses/ unable to eat any fruit/ vegetables, shade area 1	1			
2) will occasionally eat fruit/ vegetables each day, shade area 2	2			
3) eats adequate amount (age+5 = grams fibre) shade area 3	3			

(o) Fluid intake, if:		Date	Date	Date
1) drinks poor amount-<50ml/kg per day, shade area 1	1			
2) drinks 50mls/kg - <four or five drinks, shade area 2	2			
3) drinks 80ml/kg per day - six or more drinks, shade area 3	3			

Acknowledgement to Smith PS and Smith LJ (1987) Continence and incontinence: psychological approaches to development and treatment. London: Croom Helm.

Children's assessment tool for toilet training readiness and issuing of products

Assessment tool for toilet training readiness and issuing of products

Currently the provision of disposable continence products to children varies across the country, not only in type but also the number of products allowed per 24 hours. However, the fact is that some children in receipt of continence products have received them without undergoing an appropriate continence assessment first. This not only means that the child's potential for toilet training is not being fully assessed and consequently any skills deficits are not being identified and appropriate skill development programme not being put in place, but also any underlying problems (such as constipation) are not being identified and therefore treated.

This assessment tool has been developed to aid clinical decision making when assessing children for toilet training readiness when issuing of containment products is being considered. It is to be used as an aid to decision making but does not replace the need for a comprehensive continence assessment or clinical expertise.

Scoring

30 and above indicates **HIGH** clinical need but may have some potential for toilet training; will probably require long-term disposable products; ensure regular (six monthly) review.

17-30 indicates **MEDIUM** clinical need; may have potential for toilet training; should commence a toilet skill development programme. May need short-term supply of disposable products until the appropriate skills for formal toilet training are acquired but may also be appropriate for the provision of washable products with regular (three monthly) review.

Up to 16 indicates **LOW** clinical need; may respond positively to toilet training programme with regular review (at least monthly); may not be appropriate to supply products as prolonged use of disposable products in this group has been found to be unbeneficial.

Exceptions

There will always be exceptions within the scoring system and practitioners need to understand that this tool is designed as an aid to decision making and does not override clinical expertise and specific issues relating to individual children.

For example, there may be some children with anorectal problems and ongoing soiling (such as imperforate anus or Hirschsprung's disease) who may score LOW but may well be eligible for disposable products, such as pads, while they are waiting for corrective surgery/ treatment intervention.

There may be other children who may score HIGH because they have not been exposed to toileting routine previously and have total lack of awareness. Many of these children progress well on a training programme and therefore it would not be beneficial to them to provide disposable containment products. Again, it is important to use your judgement.

Children's assessment tool for toilet training readiness and issuing of products

Child's name:	Date of birth:	Score >30 HIGH , consider all-in-one product
Assessment completed by:	Date of assessment:	17-29 MEDIUM , may be able to be toilet trained but may need to consider to piece or washable product short-term. <16 LOW , consider toilet training programme and trial removal of disposable product (if worn).
Bladder/ bowel maturity		Score
(a) Bladder function, if bladder emptied:		
1) more than once per hour	3	check fluid intake, adjust if necessary.
2) between 1-2 hourly	2	indication of developing bladder maturity
3) more than 2 hourly	0	maturing bladder, consider toilet training readiness
(b) Bowel function, if:		
1) has frequent daily soiling	3	exclude underlying constipation
2) does not always have formed bowel movements, i.e. is subjected to constipation or diarrhoea	2	address underlying bowel problem before commencing toilet training (check Bristol Stool Form score)
3) has regular normally formed bowel movements	1	mature bowel, consider toilet training
(c) If night-time wetting occurs:		
1) frequently i.e. every night	3	if over the age of five years and dry in the day consider referral to community children's nurse or school nurse
2) occasionally i.e. has odd dry night	2	indication of developing bladder maturity
3) rarely/ never	0	mature bladder, consider toilet training
(d) If night-time bowel movements:		
1) occurs more than once per week	3	assess for underlying constipation, treat as appropriate
2) never occurs	1	mature bowel.

Independence/ awareness			Score
(e) Sitting on the toilet, if:			
1) afraid or refuses to sit	4	consider behaviour modification programme	
2) sits with help	2	liaise with OT if necessary re toilet adaption/ equipment	
4) sits without help for long enough to complete voiding	1	check for bladder/ bowel maturity and consider toilet training readiness	
(f) Going to the toilet, if:			
1) gives no indication of need to go to the toilet	4	consider introducing strategies to raise awareness of wet/ dry/ soiled	
2) gives some indication of need to go to toilet	2	introduce positive reinforcement for target behaviour	
3) sometimes goes to toilet of own accord	0	consider formal toilet training programme	
(g) Handling clothes at toilet, if:			
1) cannot handle clothes at all	3	if child physically able, introduce programme to encourage child to pull pants up/ down independently	
2) attempts or helps to pull pants up/ down	2	introduce positive reinforcement for target behaviour	
3) pulls clothes up and down without help	1	consider toilet training readiness	

Behaviour			Score
(h) Bladder control, if:			
1) never or rarely passes urine on toilet/ potty	4	complete baseline wetting/ soiling chart to identify voiding interval to time toilet sitting when bladder more likely to be full	
2) passes urine on toilet sometimes	2	consider removal of nappy (if worn) and introduction of formal toilet training programme	
3) can initiate a void on request	0	good evidence of bladder maturity, commence on toilet training	
(i) Bowel control, if:			
1) never or rarely opens bowels on toilet/ potty	4	complete baseline wetting/ soiling chart to identify frequency of bowel movements to time toilet sitting when bowel more likely to empty e.g. after meals	
2) opens bowels on toilet sometimes	2	consider toilet training readiness	
3) opens bowels on toilet every time	0	evidence of bowel control, consider formal toilet training	
(j) Behaviour problem, that interferes with toileting process, e.g. screaming when toileted, if:			
1) occurs frequently, i.e. once a day or more	4	consider liaison with Learning Disabilities Nurse/ CAHMS re behaviour modification programme	
2) occurs occasionally, i.e. less than once per day	2	consider assessment to identify "trigger" factors for behaviour e.g. sound of hand dryer	
3) never occurs	1	check bladder/ bowel maturity and consider toilet training readiness	
(k) Response to basic commands, e.g. "sit down", if:			
1) never/ occasionally responds to commands	4	consider introducing 'routine/ social stories' to gain co-operation	
2) usually responds	1	consider toilet training readiness	

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