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| Paediatric Continence Tool | | | | | | | | | | | | | | | | | | | | | | | | | |
| Referral pathway options (Please state to whom you are referring): | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Level 1 (0-19)** | | | | | | | | | | | | **Level 2 (Specialist Continence Service)** | | | | | | | | | | | | | |
| Initial packages of care including:   * Support for children in toilet training before referral into continence service * First line constipation management and support * First line support for daytime and night-time wetting (nocturnal enuresis) under 5 years * Behavioural support - Liaise with other services as identified, eg: CAMHS, OT. * Signpost to GP for assessment for children with constipation to rule out ‘red flags’ | | | | | | | | | | | | * Daytime wetting from age 5 after package of care * Nocturnal enuresis after package of care * Idiopathic constipation/soiling * Rectal irrigation * Clean intermittent catheterisation * Joint specialist clinics with consultant paediatricians * Liaison with CAMHS * Liaison with secondary care * Liaison with urology nurses in tertiary care * Bowel problems * Receiving care from Urology Services * Post-Surgery support | | | | | | | | | | | | | |
| Referrer’s Details | | | | | | | | | | | | | | | | | | | | | | | | | |
| Name: | | | | | | | | | | | | | Job Title: | | | | | | | | | | | | |
| Email: | | | | | | | | | | | | | Telephone Contact: | | | | | | | | | | | | |
| Date of Referral: | | | | | | | | | | | | | Has the family consented to the referral and information sharing? Yes/No | | | | | | | | | | | | |
| Patient/Service User details | | | | | | | | | | | | | | | | | | | | | | | | | |
| Name: | | | | | | | | | | | | | Date of Birth: | | | | | | | | | | | | |
| NHS No: | | | | | | | | | | | | | Address: | | | | | | | | | | | | |
| Parent/Carer Name: | | | | | | | | | | | | | Family contact details:  Telephone No:  Email address: | | | | | | | | | | | | |
| Preferred method of contact: (phone/Text/Email/Letter) | | | | | | | | | | | | | Preferred time of contact:  *(Service Hours Monday - Friday 9-5)* | | | | | | | | | | | | |
| Name of School/Nursery: | | | | | | | | | | | | |  | | | | | | | | | | | | |
| Do the child/ family require an Interpreter? | | | | | | | | | | | | | Yes/ No | | | | | | | | | | | | |
| Is the child subject to a Child Protection Plan/ Child in Need Plan or Child Looked After? | | | | | | | | | | | | | Yes/No  If Yes, Please provide name and contact details of social worker: | | | | | | | | | | | | |
| Is the child/family receiving support from any other agency? | | | | | | | | | | | | | Yes/No  If Yes, Please provide their details: | | | | | | | | | | | | |
| Is the child Toilet Trained? | | | | | | | | | | | | | Yes/No  What age were they trained? | | | | | | | | | | | | |
| Medical History: | | | | | | | | | | | | | | | | | | | | | | | | | |
| Is there a diagnosis or health need identified? | | | | | | | | | | | | | Yes/ No  If Yes, please provide details: | | | | | | | | | | | | |
| Does the child have any allergies: | | | | | | | | | | | | | Yes/No  If Yes, please provide details: | | | | | | | | | | | | |
| Is the child on any medication currently? | | | | | | | | | | | | | Yes/No  If Yes, please provide details: | | | | | | | | | | | | |
| Is the child open to Urology Services? | | | | | | | | | | | | | Yes/No  If yes please provide further details: | | | | | | | | | | | | |
| Is the child post-surgery or post-procedure related to bladder or bowel? | | | | | | | | | | | | | Yes/No  If yes please provide further details: | | | | | | | | | | | | |
| Concerns:  (*Please include as much as possible information in the boxes below*) | | | | | | | | | | | | | | | | | | | | | | | | | |
| What is the main cause for concern? (Please highlight) | | | | | | | | | | | | | | | | | | | | | | | | | |
| For 0-19 staff using this assessment document  ‘Save for future editing’ whilst delivering the 3 month package of care.  ‘Save final version’ if/when needing to send referral on to level 2 staff | | | | | | | | | | | | | | | | | | | | | | | | | |
| Daytime wetting | | | | | Night time wetting | | | | | | | | | | Constipation | | | | | | | Other | | | |
| What does the child see as the problem? (*voice of the child)* | | | | | | | | | | | | |  | | | | | | | | | | | | |
| What outcome would the child like? (*Aim*) | | | | | | | | | | | | |  | | | | | | | | | | | | |
| When did the concerns start? | | | | | | | | | | | | |  | | | | | | | | | | | | |
| Daytime wetting assessment (Highlight Box) | | | | | | | | | | | | | | | | | | | | | | | | | |
| How many times urine passed during day: | | | | | 1-4 | | | | | | | | 5-7 | | | | | | | 8+ | | | | | |
| Where passed: | Toilet | | | | Potty | | | Nappy | | | | | Other (please state) | | | | | | | Number of wet episodes each day: | | | | | |
| Size of wet patch: | | | Coin size | | | | | | Wet pants | | | | | | | Wet clothes | | | | | | | Wet clothes & puddle | | |
| Level of Urgency: | | | Desperate (cant hold) | | | | | | Can child hold on | | | | | | | Wet before toilet | | | | | | | Wet following toilet | | |
| **If child experiences any pain when opening bladder, signpost to GP for further assessment** | | | | | | | | | | | | | | | | | | | | | | | | | |
| Triggers: | | | Exercise | | | | Laughing | | | | | | | Weaning | | | | | Illness | | | | | | Nursery |
| Has a urinalysis been requested by GP? | | | | | | | | | | | | | Yes/No  Results if known: | | | | | | | | | | | | |
| **Night time wetting assessment** | | | | | | | | | | | | | | | | | | | | | | | | | |
| Has the child been dry for over 3 months?  Yes/No | | | | | | | | | | | | | Is a containment product (Nappy, Pull-up, pad) worn at night?  Yes/No | | | | | | | | | | | | |
| On Average how many wet episodes are there in a week? | | | | | | | | | | | | | Does the child go to toilet before sleeping?  Yes/No | | | | | | | | | | | | |
| What time does the child go to bed? | | | | | | | | | | | | | What time does child wake in the morning? | | | | | | | | | | | | |
| Is the child lifted to the toilet in the night? Yes/No (please provide details) | | | | | | | | | | | | | | | | | | | | | | | | | |
| Please provide details of how as to how night time wetting is currently being managed;  Offer support for 3 months in a package of care and review for improvements - note changes below | | | | | | | | | | | | | | | | | | | | | | | | | |
| Is there any family history of night time wetting? | | | | | | | | | | | | | | | | | | | | | | | | | |
| Bowel Assessment | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | Please indicate child’s most common stool (poo) type from the picture to the left  (Numbered 1 – 7): | | | | | | | | | | | | | | | |
| Frequency of passing stool per week: | | | | | | | | | | | | | | | |
| Is there any straining involved when passing? | | | | | | | | | | | | | | | |
| Is there any soiling in underwear? | | | | | | | | | | | | | | | |
| Is the child smearing? | | | | | | | | | | | | | | | |
| Is there any blood or mucus in stool? | | | | | | | | | | | | | | | |
| Is the child withholding their stool? | | | | | | | | | | | | | | | |
| Has the child ever had bowel control? | | | | | | | | | | | | | | | |
| Does the child sit on the toilet after meals? | | | | | | | | | | | | | | | |
| Please provide details as to how this is currently being managed: | | | | | | | | | | | | | | | | | | | | | | | | | |
| **RED FLAGS**   * Any constipation in the first few months of life * Any delay in passing meconium (>48hrs after birth) Any blood/mucus in stools * Ribbon Stools * Abdominal distension * Anecdotal abnormal appearance of anus * Weakness of legs or locomotor delay * Abnormalities in the lumbosacral and gluteal regions / dimple | | | | | | | | | | | | | | | | | Are there any red flags present?  Yes/No  ***If yes please refer to GP on the same day*** | | | | | | | | |
| Which picture below describes how the child feels (1-6): | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | |  | | | |  | | | | | | |  | | | | |  | | | | | |  | |
| Food and Fluid assessment | | | | | | | | | | | | | | | | | | | | | | | | | |
| How many drinks does the child drink per day? | | | | | | | | | | | | What types of drink does the child drink each day? | | | | | | | | | | | | | |
| How is the child’s appetite? | | | | | | | | | | | | Does the child eat 5 fruit/veg and fibre each day? | | | | | | | | | | | | | |
| Does the child have a gastrostomy?  Yes/No | | | | | | | | | | | | If yes please provide details: | | | | | | | | | | | | | |
| Initial advice given by referrer | | | | | | | | | | | | | | | | | | | | | | | | | |
| Day time wetting advice (highlight if given) | | | | | | | | | | | | | | | | | | | | | | | | | |
| Attend GP for  urinalysis | | | Encourage child to sit on the toilet,  relax and not rush, count to ten, is there any more wee to come? | | | | | | | | Discussion around adequate fluid intake during the day | | | | | | | | | | Timed toileting plan  every 1.5 - 2 hours or respond | | | | |
| Treat constipation if required | | | Recognising cues from child and the need to use the toilet | | | | | | | | Ability to access the toilet when needed (including school, home & other)  *Consider toilet pass or picture card* | | | | | | | | | | Fluid Frequency volume chart given | | | | |
| Offer support for 3 months in a package of care and review for improvements - note changes at bottom of form | | | | | | | | | | | | | | | | | | | | | | | | | |
| Night Time wetting Advice(highlight if given) | | | | | | | | | | | | | | | | | | | | | | | | | |
| Fluid frequency, volume  chart given | | | | 6-8 water  based drinks a day (at least 3 in school) | | | | | | | | Suggested trial without products to identify child’s reliance upon products | | | | | | | | | Advice given on bedding  protection | | | | |
| Discussion around treatment options available   * Alarms * medication * behavioural changes | | | | Reassure  problem is common and treatable | | | | | | | | Reduce/Avoid bladder irritants eg  caffeine/tea/coffee/ hot chocolate/coke/ any dark coloured cordials | | | | | | | | | Discuss causes of night time wetting:   * Lack of ADH (antidiuretic hormone) * Lack of arousability * Bladder instability * Constipation * Small bladder capacity | | | | |
|  | | | | Suggest  shower/bath in morning | | | | | | | | Encourage to go to  the toilet when getting ready for bed and before sleep | | | | | | | | | Do not use negative language | | | | |
| Offer support for 3 months in a package of care and review for improvements - note changes at bottom of form | | | | | | | | | | | | | | | | | | | | | | | | | |
| Constipation advice (highlight if given) | | | | | | | | | | | | | | | | | | | | | | | | | |
| 6-8 water  based drinks a day (at least 3 in school) | | | | Promote healthy diet  (5 fruit and veg a Day)  Fibre | | | | | | | | Good seating  position, step, seat reducer | | | | | | | | | Toilet environment, Warm,  paper, wet wipes | | | | |
| Active, engage  exercise | | | | Useful websites  [www.bbuk.org.uk](http://www.bbuk.org.uk)  [www.eric.org.uk](http://www.eric.org.uk)  [thepoonurses.uk](http://www.thepoonurses.uk/) | | | | | | | | Advice Change 4 Life website (fibre swaps) | | | | | | | | | Fluid frequency/Volume  chart given | | | | |
| Praise and reward chart for  achievable goals | | | | Attend GP to commence  Movicol if stools type 1-3 less than 3 times per week | | | | | | | |  | | | | | | | | |  | | | | |
| Offer support for 3 months in a package of care and review for improvements - note changes below | | | | | | | | | | | | | | | | | | | | | | | | | |
| Please describe any progress or changes identified within the 3 months. | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Referrals will only be accepted if assesment form is completed in full.** | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Referrals can be sent electronically into:** [**childcontinence.wirralct@nhs.net**](mailto:childcontinence.wirralct@nhs.net)  **or internally from 0-19 via Systmone task into Children’s continence admin** | | | | | | | | | | | | | | | | | | | | | | | | | |