Shropshire Community Health NHS
NHS Trust

Policies, Procedures, Guidelines and Protocols

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Title	Enuresis Policy
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Local Ref (optional)	
Main points the document covers	Management of enuresis in the community
Who is the document aimed at?	All clinicians advising children, young people and their families on nocturnal enuresis
Owner	Angela Scull Angela Scull SCPNH – School Nurse & Enuresis Lead
Approval process	
Who has been consulted in the development of this policy?	Shropshire Community Health Trust School Nursing Team
Approved by (Committee/Director)	Joint Adult & C&YF Service Delivery Group Extraordinary Meeting
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Sub Category	
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Amendments History		
No	Date	Amendment
1	February 2016	Replaces other polices, updated to include NICE guidance 111, NICE algorithms included for ease of reference
2		
3		
4		

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1.0 Introduction

This document is intended for all healthcare professionals advising children, young people and their carers on Nocturnal Enuresis. Bedwetting is a widespread and distressing condition that can have a deep impact on a child or young person's behaviour, emotional wellbeing and social life. It is also very stressful for the parents or carers. The causes of bedwetting are not fully understood. Bedwetting can be considered to be a symptom that may result from a combination of different predisposing factors. There are a number of different disturbances of physiology that may be associated with bedwetting. These disturbances may be categorised as sleep arousal difficulties, polyuria and bladder dysfunction. Bedwetting also often runs in families.

The term bedwetting is used in this policy to describe the symptom of involuntary wetting during sleep without any inherent suggestion of frequency of bedwetting or pathophysiology (NICE 2010). The treatment of bedwetting has a positive effect on the self-esteem of children. Healthcare professionals should persist in offering treatment if the first choice treatment is not successful.

Shropshire has seven enuresis clinic venues which run once or twice each month totalling 15 clinics per month. Advice and support is given to children, young people and their families and ages range from five to nineteen though children under 5 should not be excluded on the basis of age alone. All clinics are Nurse-led with one specialist Community Paediatrician clinic in Shrewsbury and Wellington each month. In October 2010 NICE (National Institute for Health and Care Excellence) published their clinical guideline 111 Nocturnal Enuresis; The management of bedwetting in children and young people**.** This policy is therefore based upon that guideline but has been adapted for local use. Treatment consists of initial treatment (ensuring adequate fluids, regular toileting and rewards to encourage compliance), first-choice treatment using enuresis alarms (which are activated when the child passes urine whilst asleep) and first-choice treatment using Desmopressin medication (which reduces urine production and increases urine concentration).

2.0 Purpose

The purpose of this document is to inform all healthcare professionals advising children, young people and their families on the management of Nocturnal Enuresis.

- Treatment of enuresis has a positive effect on self-esteem of children.
- Healthcare professionals should persist in offering different treatments and treatment combinations if the first-choice treatment is not successful.
- All healthcare professionals should be aware of and work within legal and professional codes and competence frameworks.
- The Enuresis Assessment Pathway (Appendix 1) outlines the advice and treatment for children and young people with Primary Nocturnal Enuresis.
- The enuresis service will be evaluated post treatment to monitor the quality of the service and improve service provision as required.
- Advice and treatment on Primary Nocturnal Enuresis will be guided by research and best practice and as such the assessment pathway may change over time.

3.0 Definitions

Term / abbreviation	Explanation
Daytime symptoms	Daytime urinary symptoms such as wetting, urinary frequency or urgency
Incontinence	Uncontrollable leakage of urine which may be due to a variety of reasons

NICE	National Institute for Health and Care Excellence
NMC	Nursing Midwifery Council
Nocturia	The need to wake and pass urine at night
Nocturnal enuresis	Involuntary urination during sleep on at least 2 nights a week in a child 5 years or older in the absence of any congenital or acquired defect in the central nervous system
Partial response to an intervention	The child has improved but does not meet the criteria for response to an intervention as above
Primary nocturnal enuresis	Involuntary wetting during sleep in a child 5 years or older who has never achieved consistent dry nights
Residual urine	Urine remaining in the bladder after voiding
Response to an intervention	The child has achieved 14 consecutive dry nights or a 90% improvement in the number of dry nights per week
Secondary nocturnal enuresis	Involuntary wetting during sleep in a child 5 years or older who has previously been dry at night for a period of at least 6 months
Void	To pass urine in an attempt to empty the bladder

4.0 Duties

4.1 Director of Quality and Nursing

Has overall responsibility for this clinical guideline, ensuring that it is full implemented across the Trust as best practice.

4.2 Director of Operations and Deputy Director of Operations

Must ensure that:

- All staff has access to this evidence based policy

4.3 Divisional Managers and Service Leads

Managers and Service Leads need to ensure that:

- This policy is implemented into clinical practice
- Relevant staff that to attend training and updates.
- All relevant staff has access to appropriate equipment that complies with safety and maintenance requirements according to Shropshire Community NHS Trust policies

4.4 Staff

All nurses are accountable for their own actions; therefore it is important that the nurse acquires the relevant skills and competencies to ensure safe practice. This includes accessing the relevant training and supervision in accordance with the Nursing and Midwifery Council (NMC).

All staff must ensure that they attend the relevant training on enuresis care and management.

All School nurses and Community Paediatricians should be prepared to ask children and young people and their carers about whether they are experiencing any difficulties with involuntary wetting. If a problem is identified then clinicians should carry out an initial assessment and offer initial advice. Clinicians may then refer on to the enuresis service if appropriate.

School nurses working within the enuresis clinic:

> School nurses working within the enuresis clinic should undertake a detailed assessment using the standard proforma. They should explain the condition and the aims of treatment and the advantages and disadvantages of the possible treatments. In the event that co-morbidities are identified these should be addressed, if necessary by referring on to the appropriate service. School nurses should offer advice and treatment as appropriate. In the event that a child is not making the expected progress or there are other clinical concerns the school nurse should discuss the child with the doctors working in the specialist enuresis clinics.

Doctors working in specialist enuresis clinics:

> Doctors working within the enuresis service should discuss with the school nurses any children or young people identified by the school nurses as needing further advice. If appropriate doctors should arrange to assess these children and young people themselves including appropriate physical examination. Doctors should decide upon the need for and arrange any further investigation needed. Doctors should decide upon the need for and arrange further treatment e.g. anitmuscarinic medication

5.0 Procedures

5.1 Assessment

It is nationally recognised best practice that all patients who present with bladder, bowel and / or continence related issues should be offered a full and holistic assessment.

5.2 Principles of care

- Support, assessment and treatment should be tailored to the circumstances and needs of the child or young person and their carers
- Children younger than 5 years should not be excluded from management of bedwetting on basis of age alone
- Children and young people and their cares should be informed that bedwetting is not the child or young person’s fault and that punitive measure should not be used in the management of bedwetting

5.3 Routine enquiry

- Nocturnal enuresis is common and causes distress so all clinicians should enquire about difficulties routinely when seeing children and young people for other reasons.

5.4 Initial assessment of enuresis outside the enuresis service

See NICE pathway –Bedwetting (nocturnal enuresis) in children and young people algorithm (Appendix 4.1). Use of the Enuresis Action and Management Plan (Appendix 2) will prompt and guide the discussion

- Ask about bedwetting, daytime symptoms, toileting patterns and fluid intake
- Establish whether this is a new phenomenon. If bedwetting started in the last few days or weeks the clinician needs to consider whether it could be caused by a systemic illness. Urinalysis is required in this situation, if necessary via the GP practice. Urinary tract infections need to be investigated and treated in line with ***Urinary tract infection in children NICE clinical guideline 54.*** If there is concern about Diabetes Mellitus same day referral is needed to a multidisciplinary paediatric diabetes care team for diagnosis and immediate care in line with ***Type 1 Diabetes NICE clinical guideline 15.***
- If there are daytime symptoms arrange for urinalysis to be carried out.
- Enquire about bowel habit if there is associated constipation arrange for this to be assessed and treated in line with ***Constipation in children and young people NICE clinical guideline 99.***
- Advise that adequate daily fluid intake is important

NICE recommended fluid intake

Age (years)	Sex	Total drink intake per day (ml)
4 – 8 years	Female Male	1000 – 1400 1000 - 1400
9 – 13 years	Female Male	1200 – 2100 1400 - 2300
14 – 18 years	Female Male	1400 – 2500 2100 - 3200

- Advise that caffeine-based drinks should be avoided
- Advise regular toileting during the day and before sleep (between four to seven times daily)
- Direct children and young people and their carers to appropriate sources of support and further information e.g. ERIC www.eric.org, and / or PromoCon www.disabledliving.co.uk/PromoCon

5.5 Referral to the enuresis service

- Consider whether the child is at a developmental level where continence might be expected. Offer referral on to the enuresis service for further assessment, support and treatment in children and young people who would like this from the age of 5 years (or developmental level is 5 years or above).
- If the child has physical disabilities or developmental delay they will need a continence assessment by the school nurse. The continence assessment will help to guide whether the child should be referred to the continence service or the enuresis service. If daytime continence has been achieved in this situation refer to the enuresis service if still wetting at night one year after daytime continence achieved
- In cases where there is:
    - A history of recurrent urinary infections

- Known or suspected physical or neurological problems
- Very significant daytime symptoms including wetting
- Discuss the child or young person with a community paediatrician working in the specialist enuresis clinic with a view to offering a paediatric referral.

5.6 Children under 5 years

- Reassure parents or carers that bedwetting is common under 5 years (one in five children aged 4 ½ years wet the bed at least once a week)
- Enquire about toilet training and offer advice and support if this has not been started, unless there are reasons to delay this.
- Advise parents or carers to take the child to toilet if the child wakes during the night
- If the child has been toilet trained during the day for at least 6 months suggest a trial without nappies or pull ups for 2 nights in a row. Offer advice about bed protection. Consider a longer trial if circumstances allow.
- Assess for constipation
- In children over 2 years who show an awareness of toileting needs and appropriate toileting behaviour but are continuing to wet during the day and night consider the need for further assessment and investigation.

5.7 Referral process

- There is an open referral system for children and young people of school age registered to a GP in Shropshire or Telford and Wrekin.
- Referrals are authorised by the Enuresis Lead within 2 weeks.
- Carers receive a ‘partial booking letter’ and are invited to contact Child Health to arrange a suitable appointment date and time
- Pre-appointment information will be provided to children, young people and their parents.
- Waiting times will be no more than 18 weeks from referral to first appointment being offered.

5.8 Clinic administration

- Child Health will undertake all pre-appointment administration.
- Clinic staff will prepare the clinic environment working towards ‘You’re Welcome quality criteria’ (DH 2005) guidance.
- Clinic staff will see children / young people within 20 minutes of an appointment time.
- Clinic staff should make every effort to remain available and see any child / young person arriving up to 20 minutes late for an appointment.
- Clinic staff will ensure completed paperwork is returned to Child Health as soon as possible after the clinic

5.9 Assessment in the enuresis service

See NICE pathway –Assessment and investigations of nocturnal enuresis in children and young people algorithm (Appendix 4.2). Use of the Enuresis Assessment Form (Appendix 3) and Enuresis Action and Management Plan (Appendix 2) will prompt and guide the assessment and follow-up processes.

The following provides explanations for the questions asked

Question	Explanation
How many nights a week?	If every night, then severe bedwetting, which is less likely to resolve spontaneously than infrequent bedwetting
How many times a night child wets / timing / volume?	A large volume of urine in the first few hours of the night is the typical pattern of bedwetting only A variable volume of urine, often more than once a night is the typical pattern for children and young people who have bedwetting and daytime symptoms with possible underlying overactive bladder.
Occurs away from home? Wakes in wet bed?	These reflect arousal, if child can wake once they have wet the bed this indicates already starting to show some awareness of wetting, positive sign
Longest dry period/ when?	If child has ever been dry for 6 months or more then secondary enuresis. Triggers should be looked for. Consider maltreatment if: a child or young person has secondary daytime wetting or secondary bedwetting that persists despite adequate assessment and management unless there is a medical explanation (for example, urinary tract infection) or clearly identified stressful situation that is not part of maltreatment (for example, bereavement, parental separation). This recommendation is adapted from '***When to suspect child maltreatment' (NICE clinical guideline 89)***
Own room / type of bed / toilet access / carer availability?	Practical considerations regarding ease of toileting at night and carer availability to assist. These will be important when considering treatment especially with an alarm.
Sleeping times / waking for toilet at night / time wake in morning?	Is child passing urine in the toilet during normal sleeping hours? Any reason to prevent them using toilet during the night e.g. fear of the dark.
Daytime frequency / urgency / wetting or abdominal straining or poor urinary stream or pain passing urine?	Any of these may indicate the presence of a bladder disorder such as overactive bladder or more rarely (when symptoms are very severe and persistent) an underlying urological disease. Can also be a sign of urinary tract infection
Daytime symptoms only in some situations / avoidance of toilets at school or elsewhere	Psychological factors that may be important. Regular toileting is important, between 4 – 7 times daily including before sleep.

Age dry by day?	If this achieved only recently night time dryness typically follows some months later
Fluids?	Document type of fluid / volume and timing. Certain fluids encourage wetting e.g. caffeine / cola / coffee / tea /hot chocolate and blackcurrant squashes. An inadequate fluid intake may mask an underlying bladder problem and may impede development of normal bladder capacity. A large volume of fluid at the end of the day rather than spread over the day makes bed wetting more likely.
Constipation / soiling?	Constipation is commonly associated and can cause bedwetting and needs treatment. Soiling is usually secondary to constipation which may have been unrecognised.
Urine infections?	A history of recurrent urinary tract infections may require further assessment and investigation.
Family history of enuresis?	There is a strong familial tendency to bedwetting.
General health of family / family stresses etc.?	A difficult environment may be a trigger for bedwetting and these factors should be addressed alongside the management of bedwetting. Other agencies may need to be involved.
Behavioural and emotional problems?	These may be a cause or consequence of bedwetting. May need further assessment and investigation. May need referral on and involvement of other agencies.
Developmental, attention or learning difficulties?	These may impact on acquisition of bladder control. Advice may need to be tailored to the child.

5.10 Planning management in the enuresis service

Clinician needs to:

- Establish child or young people and their carers or parents view point on their bedwetting. In particular with regard to what the main concerns are, whether they want treatment and what they hope to gain from treatment
- Establish whether parents or carers need support, particularly if they are having difficulty coping with the burden of bedwetting, or if they have expressed anger, negativity or blame towards the child or young person
- Ask about whether short term dryness is a priority e.g. for a sleep-over
- Discuss whether child or young person and their parent or carers have the necessary level of commitment including time available to engage in a treatment programme

5.11 Information for the child or young person and family

Offer information:

- That is tailored to the needs of the child or young person and their parents or carers
- About support groups
- About practical ways to reduce the impact of bedwetting, such as bed protection and washable or disposable products.

5.12 Treatment

- Interventions offered should comprise of techniques based on adequate research demonstrating effectiveness or based on clinically accepted theory.
- Treatment used should be acceptable to the child, young person and their carers and should be discontinued if they become unacceptable.
- Treatment procedures and use of any equipment should be adequately explained and demonstrated in a manner and medium suited to the age and understanding of the child, young person and their family.
- Clear written instructions with visual aids will be given to the child, young person and their family to explain the treatment method.
- Clinic staff should obtain feedback that the information given has been understood.

5.13 Advice for the child or young person and family

Fluid intake, diet and toileting patterns:
Advise children and young people and their carers:

- That adequate daily fluid intake is important (see table below)
- That the amount of fluid needed varies according to the ambient temperature, dietary intake and physical activity
- That caffeine-based drinks should be avoided
- To eat a healthy diet and not to restrict diet to treat bedwetting
- About the importance of using the toilet to pass urine regularly during the day and before sleep (between four and seven times a day). Carers should continue to encourage regular toilet use alongside treatment.

NICE recommended fluid intake

Age (years)	Sex	Total drink intake per day (ml)
4 – 8 years	Female Male	1000 – 1400 1000 - 1400
9 – 13 years	Female Male	1200 – 2100 1400 - 2300
14 – 18 years	Female Male	1400 – 2500 2100 - 3200

Reward systems:

- Explain that reward systems should be used, either alone or with other treatments for bedwetting.

- Rewards should be given for agreed behaviour rather than dry nights, for example:
    - Drinking recommended levels of fluid during the day
    - Using the toilet to pass urine before sleep
    - Engaging in management (for example, taking medication or changing sheets).
- Inform carers that they should not use systems that penalise or remove previously gained rewards.

Lifting and waking:
Offer advice on lifting and waking during the night as follows:

- Neither lifting[1] nor waking[2] will promote long-term dryness.
- Waking should be used only as a practical measure in the short-term management of bedwetting.
- Young people with bedwetting that has not responded to treatment may find self-instigated waking (for example, using a mobile phone alarm or alarm clock) a useful management strategy.

Training programmes:
Do not use:

- Strategies that interrupt normal passing of urine or encourage infrequent urination during the day
- Dry-bed training[3] with or without an alarm.

5.14 Initial treatments
See NICE pathway – Planning management and initial treatment of nocturnal enuresis in children and young people algorithm (Appendix 4.3)

- Advise on fluid intake, diet and toileting behaviour
- Address excessive or insufficient fluid intake and abnormal toileting patterns before starting other treatments
- Advise on using a reward system
- Suggest a trial without nappies or pull-ups for children and young people wearing them at night.
- Offer advice on alternative bed protection
- Consider whether alarm or drug treatment is appropriate, depending on the age, maturity and abilities of the child or young person, the frequency of bedwetting and the motivation and needs of the family
- Assess the ability of the family to cope with an alarm
- If young child has some dry nights try a reward system alone. If bedwetting less than 1 to 2 times a week an alarm is inappropriate
- If bedwetting has not responded to advice on toileting and an appropriate reward system and alarm treatment is desirable and appropriate offer alarm as first line treatment in over 7 year olds and consider using it in children younger than 7 years
- If rapid-onset and / or short-term dryness is a priority **or** Alarm treatment is undesirable **or** Alarm treatment is inappropriate (particularly if parents or carers are having emotional difficulty coping or are expressing anger, negativity or blame) **Offer** Desmopressin for children and young people over

[1] Lifting is carrying or walking a child to the toilet. Lifting without waking means that effort is not made to ensure the child is fully woken.
[2] Waking means waking a child from sleep to take them to the toilet.
[3] Dry-bed training is a training programme that may include combinations of a number of different behavioural interventions, and that may include rewards, punishment, training routines and waking routines, and may be undertaken with or without an alarm

7 years. Consider Desmopressin for children aged 5–7 years if treatment is required.

5.15 Alarm treatment

See NICE pathway – Alarm treatment for nocturnal enuresis in children and young people algorithm (Appendix 4.4)

- **Alarm treatment should be the first line treatment for enuresis except in the cases above where Desmopressin should be offered first line.**
- Do not exclude alarm treatment as an option for children and young people with:
    - Daytime symptoms as well as bedwetting
    - Secondary onset bedwetting
    - Hearing impairments (for example, consider a vibrating alarm)
    - Learning difficulties and/or physical disabilities
- Both body and bed alarms should be available as required, with clear written instructions on their use being issued with the alarm.
- A new detector or bed mat should be used for every child or young person including new batteries, used detectors should be double bagged and disposed of in a bin
- An equipment loan agreement will be signed by the child's / young person's carer; the original will be stored in the records and a copy given to the carer.
- A logging system will be used to identify issue, return and loss of alarms accompanied by a reasonable strategy to minimise alarm loss.
- On return the enuresis alarm will be inspected by the nurse and providing it is not contaminated will be cleaned using a clinical detergent and disinfectant wipe. If the alarm is contaminated with blood or mucus then the alarm must be disposed of and Child Health and Medical Engineering Service informed (SCPCT Cleaning and Disinfecting Policy V6 2010).
- Alarm equipment will be replaced every 5 years if regularly used.
- Alarm batteries, failed or damaged detectors, failed or faulty alarm equipment should be replaced within two weeks.

5.16 Using alarms with reward systems

- Inform children and young people and their carers about the benefits of combining alarm treatment with a reward system using rewards for desired behaviour (for example, waking up when the alarm goes off, going to the toilet, returning to bed and resetting the alarm).
- Encourage children and young people and their carers to discuss and agree their roles and responsibilities for using alarms and rewards.

5.17 Alarm information, advice and support

Ensure that advice and support for using an alarm are available, and agree with the child or young person and their carers how this should be obtained. They may need a considerable amount of help when learning how to use the alarm.

Inform the child or young person and their carers:

- Of the aims of alarm treatment
- That alarms have a high long-term success rate
- That using an alarm needs sustained commitment, involvement and effort
- That using an alarm can disrupt sleep, and their carers may need to help the child or young person to wake to the alarm
- That they are not suitable for all families
- That they will need to record their progress

- About what to do when the alarm goes off, how to set, use and maintain the alarm, and how to manage problems
- That it may take a few weeks before the alarm starts to have an effect, and it may take weeks before dry nights are achieved
- That they can restart using the alarm immediately, without consulting a healthcare professional, if bedwetting starts again after stopping treatment
- How to return the alarm when they no longer need it.

5.18 Alarm response

- The response to the alarm should be assessed at 4 weeks looking for early signs of response which may include – smaller wet patches, waking to the alarm, the alarm going off later and fewer times per night and fewer wet nights
- If there is no response but child or young person and their parents or cares wish to continue then offer Desmopressin with the alarm or Desmopressin alone if they wish to stop the alarm
- If there is a response should continue with the alarm until 2 weeks uninterrupted dry nights achieved

5.19 Alarm Progress

- Progress should be assessed at 3 months if bedwetting improving and child and parents or carers motivated to continue can continue
- If no progress either add Desmopressin to alarm if wish to continue with alarm or offer Desmopressin alone

5.20 Desmopressin treatment

See NICE pathway – Desmopressin treatment for nocturnal enuresis in children and young people algorithm (Appendix 4.5)

- **Desmopressin should be used as first line treatment if an alarm is undesirable or if short term dryness is the priority.**
- Desmopressin should not be excluded as a treatment option for children and young people with:
    - Daytime symptoms as well as bedwetting, however do not use Desmopressin for children and young people who only have daytime wetting
    - Sickle cell disease, if they can comply with night-time fluid restriction. Provide advice about withdrawal of Desmopressin at times of sickle cell crisis
    - Emotional, attention or behavioural problems or developmental or learning difficulties, if they can comply with night-time fluid restriction.
- Desmopressin should be started at a dose of 200 micrograms of Desmotabs or 120 micrograms of Desmomelts. If complete dryness is not achieved in 1-2 weeks then the dose can be increased to 400 micrograms of Desmotabs or 240 micrograms of Desmomelts
- Desmopressin can be used if alarm treatment has not worked, either alone or in combination with an alarm see above
- Desmopressin is contraindicated if there is cardiac insufficiency and in other conditions treated with diuretics. It is also contraindicated in psychogenic polydipsia and polydipsia in alcohol dependence

5.21 Desmopressin information and advice

Inform the child or young person and their carers:

- That many children and young people will experience a reduction in wetness, but many relapse when treatment is withdrawn
- How Desmopressin works
- Of the importance of fluid restriction from 1 hour before and until 8 hours after taking Desmopressin
- That it should be taken at bedtime
- How to increase the dose if the response to the starting dose is not adequate
- That treatment should be continued for 3 months and then withdrawn to assess response
- That repeated courses can be used. Desmopressin should be withdrawn gradually if using repeated courses

Clear written instructions, with visual aids to explain the use of medication and potential side effects will be given to the child, young person and their family

For children and young people being treated with Desmopressin, do not routinely measure:

- Weight
- Serum electrolytes
- Blood pressure
- Urine osmolality

5.22 Desmopressin response

The response should be assessed at 4 weeks

- If there is a response (which may include smaller wet patches, fewer wetting episodes per night and fewer wet nights) it can be continued for 3 months.
- If there is no response or only a partial response consider advising that Desmopressin is taken 1- 2 hours before bedtime instead of at bedtime if they can comply with fluid retention. If not then stop Desmopressin
- If partial or no response to Desmopressin consider referral to doctor for further review and assessment of factors associated with poor response .e.g. overactive bladder, underlying disease or social and emotional factors

Consider alarm treatment as an alternative to continuing drug treatment for children and young people who have recurrences of bedwetting, if an alarm is now appropriate and desirable.

Perform regular medication reviews for children and young people on repeated courses of drug treatment for bedwetting.

5.23 Desmopressin partial response

- Consider continuing treatment for bedwetting that has partially responded to Desmopressin combined with anitmuscarinic medication, as bedwetting may further improve for up to 6 months.
- Consider repeated courses of Desmopressin combined with anitmuscarinic medication for bedwetting that recurs repeatedly after successful treatment with Desmopressin combined with anitmuscarinic medication

5.24 Doctor led specialist enuresis clinics

See NICE pathway – Further treatments of nocturnal enuresis in children and young people algorithm (Appendix 4.6)

- Children or young people with nocturnal enuresis in whom the alarm and or Desmopressin has not been successful should be discussed with the doctor for consideration of further assessment and treatment.
- Children with daytime symptoms that have not responded to advice about fluids and regular voiding should be discussed with the doctor for consideration of further assessment and treatment.

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5.25 Anitmuscarinic medication

- Consider Desmopressin combined with anitmuscarinic medication for children and young people who have been assessed by a healthcare professional with expertise in the management of bedwetting that has not responded to an alarm and / or Desmopressin and have any of the following:
    - Bedwetting that has partially responded to Desmopressin alone
    - Bedwetting that has not responded to Desmopressin alone
    - Bedwetting that has not responded to an alarm combined with Desmopressin
    - Who have been assessed by a healthcare professional with expertise in prescribing this combination and have daytime symptoms and bedwetting.
- Do not use anitmuscarinic medication:
    - Alone for children and young people with bedwetting without daytime symptoms
    - Combined with imipramine.
- Not all anitmuscarinic medications have a UK marketing authorisation for treating bedwetting in children and young people. If a drug without a marketing authorisation for this indication is prescribed, informed consent should be obtained and documented
- Inform the child and young person and parents or carers:
    - That success rates are difficult to predict, but more children and young people are drier with a combination of Desmopressin and anitmuscarinic medication than with Desmopressin alone
    - That the combination can be taken together at bedtime
    - That treatment should be continued for 3 months
    - That repeated courses can be used.

5.29 Imipramine treatment

Imipramine is not recommended.

6.0 Consultation

The policy was developed by The Enuresis Team leader in association with School Nurses, School Nurse managers, Community paediatricians and the Infection Prevention and Control Team. It has been circulated widely by consultation with the following people:

- Shropshire School Nurses led by Jo France
- Continence Service led by Andrea Davies
- Infection Prevention and Control Team led by Rachael Allen
- Community Nurses and Children's Nurses led by Sharon Boyle

- Parents Opening Doors (PODS) led by Debbie Hart
- Clinical leads and Divisional Managers led by Sara Vale
- Dr Sue Reeves & Dr Sam Postings Community Paediatricians
- Parents and Carers Council

7.0 Dissemination and Implementation

This policy and guidelines will be disseminated to staff by the following methods:

- Deputy Director – cascading to Divisional Managers
- Disseminated to all relevant staff by Datix
- Inform article
- Published to Web Site
- Raising awareness through specialist groups e.g. Link Nurse Meetings

Implementation will be via a rolling programme of training delivered by the Continence Team which includes Continence Nurses; Community Children's Nurses; School Nurses and School Nurse Enuresis Lead via Shropshire Community Health NHS Trust Training and Development Unit

For advice and guidance on this policy or training information contact the Continence Nurses or School Nurse Enuresis Lead

8.0 Monitoring Compliance

Compliance will be monitored through audit developing specified audit standards.

9.0 References

- Department of Health (2000) Good Practice in Continence Services.
- Department of Health (2003) Good Practice in Paediatric Continence Services Benchmarking in Action, NHS Modernisation Agency, London
- Department of Health (2004) National Service Framework for Children, Young People and Maternity Services. Every Child Matters
- Getliffe K, Dolman (2007) Promoting Continence – A clinical and research resource London. Balliere Tindall
- Managing Bowel and Bladder Problems in Schools and Early Years Settings guidelines for good practice (2006). Promocon
- National Institute for Clinical Excellence (NICE) 2010 Clinical Guidance111 Nocturnal enuresis London: NICE
- Nursing and Midwifery Council (NMC) (2015) The Code Professional standards of practice and behaviour for nurses and midwives, NMC, London
- RCN (2006) Paediatric assessment of toilet training readiness and the issue of products. Royal College of Nursing, London

- Skills of Health competencies continence care bundle:2011
- www.skillsforhealth.org

10 Associated Documents

- Shropshire Community Health NHS Trust Infection Prevention and Control Policies
- Shropshire Community Health NHS Trust Consent to Examination and Treatment Policy
- Shropshire Community Health NHS Trust Records Management Policy
- Shropshire County NHS Primary Care Trust and Telford and Wrekin NHS Primary Care Trust Waste Management policy
- Shropshire Community Health NHS Trust Privacy and Dignity Policy

Appendices:

Appendix 1: Enuresis Assessment Pathway
Appendix 2: Enuresis Action and Management Plan
Appendix 3: Enuresis Assessment Form
Appendix 4: NICE Pathways for Bedwetting (nocturnal enuresis) in Children and Young People

Shropshire Community Health NHS
NHS Trust

Enuresis Care Pathway

Enuresis Assessment Pathway

Referral Process
Referral form completed by SN/ GP/ HV / Parent /Carer/ Other Professional
Arrives at Child Health & is authorised by Lead Nurse
Partial Booking Letter with ERIC Advice for Parents booklet sent to parent / carer

⇩

Clinic Administration
Parent / Carer contacts Child Health to arrange appointment
Child Health allocate to clinic, generate green file & send to Nurse 1 week before clinic

⇩

Discharge if no response to 2 partial booking letters or Did Not Attend 1st Appointment

⇩

Clinic Appointment Process
Clinics are run by Continence Nurses for Paediatrics
Assessed following NICE enuresis guidelines 111, QS70 & Enuresis Policy. Initial advice given
Follow NICE assessment & Investigations algorithm

⇩

Follow Up Process
No progress after changing usual routine, implementation of initial advice & reward system.
Discuss, explain & offer treatment options
Follow NICE initial treatment algorithm

⇩ ⇩

Alarm appropriate for initial treatment **Follow NICE alarm algorithm**	**Desmopressin appropriate for initial treatment** **Follow NICE Desmopressin algorithm**

⇩

Follow Up Process
Ongoing advice & support by Continence Nurses for Paediatrics

⇩

Discharge Process
Discharged why dry or dry to child / parent / carer satisfaction or no response to 2 partial booking letters

At any stage child / young person may be discussed with / referred to Community Paediatrician for advice / assessment. Follow NICE further treatments algorithm

Introduction

Nocturnal enuresis is regarded as 'involuntary wetting during sleep without inherent suggestion of frequency of bedwetting or pathophysiology' (NICE 2010).

Shropshire has seven enuresis clinic venues which run once to twice each month totalling 15 clinics per month. Advice and support is given to children, young people and their families and ages range from five to sixteen, though children under 5 should not be excluded on the basis of age alone. Treatment consists of initial treatment (ensuring adequate fluids, regular toileting and rewards to encourage compliance), first-choice treatment using enuresis alarms (which are activated when the child passes urine whilst asleep) and first-choice treatment using medication (Desmopressin - which reduces urine production and increases urine concentration).

The purpose of this enuresis care pathway is to inform all healthcare professionals advising children, young people and parents on the management of Primary Nocturnal Enuresis. This includes the referral process, the role of Child Health, advice and support given by clinicians and written information given to aid compliance. The enuresis service will be evaluated post treatment to monitor the quality of the service and improve service provision as required. Good communication between all agencies is an important part of the Care Pathway as this will ensure a child-centred and family focussed approach is achieved and maintained.

As this is a working document, advice and treatment on Primary Nocturnal Enuresis will be guided by research and best practice and as such may change over time.

NOTE: The language that children, parents and professionals use to describe the urinary system inevitably varies. However whilst it is important to use the right language when communicating with children and parents the text used in this Care Pathway will be the language most commonly used by professionals.

Contents

1. Section 1 – Referral Process

1.1 General Information On Enuresis To Aid Practitioners

It is estimated that over half a million children between the ages of 5 – 16 years in the UK regularly wet the bed. From research we know that bed wetting causes many to lose their self-esteem, they feel different and fear being discovered by others, enuresis also limits their social life and experiences. Although most parents are supportive some (up to 30%) feel frustrated and helpless with increased financial burden (estimated to be an extra £22 per week) adding to these pressures (Dobson 1995)

Definition: The term bedwetting is used in the guideline to describe the symptom of involuntary wetting during sleep without any inherent suggestion of frequency of bedwetting or pathophysiology (NICE 2010).

The number of children who regularly wet the bed:

- 1 in 6 five year olds (13-19% male / 9-16% female)
- 1 in 7 seven year olds (15-22% male / 7-15% female)
- 1 in 11 nine year olds (9-13% male / 5-10% female)
- 1 in 50 – 100 fifteen and older (1-2% male & female) (including adults)

It is proposed that parental concern and child distress should also play a part in determining the clinical significance of the problem (Butler 1994). However, there are three main areas where options vary:

- ***Age:*** most definitions refer to five years as the watershed, although sometimes the child's mental age should be taken into account. Five years is the generally accepted age, as most children at this stage are able to urinate at 'will' and have therefore developed cognitive control over voiding (Crawford 1989).
- ***Frequency of wetting episodes****:* In a longitudinal survey of over 8,000 children in the County of Avon, Butler et al (2005) found that at 7.5 years of age the frequency of wetting was:
    - Multiple bedwetting (>once/night) 0.2%
    - Frequent bedwetting (>twice/week) 2.4%
    - Infrequent bedwetting (once or less/week) 12.8%
    - Non bedwetting 84.5%

  It is likely that those wetting most severely are the ones who continue wetting into their later years. In clinical practice, parental and child concern over the bedwetting, rather than the severity itself seems the relevant issue. Some children and parents are concerned over an occasional wet bed, whilst others will accept regular wetting episodes.
- ***Duration:*** most definitions do not include duration.

Causes: Evidence suggests that bedwetting is multifactorial in origin, arising from a number of conditions:

- ***Genetic predisposition:*** There is strong evidence of a hereditary component to bedwetting. If one or both parents wet the bed the risk of his/her children also being affected is 40% and 70% respectively.
- ***Nocturnal polyuria (low natural vasopressin levels):*** Arginine vasopressin (AVP – anti-diuretic hormone), produced by the hypothalamus and stored in the posterior pituitary gland, is normally released in increased amounts during sleep compared to daytime levels, causing increased reabsorption of water in the kidneys and therefore a reduction of urine volume. Some children who wet the bed have been found in several independent studies, to have a lack of circadian rhythm of vasopressin, resulting in a high night-time urine production that exceeds bladder capacity.
- ***Bladder instability / low functional bladder capacity:*** A normal bladder is able to store urine by keeping the detrusor muscle relaxed and the sphincter mechanism closed during bladder filling. Some children who wet the bed have an unstable bladder with a low capacity. Children with bedwetting due to detrusor instability are not always wet in the day, although they may have signs such as urinary frequency or urgency.
- ***Lack of arousal from sleep:*** Research clearly demonstrates that children who wet the bed have the same sleep pattern as those who do not. The problem is the child's inability to arouse from sleep when the bladder reaches its maximum capacity.
- ***Stress:*** Stressful early life events can trigger bed wetting, particularly in those who have previously been dry. However, stress is usually the result of and not the cause of the wetting
- ***Organic causes of bedwetting:*** Night time bedwetting is rarely the result of structural disease affecting the urinary tract and such problems should easily be detected from history etc.

Hallmarks of good practice:

1) Link treatment to the results of the assessment
2) Ensure that the treatment programme is acceptable to both the child and the parents
3) Engage the child
4) Where possible, offer choice
5) Intervene at one level at a time
6) Regular supervision
7) Focus on the positive
8) Involve the child in evaluating progress (Butler & Swithinbank 2007)

Key Priorities for implementation of NICE Guidance 111 (2010)

- Nocturnal enuresis is common and causes distress so all clinicians should enquire about difficulties routinely when seeing children and young people for other reasons.
- Inform children and young people with bedwetting and their parents or carers that bedwetting is not the child or young person's fault and that punitive measures, should not be used in the management of bedwetting.
- Offer support, assessment and treatment tailored to the circumstances and needs of the child or young person and parents or carers.
- Do not exclude younger children for example, those under 7 years, from the management of bedwetting on the basis of age alone Ask about bedwetting, daytime symptoms, toileting patterns and fluid intake
- Establish whether this is a new phenomenon. If bedwetting started in the last few days or weeks the clinician needs to consider whether it could be caused by a systemic illness. Urinalysis is required in this situation, if necessary via the GP practice. Urinary tract infections need to be investigated and treated in line with ***Urinary tract infection in children NICE clinical guideline 54.*** If there is concern about Diabetes Mellitus same day referral is needed to a multidisciplinary paediatric diabetes care team for diagnosis and immediate care in line with ***Type 1 Diabetes NICE clinical guideline 15.***
- If there are daytime symptoms arrange for urinalysis to be carried out.
- Enquire about bowel habit if there is associated constipation arrange for this to be assessed and treated in line with ***Constipation in children and young people NICE clinical guideline 99.***

Advise that adequate daily fluid intake is important NICE recommended fluid intake

Age (years)	Sex	Total drink intake per day (ml)
4 – 8 years	Female Male	1000 – 1400 1000 - 1400
9 – 13 years	Female Male	1200 – 2100 1400 - 2300
14 – 18 years	Female Male	1400 – 2500 2100 - 3200

- Advise that caffeine-based drinks should be avoided
- Advise regular toileting during the day and before sleep (between four to seven times daily)
- Direct children and young people and their carers to appropriate sources of support and further information e.g. ERIC www.eric.org, and / or PromoCon www.disabledliving.co.uk/PromoCon

- See NICE pathway –Bedwetting (nocturnal enuresis) in children and young people algorithm (Enuresis Policy Appendix 4.1). Use of the Enuresis Action and Management Plan (Enuresis Policy Appendix 2) will prompt and guide the discussion.
- Consider whether the child is at a developmental level where continence might be expected. Offer referral on to the enuresis service for further assessment, support and treatment in children and

young people who would like this from the age of 5 years (or developmental level is 5 years or above).

- If the child has physical disabilities or developmental delay they will need a continence assessment by the school nurse. The continence assessment will help to guide whether the child should be referred to the continence service or the enuresis service. If daytime continence has been achieved in this situation refer to the enuresis service if still wetting at night one year after daytime continence achieved
- In cases where there is:
    - A history of recurrent urinary infections
    - Known or suspected physical or neurological problems
    - Very significant daytime symptoms including wetting
    - Discuss the child or young person with a community paediatrician working in the specialist enuresis clinic with a view to offering a paediatric referral.

Children under 5 years

- Reassure parents or carers that bedwetting is common under 5 years (one in five children aged 4 ½ years wet the bed at least once a week)
- Enquire about toilet training and offer advice and support if this has not been started, unless there are reasons to delay this.
- Advise parents or carers to take the child to toilet if the child wakes during the night
- If the child has been toilet trained during the day for at least 6 months suggest a trial without nappies or pull ups for 2 nights in a row. Offer advice about bed protection. Consider a longer trial if circumstances allow.
- Assess for constipation
- In children over 2 years who show an awareness of toileting needs and appropriate toileting behaviour but are continuing to wet during the day and night consider the need for further assessment and investigation.

Referral process

- There is an open referral system for children and young people of school age registered to a GP in Shropshire or Telford and Wrekin.
- Referrals are authorised by the Enuresis Lead within 2 weeks.
- Carers receive a ‘partial booking letter’ and are invited to contact Child Health to arrange a suitable appointment date and time
- Pre-appointment information will be provided to children, young people and their parents.
- Waiting times will be no more than 18 weeks from referral to first appointment being offered.

1.2 Clinic Venues / CONTACT POINTS FOR SHROPSHIRE ENURESIS CLINIC NURSES

Clinic Venue	Frequency
Bridgnorth Enuresis Child Health Clinic Northgate Bridgnorth WV16 4ET	3rd Thursday of each month 09.30 – 12:10
Donnington Enuresis Donnington Medical Practice Health Centre, Wrekin Drive, Donnington, Telford TF2 8EA	1st Monday of each month 09:00 – 16:20
Ludlow Enuresis Ludlow Hospital New Road Ludlow SY8 1QX	1st Thursday of each month 09.30 – 12:50 4th Monday of each month 13:20 – 16:40
Oswestry Enuresis Child Health Clinic Victoria Road Oswestry SY11 2PQ	1st Tuesday of each month 13:20 – 14:20 3rd Thursday of each month 09.30 – 12:50
Shrewsbury Enuresis Haughmond View Medical Practice Severn Fields Health Village Sundorne Road Shrewsbury SY1 4RQ	1st Thursday of each month 13:20 – 16:20 2nd Monday of each month 09:20 – 16:20 4th Thursday of each month 09.30am – 12:50 5th Monday of any month 13:20 – 16:20

Stirchley Enuresis Stirchely Medical Practice Sandino Road Stirchley Telford TF3 1FB	1st Friday of each month 09:00 – 12:40 3rd Friday of each month 09:00 – 12:40 5th Friday of any month 09:00 – 12:40
Wellington Enuresis Wellington Medical Practice Chapel Lane, Wellington, Telford TF1 1PZ	1st Wednesday of each month 13:00 – 16:20 3rd Wednesday of each month 13:00 – 16:20 5th Wednesday of any month 13:00 – 16:20
Whitchurch Enuresis Whitchurch Hospital Deermoss Lane Whitchuch SY13 1NT	2nd Wednesday of each month 09.30 – 12:50 4th Wednesday of each month 13:30 – 15:40

For general information regarding bedwetting, clinics, advice please contact Angela Scull, School Nurse and Enuresis Lead. Tel: 01691 663610.

1.3 Enuresis Clinic Referral Form

SN100 – Enuresis Clinic Referral Form

- The referral form arrives at Child Health and is authorised by the Lead Nurse for Enuresis.
- The referral will be allocated to the waiting lists.
- A ‘Green file’ will be generated and referral code ENURF is activated in the Lorenzo database.
- Child Health sends out up to two ‘partial booking’ letters,
- An appointment letter is sent to parents once the clinic date is agreed and appointment is booked, text reminders are send 2 weeks and 1 week prior to the appointment
- Child Health arranges all appointments and sends the green file to the clinic venue prior to the clinic date in a secure red bag.
- Child Health staff informs the Nurse running the clinic of the security tab number attached to the red bag.
- The Nurse informs Child Health when she receives the red bag.
- At the end of each clinic the appointment sheet is sent back to child health along with any files of children discharged from the service.
- Child Health are informed by the Nurse of the red bag tag details
- All appointments and outcomes are entered onto Lorenzo by Child Health staff.
- Child health send letters out to GP or parents dependant on code entered into clinic appointment sheet.
- Following discharge from the service the referral is closed by Child Health and the ‘Green File’ is archived.

1.4 Letter: Waiting List Letter to Parent

Dear Parent/Guardian,

ENURESIS CLINIC

Re:- Child's Name NHS Number:-

We have received a referral for (name) to be seen in a Community Paediatric Clinic for an Enuresis (bedwetting) Assessment

To arrange an appointment please contact:-

The Child Health Team on 10743 450800 within 14 days of the date of this letter, to arrange an appointment that is convenient to you. If you do not require an appointment, please also let us know. If we do not hear from you an appointment will not be sent.

Should you be unable to attend the appointment after you have called to arrange it please let us know, otherwise a further appointment will not be offered.

Yours sincerely

Targeted Child health Team

cc. , GP
, Health Visitor
, School Nurse

1.5 Handout – Advice to Parents Leaflet

See 🕮PIL100 – Nocturnal Enuresis – A Guide for Parents

2. Appointment Offered / Clinic Administration

2.1 Letter: Appointment Offered Letter – School Nurse

Dear Parent/Guardian of

ENURESIS CLINIC

An appointment has been arranged for «Full_Name» (d.o.b. - «DOB»), who attends «School» School, to attend the Enuresis Clinic on «Appointment_Date» at «Appointment_Time» at Oswestry Child Health Clinic, Thomas Savin Road, Oswestry SY11 3QA.

Your appointment will normally take approximately 40 minutes with a Continence Nurse for Paediatrics School Nurse.

Please do your very best to attend as there is quite a large number of children waiting to attend the Clinic.

IMPORTANT INFORMATION

If this appointment is not kept, no further appointment will be offered

- **Encourage your child to have at 6-8 large drinks spaced out through the day**
- **Your child can have a very small drink of water / milk before bedtime**
- **Usually lifting the child before parents bedtime does not help**
- **If your child is in pull-ups / nappies try without 1 – 2 nights each week**

We are always looking for ways to improve and ensure that you have the best possible experience of our services; you can help us to get it right by telling us what you think of our services, whether you have a comment, concern, complaint or compliment.

To do this, please contact our Patient Advice and Liaison Service (PALS) on:

01743 277689 or 0800 0321107 or e-mail pals@shropcom.nhs.uk

Alternately, you can tell your story and make a difference by using the online Patient feedback forum www.patientopinion.org.uk and we will come back to you with our response

We also operate a text messaging appointment reminder service. It is important that the contact number we hold for you is correct. Please contact us by using then number on the top of this letter, to inform us of your contact number and any changes to you contact details. If you do not wish to participate in the reminder service, please also let us know by contacting the number on the top of the letter.

Yours sincerely

Targeted Child Health Team

CC: GP
<referrer>

2.2 Clinic Administration /Appointment Sheet

See form Z101 – Enuresis Clinic Appointment Sheet

2.3 Enuresis Clinic Resources Order Form

See form 🗎Z104 – Clinic Resources Order Form

2.4 Patient Cancellations (CAN) – New Outpatient Appointments

Patients who cancel their agreed appointment after the date of the clock start will be contacted and a second appointment negotiated up to a maximum of 5 weeks. Subsequently cancellations by the patient will then result in discharge back to the referrer.

If the patient is still not able to attend within 5 weeks they will be discharged back to the referrer and their 18 week clock stopped

The exception to this will be where, in the clinical judgement of the consultant;

- The patient needs to be offered another appointment on the grounds of clinic need
- The patent could be considered to be vulnerable due to age, reliance on carers, mental capacity etc.

2.5 Patent cancelations – Follow up Outpatient Appointments

If a patent cancels an appointment anywhere in the RTT pathway another appointment should be re-arranged if required.

The patent will be offered a second appointment date negotiated up to a maximum of 5 weeks. If the patient can still not attend within this timeframe they will be discharged back to the referrer and their 18 week clock stopped.

The exception to this will be where, in the clinical judgement of the consultant;

- The patient needs to be offered another appointment on the grounds of clinic need
- The patent could be considered to be vulnerable due to age, reliance on carers, mental capacity etc.

3. Clinic Appointment Process

3.1 Collecting Background Information – Guidance Notes

Gender

- More boys suffer with nocturnal enuresis until teenage years, when it equals out
- For girls with nocturnal enuresis there is more likelihood of secondary wetting, associated daytime wetting and Urinary Tract Infection (UTI)

Age

- About 15% of children at 7years wet the bed, reducing to around 2% at 18 years
- Much fewer (2.6% at 7 years) wet the bed with a frequency that meets the definition of nocturnal enuresis (2 or more wet nights per week)
- Those who wet frequently are more likely to persist wetting if they do not receive appropriate treatment
- Spontaneous remission rates are approximately 14-16% a year
- We cannot predict when a particular child will become dry
- Children do not 'grow out' of bedwetting – they develop mechanisms which enable them to stay dry

Family history of bedwetting

- Strong genetic influence in boys
- Where both parents were enuretic there is a 70% chance the child will wet the bed
- Where one parent was enuretic there is a 40% risk of a child wetting the bed
- Attitude as well as genes are transferred across generation

Wetting history

- Enuresis pattern (number of nights; volume; times; waking after wetting)
- Daytime pattern (frequency – 7+ times per day; urgency; wetting; abnormal straining; poor urinary stream; pain)
- Daytime toileting patterns (certain situations; avoidance of school toilets / settings; more or less often than peers)
- Secondary enuresis (dry at night without assistance for 6 months) is often associated with stressful life events such as family break up and separation from parents
- Secondary enuresis is more common in girls

Sleeping arrangements

- Improving toilet access and heating can increase the child's attempts to toilet at night
- Sharing beds/rooms can hinder treatments such as the enuresis alarm
- Lighting or falling asleep in front of the TV may inhibit vasopressin

Drinking pattern

- Fluid restriction may reduce the ability of the bladder to store a reasonable volume of urine
- A child needs a regular day-time fluid intake balanced throughout the day (150-200mls 6-8 times a day). Daily fluid intake varies according to ambient temperature, dietary intake and physical activity, a suggest minimum is 1litre per day at 5 years and 1.5 litres at 10 years
- More caution is needed in the 1 ½ hours prior to sleep, let the child determine if they are particularly vulnerable to any fluid type though high sugar and caffeine based drinks should be avoided

Adapted from Butler, RJ. (2006) **Nocturnal Enuresis Resource Pack;** ERIC 5th Edition

Key Priorities for implementation of NICE Guidance 111 (2010)

The following provides explanations for the questions asked

Question	Explanation
How many nights a week?	If every night, then severe bedwetting, which is less likely to resolve spontaneously than infrequent bedwetting
How many times a night child wets / timing / volume?	A large volume of urine in the first few hours of the night is the typical pattern of bedwetting only A variable volume of urine, often more than once a night is the

	typical pattern for children and young people who have bedwetting and daytime symptoms with possible underlying overactive bladder.
Occurs away from home? Wakes in wet bed?	These reflect arousal, if child can wake once they have wet the bed this indicates already starting to show some awareness of wetting, positive sign
Longest dry period/ when?	If child has ever been dry for 6 months or more then secondary enuresis. Triggers should be looked for. Consider maltreatment if: a child or young person has secondary daytime wetting or secondary bedwetting that persists despite adequate assessment and management unless there is a medical explanation (for example, urinary tract infection) or clearly identified stressful situation that is not part of maltreatment (for example, bereavement, parental separation). This recommendation is adapted from '***When to suspect child maltreatment' (NICE clinical guideline 89)***
Own room / type of bed / toilet access / carer availability?	Practical considerations regarding ease of toileting at night and carer availability to assist. These will be important when considering treatment especially with an alarm.
Sleeping times / waking for toilet at night / time wake in morning?	Is child passing urine in the toilet during normal sleeping hours? Any reason to prevent them using toilet during the night e.g. fear of the dark.
Daytime frequency / urgency / wetting or abdominal straining or poor urinary stream or pain passing urine?	Any of these may indicate the presence of a bladder disorder such as overactive bladder or more rarely (when symptoms are very severe and persistent) an underlying urological disease. Can also be a sign of urinary tract infection
Daytime symptoms only in some situations / avoidance of toilets at school or elsewhere	Psychological factors that may be important. Regular toileting is important, between 4 – 7 times daily including before sleep.
Age dry by day?	If this achieved only recently night time dryness typically follows some months later
Fluids?	Document type of fluid / volume and timing. Certain fluids encourage wetting e.g. caffeine / cola / coffee / tea /hot chocolate and blackcurrant squashes. An inadequate fluid intake may mask an underlying bladder problem and may impede development of normal bladder capacity. A large volume of fluid at the end of the day rather than spread over the day makes bed wetting more likely.
Constipation / soiling?	Constipation is commonly associated and can cause bedwetting and needs treatment. Soiling is usually secondary to constipation which may have been unrecognised.
Urine infections?	A history of recurrent urinary tract infections may require further assessment and investigation.

Family history of enuresis?	There is a strong familial tendency to bedwetting.
General health of family / family stresses etc.?	A difficult environment may be a trigger for bedwetting and these factors should be addressed alongside the management of bedwetting. Other agencies may need to be involved.
Behavioural and emotional problems?	These may be a cause or consequence of bedwetting. May need further assessment and investigation. May need referral on and involvement of other agencies.
Developmental, attention or learning difficulties?	These may impact on acquisition of bladder control. Advice may need to be tailored to the child.

Planning management in the enuresis service

Clinician needs to:

- Establish child or young people and their carers or parents view point on their bedwetting. In particular with regard to what the main concerns are, whether they want treatment and what they hope to gain from treatment
- Establish whether parents or carers need support, particularly if they are having difficulty coping with the burden of bedwetting, or if they have expressed anger, negativity or blame towards the child or young person
- Ask about whether short term dryness is a priority e.g. for a sleep-over
- Discuss whether child or young person and their parent or carers have the necessary level of commitment including time available to engage in a treatment programme

Information for the child or young person and family

Offer information:

- That is tailored to the needs of the child or young person and their parents or carers
- About support groups
- About practical ways to reduce the impact of bedwetting, such as bed protection and washable or disposable products
- Discuss with the parents or carers whether they need support, particularly if they are having difficulty coping with the burden of bedwetting, or if they are expressing anger, negativity or blame towards the child or young person.
- Consider whether or not it is appropriate to offer alarm or drug treatment, depending on the age of the child or young person, the frequency of bedwetting and the motivation and needs of the child or young person and their family.
- Address excessive or insufficient fluid intake or abnormal toileting patterns before starting other treatment for bedwetting in children and young people.
- Explain that reward systems with positive rewards for agreed behaviour rather than dry nights, should be used either alone or in conjunction with other treatments for bedwetting. For example, rewards may be given for :
    - Drinking recommended levels of fluid during the day
    - Using the toilet to pass urine before sleep
    - Engaging in management, for example, taking medication or helping to change sheets.
- Offer an alarm as the first-choice treatment to children and young people whose bedwetting has not responded to advice on fluids, toileting or an appropriate reward system, unless:
    - An alarm is considered undesirable to the child or young person or their parents and carers
    - Bedwetting is very infrequent (less than 1–2 wet beds per week)
- Offer Desmopressin as the first-choice treatment to children and young people over 7 years, if:
    - Rapid onset and/or short-term improvement in bedwetting is the priority of treatment
    - If an alarm is inappropriate or undesirable
    - If bedwetting is very infrequent (less than 1–2 wet beds per week)
    - The parents or carers are having emotional difficulty coping with the burden of bedwetting

- The parents or carers are expressing anger, negativity or blame towards the child or young person.

Refer children and young people with bedwetting that has not responded to courses of treatment with an alarm and /or Desmopressin for further review and an assessment of factors that may be associated with a poor response, such as an overactive bladder, an underlying disease or social and emotional factors.

3.2 Interventions tried in the past – guidance notes

Absorbent pads

- It is preferable to encourage trying without absorbent pads or pull ups
- Try and understand the reason for continued use
- Should the child/parent wish to continue, all treatment interventions can still be engaged with younger children still in absorbent pants

Lifting

- If the child is not fully awake when taken to the toilet, the child is in effect voiding during sleep and the problem is likely to be maintained
- If woken, the child is denied the sensation of a full bladder and also denied the opportunity to respond appropriately to a full bladder

Restricting fluids

- May reduce the capacity of the bladder to store urine and lead to bladder over-activity
- Encourage regular daytime drinking
- Assess using the 'drinks chart' whether the child is vulnerable to any type of evening drink

Star charts / rewards

- These tend to focus on the outcome (being dry) which assumes the child has control over this
- It is better to reward behaviours which increase the child's chances of becoming dry. The child has more potential control over such behaviours, such as toileting before bed; increasing daytime drinking; regular daytime toileting; using the toilet if they wake in the night, helping to change sheets, etc.

Punishment

- Always avoid any form of punishment; enuresis is not the child's fault. It does nothing to increase the child's development of night-time bladder control. The associated stress and anxiety may even make the problem worse
- Try to encourage an attitude of looking for positive reactions and progress (however small)

Medication

- Explain the mode of action
- Desmopressin reduces night-time urine production
- How Imipramine works is not well understood
- Anticholinergic medication specifically relaxes the bladder wall muscles

Alarms

- Effective when the child shows an ability to wake from sleep
- Allow the child a choice of alarm
- Describe how the alarm is designed to help the child overcome the problem

Adapted from Butler, RJ. (2006) **Nocturnal Enuresis Resource Pack;** ERIC 5th Edition

3.3 Enuresis Assessment Form

🗎 SN102 Enuresis Assessment Form

3.4 Diagram of the urinary system and explanation

🕮PIL108 – Diagram of Urinary System

3.5 Choose Your Poo diagram

🕮PIL101 – Choose your Poo

3.6 General Advice (action plan) at first and subsequent appointments

Normal Bladder & Bowel 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 maturing 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: age + 1 x 30 = average voided volume. Therefore the bladder capacity for a 5 year old is:
- 5 + 1 x 30 = 180mls
- Urine is produced form the kidneys at around 60mls per hour. Therefore a five year old should be able to stay dry for 3 hours
- The ability to 'hold on' increases with age
- The expected number of voids per day is between six and eight

Bowel Development

- Most babies stop opening their bowels at night before they become one year old
- Expected bowel movements in a child should range form no more than three times per day to no less than three times per week
- Soiling at night above the age of one year may be an indication of constipation

Development of Toileting Skills

- Physiological maturity; linking the sensation of a full bladder / bowel to the action required
- Communication skills; the child is able to tell an adult there is a need
- Mobility; the child is able to get to the toilet or potty
- Social skills; the child is aware of where and when the action can be taken

Fluid Intake

- Children should be encouraged to drink water-based fluids
- Children should drink between 150-200ml / 6-8 x per day
- School aged children should have three of those drinks during the school day

Advice on Fluid, Diet, and Toileting

- Explore the child or young person's view of their problem and if the problem requires treatment
- Fluids amount: type, times, volume (150-200ml / 6-8 x per day, spaced regularly and avoiding stimulants later in day – tea, coffee, hot chocolate, coke and other fizzy drinks, blackcurrant, sometimes orange etc). A small drink before bed
- Regular toileting during the day (typically 4-5 times a day) and before sleep
- Constipation may cause a child to wet the bed more
- Bedtime toilet routine (double micturition) with easy access to toilet, switch off lights and TV (light may be a factor which inhibits vasopressin), use a torch to find way to toilet if wakes in night
- Childs responsibilities i.e. drinking, recording fluids / dry nights, changing bed etc. Think positive
- Parents responsibilities i.e. stop nappies, stop lifting, encouragement, protective bed coverings etc
- Monitor progress, give charts to record and praise any progress
- Clinic nurse to offer contact details for advice if required with next appointment date
- Any deviation from primary nocturnal enuresis refer to Community Paediatrician / Enuresis Nurse Specialist for the next appointment

Assessing progress:

- ✓ Child is drinking regularly throughout the day with increased fluid intake (6-8 mug sized drinks)
- ✓ Bed is less wet
- ✓ More dry nights
- ✓ Child wakes to full bladder sensation
- ✓ Child / parent satisfied with progress
- ✓ Increase in functional bladder capacity
- ✓ Child sleeps through night and bed remains dry

Key priorities for implementation of NICE clinical guideline 111

Principles of care:

- Inform children and young people with bedwetting Inform children and young people with bedwetting and their parents or carers that bedwetting is not the child or young person's fault and that punitive measures should not be used in the management of bedwetting.
- Offer support, assessment and treatment tailored to the circumstances and needs of the child or young person and parents or carers.
- Do not exclude younger children (for example, those under 7 years) from the management of bedwetting on the basis of age alone.

Assessment and investigation:

- Discuss with the parents or carers whether they need support, particularly if they are having difficulty coping with the burden of bedwetting, or if they are expressing anger, negativity or blame towards the child or young person.

Planning management:

- Consider whether or not it is appropriate to offer alarm or drug treatment, depending on the age of the child or young person, the frequency of bedwetting and the motivation and needs of the child or young person and their family.

Advice on fluid intake, diet and toileting patterns:

- Address excessive or insufficient fluid intake or abnormal toileting patterns before starting other treatment for bedwetting in children and young people.

Reward systems:

- Explain that reward systems with positive rewards for agreed behaviour rather than dry nights should be used either alone or in conjunction with other treatments for bedwetting. For example, rewards may be given for:
    - Drinking recommended levels of fluid during the day
    - Using the toilet to pass urine before sleep
    - Engaging in management (for example, taking medication or helping to change sheets).

Initial treatment:

- **Offer an alarm** as the first-line treatment to children and young people whose bedwetting has not responded to advice on fluids, toileting or an appropriate reward system, unless:
    - An alarm is considered undesirable to the child or young person or their parents and carers **or** an alarm is considered inappropriate, particularly if: bedwetting is very infrequent (that is, parents or carers are having emotional difficulty coping with the burden of bedwetting the parents or carers are expressing anger, negativity or blame towards the child or young person.
- **Offer Desmopressin** as first-line treatment to children and young people over 7 years, if: rapid-onset and/or short-term improvement in bedwetting is the priority of treatment **or** an alarm is inappropriate or undesirable.

Lack of response to initial treatment options:

Refer children and young people with bedwetting that has not responded to courses of treatment with an alarm and/or Desmopressin for further review and assessment of factors that may be associated with a poor response, such as an overactive bladder, an underlying disease or social and emotional factors.

Drinks Chart

Collecting 'baseline' information is a useful process, from the completed chart, the following information may be determined:

- Their **attitude** to monitoring information and keeping records of progress
- Whether there is an obvious relationship between **type of drink** before sleep and bedwetting. There are marked variations in which evening drinks increase a child's vulnerability to wetting the bed. They can be encouraged to discover which (if any) drinks they are vulnerable to, by completing the 'Drinks Chart'. The child is asked to record the type of drink they had during the 1½ hours leading up to bedtime. In the morning they should note on the chart whether they were dry or, if wet, the extent of the wet patch (small, medium or large). Should a pattern emerge indicating a certain drink may influence bedwetting, the child should be encouraged to adjust their drinking pattern accordingly
- The possibility of lack of **vasopressin release** as a cause of the bedwetting, indicated by wetting (if large patches) during the early part of the night (at parents check)
- The child's **ability to wake** in terms of whether they wake to toilet. Evidence of wake-ability is important in deciding on using an enuresis alarm
- **Severity** of bedwetting. Children who wet twice or more in one week are likely to continue bedwetting unless they receive a treatment intervention designed to meet their needs

The **Drinks Chart** is also useful for longer term monitoring to assess progress, an increase in fluid volumes, a decrease in wetting and an increase in dry nights

3.7 Hand out – Drinks Chart Examples

Bladder and Bowel Diary
Nocturnal Enuresis Clinical Management Tool

📖 PIL102 – Drinks Chart.
📖 PIL103 – Drinks Chart (empty Glasses)

3.8 11 Steps to Develop Bladder Control

Aim:

- To explore ideas with children and parents as to what they might DO to increase the chances of being dry at night

Age:

- From 5 years

Method:

- Find out what children and parents are doing at present to encourage dry nights
- Use the information below to discuss the best methods of management
- Provide children and patents with a copy of **'11 steps to developing bladder control'**

THE 11 STEPS TO DEVELOPING BLADDER CONTROL:

1) Increase daytime fluid intake

- Many children drink very little during the day. They may believe drinking causes wetting, when the opposite appears to be the case. Fluid restriction can lead to the bladder storing low urine volumes and bladder over-activity. The bladder needs to fill and empty regularly in order to function well
- Children should be encouraged to drink regularly throughout each day (150-200mls / 6-8 drinks spaced at regular intervals during the day)

2) Toilet regularly during the day

- There are two distinct patterns of voiding difficulties:
  - Those who void frequently, usually small volumes, often associated with bladder over-activity
  - Those who postpone voiding
- For both groups it is important to encourage a regular voiding pattern. It may be useful to suggest the child goes to the toilet each break time at school and every 2-3 hours at home, or go to the toilet to pass urine each time they have a drink
- Regular toileting is sometimes called 'normalising voiding'. It has been shown to improve the chances of a child developing better bladder control and thus improve the chances of becoming dry. Regular voiding increases 'cognitive control' over the bladder, allowing the child to plan when to void rather than relying on signals from an often over-active bladder

3) Measure and monitor voided volumes

- Low voided volumes are related to bladder over-activity. To measure maximum voided volume, ask the child to void into a measuring jug during the day when he or she senses bladder fullness. Avoid early morning measure as bladder capacity during sleep appears to be larger than during the day. Comparing the child's maximum void with the expected voided volume will give an indication as to whether the child's bladder only holds low volumes of urine
- Expected maximum voided volume in mls is the child's age+1 x 30
- Monitoring voided volumes (possibly once a week) can be a useful way to determine if bladder retraining (increasing daytime drinking and regular daytime voiding) is working

4) Have a small drink before bed

- Restricting drinks before bed is rarely helpful. It is usually fine to have a small drink during the 1 ½ hours before bed

- Some drinks may not be ideal, but check these out with each child before suggesting they be avoided. Encourage children make a note of the drinks they have to see which, if any, influences whether they are wet or dry in the morning

5) Empty the bladder before sleep

- This is one element of taking responsibility. A child may feel dependant upon parents or a sibling to make decisions about their behaviour and bladder control. If a child read before sleep or watch TV in bed they may 'forget' to empty their bladder before they drop off to sleep
- Place a small note by the bedside to remind the child to empty their bladder before sleep

6) Switch off lights and TV

- Light may be a factor which inhibits vasopressin release. A child might be encouraged to try sleeping in the dark to see if it improves the chances of being dry
- Let the child have a torch to help use the toilet if he or she wakes in the night
- For those children who achieve some dry nights interspersed between the wet nights, it can be useful to try and monitor if any factors are associated with the dry nights, particularly if the child sleeps through the night

7) Make sure you are warm enough in bed

- Some children fail to have significant covers on the bed or resist leaving the bed to toilet after waking up because they feel they will become cold
- It is important to talk with the child about practicalities that might improve the chances of waking to use the toilet

8) Positive thinking

- Many children unintentionally go to bed with a negative thought. Statements which contain 'not' such as 'I won't wet tonight' focus on wetting and direct the mind to the very thing the child does not want to do!
- It is important to phrase any self-statement positively. Help the child to consider statements which 'instruct' them what to do. Examples include
    - 'I'll be dry tonight'
    - 'I'll wake up for a wee if my bladder becomes full'

9) No lifting

- Over 90% of parents indicate that they have tried lifting. Unfortunately whilst it may appear logical, it may actually maintain the bedwetting. The problems with lifting are:
    - If the child is not woken fully, voiding during sleep is encouraged
    - If woken, the child's bladder is unlikely to be full, therefore denying the child the chance to experience a full bladder and learn to wake to the signals
- Encourage parents to refrain from lifting. Should they wish to continue, urge them to ensure the child is awake, vary the time and use only as a short term measure. A better option will always be a treatment directed at helping the child develop the 'Three Systems'

10) Toilet if you wake

- Many children will wake to a full bladder but resist leaving the bed they turn over, go back to sleep and wet. Cold, darkness or non-availability of the toilet are some of the reasons why children resist toileting.
- Helping the child to leave the bed if they wake to a full bladder can be accomplished by considering:
    - A torch by the side of the bed
    - A dressing gown hung on the bed
    - A receptacle in the room for voiding into

11) Monitor progress

- There are numerous charts which can help children monitor their progress, or encourage them to design their own
- Children often like to please professionals by bringing along a chart to show their improvement. It is therefore important to select or design a chart which will pick up on the child's progress – the behaviour he or she is beginning to display. As a professional it is imperative to try and find something positive to focus on
- Always feedback to the child the progress they are making
- Another important element is to find out with the child **why** he or she is making progress. It is useful to use 'The Three Systems' approach. For example:
    - Waking to the toilet indicates improvement in arousing to the sensation of a full bladder
    - Sleeping through the night indicates the development of the vasopressin system

From Butler, RJ. (2006) **Nocturnal Enuresis Resource Pack;** ERIC 5th Edition

3.9 11 Steps to Bladder Control Handout

See 🕮PIL108 – 11 Steps to Bladder Control

3.10 🗎 Letter: Letter to GP – ENU 1

Dear GP

Re : Name – (dob/NHS no)
Address

The above named child has recently attended the Enuresis Clinic as a new patient.

The child has been fully assessed following NICE Enuresis Guidelines 2010 and Shropshire's Enuresis Policy and Care Pathway 2016.

Advice has been given on fluid intake, diet and toileting patterns, reward systems and initial treatments of Fluids, Alarm or Desmopressin.

He/she will be seen again in a few weeks' time.

Yours sincerely,

4. FOLLOW UP PROCESS

4.1 Understanding Nocturnal Enuresis

Three Systems Model:

The Three Systems approach helps professional to assess nocturnal enuresis. It also provides an explanation for children and parents', reiterating that bedwetting is not under the child's control. An appropriate assessment leads to relevant treatment interventions. Nocturnal enuresis can best be understood as a result of inappropriate functioning of systems that enable a child to stay dry

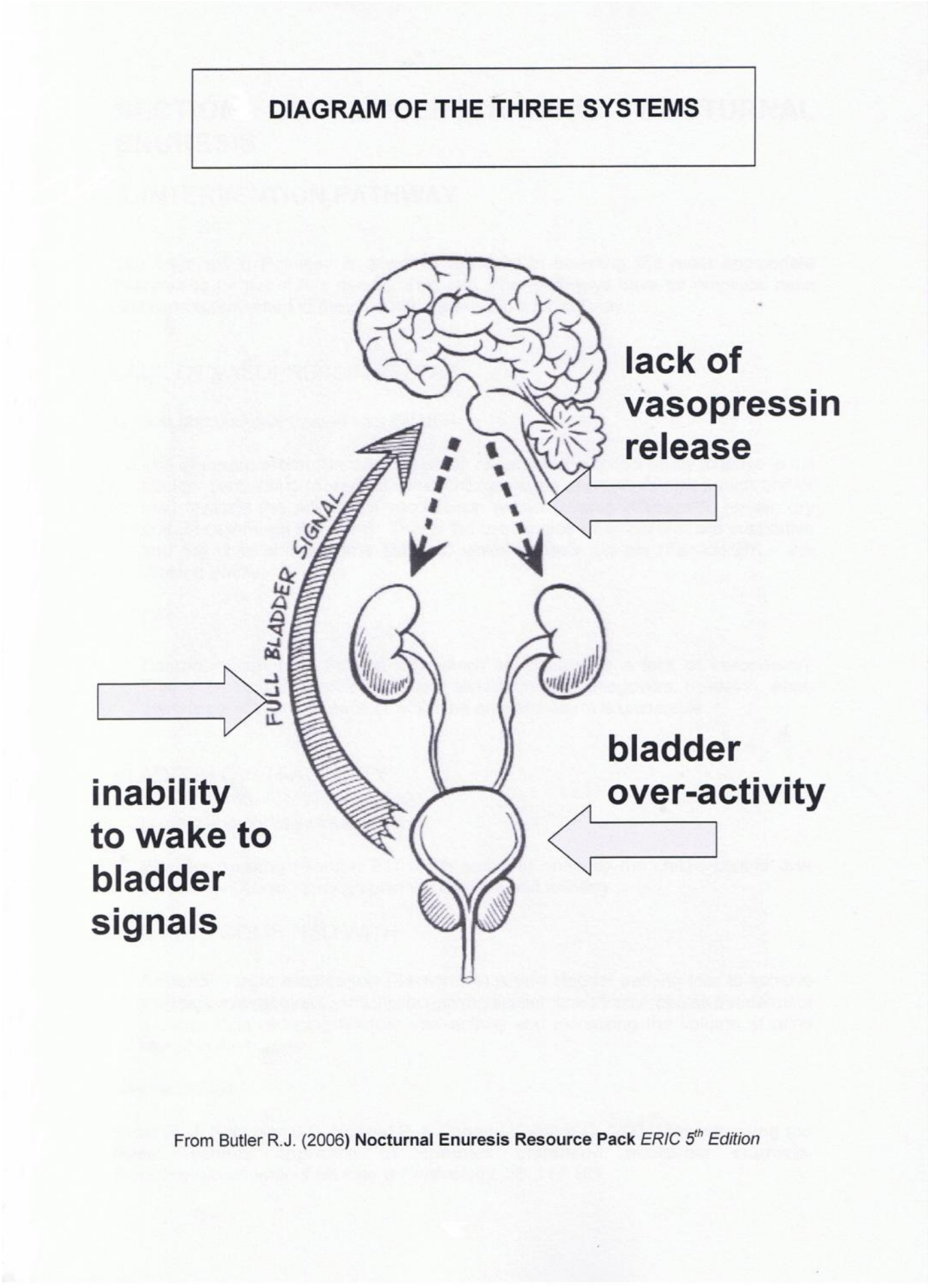
The Three systems are:

- **Lack of Vasopressin Release:** Arginine vasopressin (AVP) is naturally released from the hypothalamus – pituitary axis during sleep. It acts by stimulating the kidneys to concentrate urine, thus reducing the volume of urine during sleep. Many children who wet the bed fail to produce or release sufficient vasopressin during sleep resulting in the production of large volumes of dilute urine. The bladder soon becomes full, and if the child fails to wake to full bladder sensations, a wetting episode results. **Clinical signs of low vasopressin release include: wetting soon after sleep, consistently large wet patches, weak urine concentration.**

- **Bladder over-activity:** The bladder is essentially a storage organ, with the detrusor muscles of the bladder well relaxed during the filling stage. Once the bladder reaches its maximum volume, the detrusor muscles contract, which gives the sense of 'fullness'. Voiding results from full contraction of the detrusor muscles. For about 30% of children with nocturnal enuresis, the detrusor muscles contract before the bladder is full and without any awareness on the child's behalf. When such bladder over-activity occurs during sleep, the contractions may be strong enough to cause wetting. **Clinical signs of over-active bladder include: a sense of daytime urgency, frequent toileting (>7x/day), small voiding volumes of urine, small or variable sized wet patches, waking up immediately after wetting.**

- **Inability to wake to bladder signals:** Most non-enuresis children sleep through the night. However, if a child has low vasopressin release or bladder over-activity, staying dry requires them to wake to bladder sensations and void in the toilet. **Those with nocturnal enuresis find it very difficult to wake from sleep when the bladder is either full or over-active. The ability to wake up is not determined by depth of sleep.**

4.2 Three Systems Diagram



From Butler R.J. (2006) **Nocturnal Enuresis Resource Pack** *ERIC 5th Edition*

4.3 **Planning Management**

Key priorities for implementation of NICE clinical guideline 111

- Explain the condition, the effect and aims of treatment, and the advantages and disadvantages of the possible treatments to the child or young person and parents or carers.
- Clarify what the child or young person and parents or carers hope the treatment will achieve. Ask whether short-term dryness is a priority for family or recreational reasons (for example, for a sleep-over).
- Explore the child or young person's views about their bedwetting, including: what they think the main problem is whether they think the problem needs treatment.
- Explore and assess the ability of the family to cope with using an alarm for the treatment of bedwetting.
- Consider whether or not it is appropriate to offer alarm or drug treatment, depending on the age of the child or young person, the frequency of bedwetting and the motivation and needs of the child or young person and their family.

Offer information:

- That is tailored to the needs of the child or young person and their parents or carers
- About support groups
- About practical ways to reduce the impact of bedwetting, such as bed protection and washable or disposable products.

Treatment:

- Interventions offered should comprise of techniques based on adequate research demonstrating effectiveness or based on clinically accepted theory.
- Treatment used should be acceptable to the child, young person and their carers and should be discontinued if they become unacceptable.
- Treatment procedures and use of any equipment should be adequately explained and demonstrated in a manner and medium suited to the age and understanding of the child, young person and their family.
- Clear written instructions with visual aids will be given to the child, young person and their family to explain the treatment method.
- Clinic staff should obtain feedback that the information given has been understood.

5. Fluid intake, toileting and reward systems

5.1 Advice for the child or young person and family

Fluid intake, diet and toileting patterns:
Advise children and young people and their carers:

- That adequate daily fluid intake is important (see table below)
- That the amount of fluid needed varies according to the ambient temperature, dietary intake and physical activity
- That caffeine-based drinks should be avoided
- To eat a healthy diet and not to restrict diet to treat bedwetting
- About the importance of using the toilet to pass urine regularly during the day and before sleep (between four and seven times a day). Carers should continue to encourage regular toilet use alongside treatment.

NICE recommended fluid intake

Age (years)	Sex	Total drink intake per day (ml)
4 – 8 years	Female Male	1000 – 1400 1000 - 1400
9 – 13 years	Female Male	1200 – 2100 1400 - 2300
14 – 18 years	Female Male	1400 – 2500 2100 - 3200

Reward systems:

- Explain that reward systems should be used, either alone or with other treatments for bedwetting.
- Rewards should be given for agreed behaviour rather than dry nights, for example:
    - Drinking recommended levels of fluid during the day
    - Using the toilet to pass urine before sleep
    - Engaging in management (for example, taking medication or changing sheets).
- Inform carers that they should not use systems that penalise or remove previously gained rewards.

Lifting and waking:
Offer advice on lifting and waking during the night as follows:

- Neither lifting[1] nor waking[2] will promote long-term dryness.
- Waking should be used only as a practical measure in the short-term management of bedwetting.
- Young people with bedwetting that has not responded to treatment may find self-instigated waking (for example, using a mobile phone alarm or alarm clock) a useful management strategy.

Training programmes:
Do not use:

- Strategies that interrupt normal passing of urine or encourage infrequent urination during the day
- Dry-bed training[3] with or without an alarm.

Initial treatments

See NICE pathway – Planning management and initial treatment of nocturnal enuresis in children and young people algorithm (Enuresis Policy Appendix 4.3)

- Advise on fluid intake, diet and toileting behaviour
- Address excessive or insufficient fluid intake and abnormal toileting patterns before starting other treatments

[1] Lifting is carrying or walking a child to the toilet. Lifting without waking means that effort is not made to ensure the child is fully woken.
[2] Waking means waking a child from sleep to take them to the toilet.
[3] Dry-bed training is a training programme that may include combinations of a number of different behavioural interventions, and that may include rewards, punishment, training routines and waking routines, and may be undertaken with or without an alarm

- Advise on using a reward system
- Suggest a trial without nappies or pull-ups for children and young people wearing them at night.
- Offer advice on alternative bed protection
- Consider whether alarm or drug treatment is appropriate, depending on the age, maturity and abilities of the child or young person, the frequency of bedwetting and the motivation and needs of the family
- Assess the ability of the family to cope with an alarm
- If young child has some dry nights try a reward system alone. If bedwetting less than 1 to 2 times a week an alarm is inappropriate
- If bedwetting has not responded to advice on toileting and an appropriate reward system and alarm treatment is desirable and appropriate offer alarm as first line treatment in over 7 year olds and consider using it in children younger than 7 years
- If rapid-onset and / or short-term dryness is a priority **or** Alarm treatment is undesirable **or** Alarm treatment is inappropriate (particularly if parents or carers are having emotional difficulty coping or are expressing anger, negativity or blame) **Offer** Desmopressin for children and young people over 7 years. Consider Desmopressin for children aged 5–7 years if treatment is required.

5.2 BLADDER RETRAINING RATIONAL

The following information is taken from Nocturnal Enuresis and Daytime Wetting: A Handbook for Professionals 2007 (Butler & Swithinbank) Pages 46-47

Bladder retraining may be used for:

- Children aged five years and over
- To facilitate the child developing 'voluntary' control over the bladder
- When nocturnal enuresis is caused by bladder over activity

Method:

- This form of bladder retraining is designed to help children gain control over their bladder function.
- Advise the family to use bladder retraining and rewards alone for the initial treatment of bedwetting in previously untreated children

Advantages:

- Helps the child to focus on ensuring adequate fluids and regular toileting
- Useful for training children who are not conscious of the need to void
- Helps children and young people to engage with treatment (helping to change sheets, taking medication)

When using star / reward charts it is important to focus on the behaviour needing to be encouraged, for example, drinking regularly throughout the day or going to the toilet regularly. Rather than what the child has no control over i.e. the enuresis. When first using star charts it is important to reward the child each time they exhibit the desired behaviour (schedule of continuous reinforcement). To ensure this behaviour is maintained and to prevent the child becoming bored with the star chart then intermittent reinforcement (rewarding intermittently) is the most powerful schedule to help maintain the behaviour over time (Griggs 2008).

5.3 Handout Bladder retraining

📖PIL103 – Bladder retraining Handout

5.4 Reward Systems – Information

Children's record charts 5-7 years

Colour in charts

Aim:

- Colouring in charts may be used to engage younger children and encourage them to record their progress towards becoming dry

Age:

- 5-7 years

Method:

- Agree with the child and parent/s the aim of the chart, focussing on one objective at a time. The objective should be possible for the child to achieve (i.e. there should be evidence that the child already achieves the behaviour to some degree). It might be, for example, be to achieve:
    - Increased fluid intake
    - Increased day-time toileting
    - More regular toileting
    - Spontaneous use of the toilet

- Encourage the child to choose the chart they need to work on
- With the child write the objective on the chart, 'I can colour in a star or spot for……'
- A privilege or small reward negotiated with the parents is written, 'my reward for 10 will be……'
- Each time the child is success, he or she can colour in a spot/patch/star/etc
- When the child has filled 10 spot/patch/star/etc he or she gets the reward
- After successfully completing one chart they may wish to use a different chart or design their own to maintain interest

Adapted from Butler, RJ. (2006) **Nocturnal Enuresis Resource Pack;** ERIC 5th Edition

5.5 Hand Out - Colour In The Clown

📖PIL 105 – Colour in the Clown

5.6 Hand Out – Walk tall Like A Giraffe

📖PIL 106 – Walk Tall Like a Giraffe

5.7 Children's record charts 7 years + Information

Monitoring progress

Aim:

- This is a very straightforward chart and is particularly helpful either during baseline monitoring, bladder retraining or for monitoring progress with the enuresis alarm
- It requires minimum effort to complete but provides important information
- Linked to the 'Three Systems' model it provides the professional with information to feed back to the child – how he or she is developing the mechanisms that will ultimately ensure dryness

Age:

- 7 years +

Method:

- There are only 4 possibilities for each night, each represented by a column. The child is invited to record details in only ONE of the columns for each night:
    - Were they **DRY** and **slept through** the night? This suggests the child has on that night produced sufficient vasopressin
    - Were they **DRY** and **woke to toilet**? This suggest the child has demonstrated the ability to arouse form sleep when the bladder is full
    - Were they **WET** but **woke afterwards**? This suggests that when an alarm is being used, the child has responded to the alarm triggering. The child might be asked to record the time of waking to see if this changes over time
    - Were they **WET** and **slept through**, discovering the wet bed in the morning? This would suggest if an alarm is being used the child is not responding to the triggering, or that there is a fault in the alarms triggering device

Adapted from Butler, RJ. (2006) **Nocturnal Enuresis Resource Pack;** ERIC 5th Edition

5.8 Handout 7 Years + - Children's Record Chart

📖PIL107 – Monitoring Chart – 7 Years +

5.9 Letter: Fluid Letter to School

Dear

Re : _____
Address: _____

_____ is attending one of my clinics for a medical problem which requires a good fluid intake during the school day. His/Her parent is happy to supply the extra drinks to take to school and it is important that access is allowed to these drinks regularly through the day.

Given the nature of the problems it is likely that increasing their access to drinks in the daytime will result in the need for more frequent toileting and there may be a degree of urgency to this. Would you please allow him/her to visit the toilet when necessary and without drawing too much attention to this need.

6. Alarms

6.1 ALARM INFORMATION / RATIONAL FOR ISSUING

The following information is taken from Nocturnal Enuresis and Daytime Wetting: A Handbook for Professionals 2007 (Butler & Swithinbank) Pages 40 - 44

The enuresis alarm may be used:

- With children from five years, though special care is required with the younger group
- With mono-symptomatic nocturnal enuresis
- Where there is evidence that the child is able to wake to external stimuli at night
- With motivated children who are committed to becoming dry and are willing to take responsibility for the alarm
- With children whose parents are willing to engage and support their child (particularly support with waking)

There are two major types of alarm – the bed alarm (otherwise known as the 'pad and bell') and the body-worn alarm (sometimes called a 'mini' alarm). With both types there is a moisture sensor, contacted to a control or alarm unit. Urine triggers the alarm to sound; there are also vibrator options for both alarms. The purpose of all alarms is to 'alert and sensitise the body to respond quickly and appropriately to a full bladder during sleep', converting the signal from one of urination to that of urination and waking (Butler 2004).

The child generally reacts to the noise of the buzzer (as urination begins) by contracting the muscles of the pelvic floor (thus stopping the urine flow) and waking. When treatment starts to work, the child either wakes to the sensation of the full bladder before the alarm sounds or begins sleeping through the night without needing to empty the bladder (Butler & Robinson 2002).

Advantages:
Used properly there is an average initial success rate of 60-80%. Children successfully treated with an alarm are less likely to relapse compared to those treated with pharmacological interventions.

Disadvantages:
Some children may drop out of treatment, but effective selection, helpful feedback and good monitoring of process can reduce this. 15-30% children relapse, usually within six to twelve months of treatment, but can be re-treated successfully with the alarm.

Signs of progress:
Progress is likely to be uneven, but there should be some signs of progress within the first three weeks. Good signs are:

- The child waking consistently to the alarm triggering
- The child's involvement and participation, including completing the progress charts
- Spontaneous waking to toilet
- A reduction in the size of the wet patch, and more to 'finish off' in the toilet, indicating a good reaction of the urethral sphincter
- Later triggering of the alarm, which indicates either reduced urine production or increased bladder capacity
- An increase in dry nights. Some children acquire dry nights through a reduction in urine volume and others through 'waking up'.

Alarm treatment should continue until the child has been dry for a good sequence of dry nights (10 – 14). Potential relapse is best avoided by helping the child to focus on the dry nights and internalise success.

Key priorities for implementation of NICE clinical guideline 111

Alarm treatment
See NICE pathway – Alarm treatment for nocturnal enuresis in children and young people algorithm (Enuresis Policy Appendix 4.4)

- **Alarm treatment should be the first line treatment for enuresis except in the cases above where Desmopressin should be offered first line.**
- Do not exclude alarm treatment as an option for children and young people with:

    - Daytime symptoms as well as bedwetting
    - Secondary onset bedwetting
    - Hearing impairments (for example, consider a vibrating alarm)
    - Learning difficulties and/or physical disabilities
- Both body and bed alarms should be available as required, with clear written instructions on their use being issued with the alarm.
- A new detector or bed mat should be used for every child or young person including new batteries, used detectors should be double bagged and disposed of in a bin
- An equipment loan agreement will be signed by the child's / young person's carer; the original will be stored in the records and a copy given to the carer.
- A logging system will be used to identify issue, return and loss of alarms accompanied by a reasonable strategy to minimise alarm loss.
- On return the enuresis alarm will be inspected by the nurse and providing it is not contaminated will be cleaned using a clinical detergent and disinfectant wipe. If the alarm is contaminated with blood or mucus then the alarm must be disposed of and Child Health and Medical Engineering Service informed (SCPCT Cleaning and Disinfecting Policy V6 2010).
- Alarm equipment will be replaced every 5 years if regularly used.
- Alarm batteries, failed or damaged detectors, failed or faulty alarm equipment should be replaced within two weeks.

Using alarms with reward systems

- Inform children and young people and their carers about the benefits of combining alarm treatment with a reward system using rewards for desired behaviour (for example, waking up when the alarm goes off, going to the toilet, returning to bed and resetting the alarm).
- Encourage children and young people and their carers to discuss and agree their roles and responsibilities for using alarms and rewards.

Alarm information, advice and support

Ensure that advice and support for using an alarm are available, and agree with the child or young person and their carers how this should be obtained. They may need a considerable amount of help when learning how to use the alarm.

Inform the child or young person and their carers:

- Of the aims of alarm treatment
- That alarms have a high long-term success rate
- That using an alarm needs sustained commitment, involvement and effort
- That using an alarm can disrupt sleep, and their carers may need to help the child or young person to wake to the alarm
- That they are not suitable for all families
- That they will need to record their progress
- About what to do when the alarm goes off, how to set, use and maintain the alarm, and how to manage problems
- That it may take a few weeks before the alarm starts to have an effect, and it may take weeks before dry nights are achieved
- That they can restart using the alarm immediately, without consulting a healthcare professional, if bedwetting starts again after stopping treatment
- How to return the alarm when they no longer need it.

Alarm response

- The response to the alarm should be assessed at 4 weeks looking for early signs of response which may include – smaller wet patches, waking to the alarm, the alarm going off later and fewer times per night and fewer wet nights
- If there is no response but child or young person and their parents or cares wish to continue then offer Desmopressin with the alarm or Desmopressin alone if they wish to stop the alarm
- If there is a response should continue with the alarm until 2 weeks uninterrupted dry nights achieved

Alarm Progress

- Progress should be assessed at 3 months if bedwetting improving and child and parents or carers motivated to continue can continue
- If no progress either add Desmopressin to alarm if wish to continue with alarm or offer Desmopressin alone

Assessing the Problem - The Waking Profile

Background:

- Research suggests that alarm treatment is most effective when children react to the alarm triggering. Although it is important for parents / carers to wake the child if they fail to wake, the 'waking profile' enables an assessment of the child's wakability.

Method:

- It is explained that it would be interesting to know whether the child is able to wake at night to anything. The child is asked whether they tend to wake to a variety of stimuli, responding with 'never', 'sometimes' or 'often'

Interpretation:

- Although the profile is not scored as such, the greater the extent of the child's wake-ability, the more likely they will respond effectively to the alarm. The implications for waking to particular stimuli are;
    - Wake to wee – the child might be encouraged to increase their waking to bladder sensations through praise and positive reinforcements
    - Wake-to-wee but go back to sleep – it is worth trying to understand what might prevent the child from using the toilet (e.g. dark, cold, fear, inaccessibility of toilet) and addressing these appropriately

6.2 Waking Profile Chart

📖PIL 112 – Waking Profile Chart

6.3 Enuresis Equipment Loan

📄SN 104 – Enuresis Alarm Loan Form

6.4 Enuresis Alarm

📖PIL 113 –Enuresis Alarm

6.5 Alarm progress chart 5-7 years +

Aim:

- This chart is designed to be used with an alarm. As it may be a few weeks before dry nights are achieved, its aim focuses upon small steps of progress, and thereby maintaining a positive attitude
- This chart is quite comprehensive in the amount of detail it requires. However each column should be explained to the child / young person and the reasons such information is needed. There should be signs of progress during the first three weeks of treatment with an alarm. If there are no signs of progress in this time, there should be serious considerations as to whether the alarm is the most appropriate treatment at this time

Age:

- 5 – 7 years +

Method:

- The chart covers fourteen nights, which is the recommended interval between supervision sessions
- There is a comments column so the child or parent can make notes
- The chart monitors the following aspects:
    - The occurrence of dry nights. Wet nights are not recorded. If on the dry night the child sleeps through, it indicates the release of natural vasopressin
    - Self-waking, or spontaneous waking by the child to use the toilet, which suggests the development of awareness of bladder signals and waking to these signals
    - The time of the alarm triggering. If these become alter in the night, it suggests either that the child is developing an enhanced release of vasopressin or there is an increase in the volume of urine stored in the bladder
    - Whether the child woke to the alarm (yes / no). Successful treatment will depend on the child's sensitivity and responsiveness to the alarm triggering. If the child does not wake consistently to the alarm triggering then the progress can be slow. A range of interventions might help improve the child's response to the alarm triggering:
        - Encourage the parents to wake the child up quickly. Switching off the alarm should be the child's responsibility
        - Enhance the importance of the alarm signal by suggesting that we sleep through some sounds that are not important (e.g. traffic noises) but wake to signals that are important (e.g. feeling poorly, thunderstorms, a clock alarm when we are going on holiday). If we can assist the child to believe that the alarm is an important signal, his or her chances of waking to the alarm are enhanced
        - Develop the skill of waking to the alarm by self suggestion, such as 'I will wake quickly if the alarm goes off', just before dropping off to sleep
    - The size of the wet patch (small, medium, large). Smaller patches suggest the child is responding quickly to the alarm being triggered
- Progress should be fed back and explained to the child and parent. This encourages them to persist with the treatment

Adapted from Butler, RJ. (2006) **Nocturnal Enuresis Resource Pack;** ERIC 5th Edition

6.6 Handout: Alarm Progress Chart

See 🕮PIL 115 –Alarm Progress Chart

7. Desmopressin

7.1 DESMOPRESSIN INFORMATION / RATIONAL FOR PRESCRIBING

The following information is taken from Nocturnal Enuresis and Daytime Wetting: A Handbook for Professionals 2007 (Butler & Swithinbank) Pages 45 – 46

May be used:

- For children aged five and over
- With mono-symptomatic nocturnal enuresis
- Where there are signs of low vasopressin production (large wet patch on the bed; wetting early in the night)

Desmopressin is a synthetic analogue of the naturally occurring anti-diuretic hormone arginine vasopressin (AVP). Its mode of action is through decreasing urine production and increasing urine concentration. It is available as a tablet (Desmotabs) which is swallowed with a small amount of water, or as a melt (DesmoMelt) that rapidly dissolves when placed under the tongue. It is only available on prescription. The starting does is a 0.2 mg tablet or a single 120mcg Melt taken as late as possible in the evening, after emptying the bladder. The dose may be increased to two 0.2 mg tablets or 240mcg Melt should the lower dose prove ineffective. The effectiveness of Desmopressin has been found to be enhanced in the following situations:

- The older child
- Less severe wetting in terms of number of wet nights / week
- Normal maximum voided volumes
- Primary as opposed to secondary enuresis
- Wetting soon after sleep – during the first two hours of sleep

Mode of action:
Although it is understood that Desmopressin acts by reducing urine production and increasing urine concentration some work also suggests that Desmopressin also increases arousability. Lackgren et al (1998) found over 70% of individuals treated with Desmopressin became dry by waking from sleep to void. However, it may be that by reducing urine volume, Desmopressin shifts the point at which the bladder becomes full to the early morning, when arousal from sleep is easier for the child (Wolfish 1999).

As there is no effect on endogenous AVP secretion, Desmopressin can be safely used long-term (van Kerrebrock 2002), but it is recommended that after three months a break is taken to establish the need for continued use, at least one week is recommended by the product licence.

Advantages:

- About one third of children with nocturnal enuresis, in unselected groups, treated with Desmopressin became completely dry whilst taking the medication; another third experienced 50% or more reduction in wetting frequency, while a third showed little, if any, response (Terho 1991). In more selected groups, effectiveness is significantly enhanced, with 70% success rate in children with primary mono-symptomatic nocturnal enuresis, whilst taking Desmopressin.

- Desmopressin has an almost immediate effect and lasts for five to nine hours. It is therefore, particularly useful in situations where an immediate resolution is preferred e.g. families in distress; parental intolerance; short breaks away from home

Disadvantages:

- As Desmopressin alleviates rather than remedies the problem there is a high relapse rate. Stopping the medication causes a relapse rate of approximately 75%. However, there is some evidence that the relapse rate can be reduced by using a schedule of withdrawal.

- It is, however, necessary to inform children and parents that fluid intake should be reduced to a minimum from one hour before administration – only to satisfy thirst (max 240ml) and for up to eight hours after taking the drug. This is because of the rare possibility of hyponatremia, or water intoxication, should the child drink excessively just prior to taking the Desmopressin, or drink excessively during the night. This is particular concern to teenagers who may socialise having taken the tablet or children who go swimming and swallow water

- Other reported side effects include headaches and stomach ache. But the reported prevalence of side effects is low, as Desmopressin mimics a normal physiological process and is being used as a replacement therapy. Even during long term treatment, side effects are rarely reported.

Additional information:

- Clinic staff must read the product characteristics before recommending Desmopressin
- Clinic staff must ensure the parent is aware that DesmoMelt is available in doses of 120mcg and 240mcg. Particular care must be given when discussing Desmopressin has already been prescribed by the GP
- Desmopressin must be discontinued during a bout of vomiting or diarrhoea
- Side effects must be explained to the parent and child and a patient information leaflet given to the family

Key priorities for implementation of NICE clinical guideline 111

Desmopressin treatment

See NICE pathway – Desmopressin treatment for nocturnal enuresis in children and young people algorithm (Enuresis Policy Appendix 4.5)

- **Desmopressin should be used as first line treatment if an alarm is undesirable or if short term dryness is the priority.**
- Desmopressin should not be excluded as a treatment option for children and young people with:
    - Daytime symptoms as well as bedwetting, however do not use Desmopressin for children and young people who only have daytime wetting
    - Sickle cell disease, if they can comply with night-time fluid restriction. Provide advice about withdrawal of Desmopressin at times of sickle cell crisis
    - Emotional, attention or behavioural problems or developmental or learning difficulties, if they can comply with night-time fluid restriction.
- Desmopressin should be started at a dose of 200 micrograms of Desmotabs or 120 micrograms of Desmomelts. If complete dryness is not achieved in 1-2 weeks then the dose can be increased to 400 micrograms of Desmotabs or 240 micrograms of Desmomelts
- Desmopressin can be used if alarm treatment has not worked, either alone or in combination with an alarm see above
- Desmopressin is contraindicated if there is cardiac insufficiency and in other conditions treated with diuretics. It is also contraindicated in psychogenic polydipsia and polydipsia in alcohol dependence

Desmopressin information and advice

Inform the child or young person and their carers:

- That many children and young people will experience a reduction in wetness, but many relapse when treatment is withdrawn
- How Desmopressin works
- Of the importance of fluid restriction from 1 hour before and until 8 hours after taking Desmopressin
- That it should be taken at bedtime
- How to increase the dose if the response to the starting dose is not adequate
- That treatment should be continued for 3 months and then withdrawn to assess response
- That repeated courses can be used. Desmopressin should be withdrawn gradually if using repeated courses

Clear written instructions, with visual aids to explain the use of medication and potential side effects will be given to the child, young person and their family

For children and young people being treated with Desmopressin, do not routinely measure:

- Weight
- Serum electrolytes
- Blood pressure
- Urine osmolality

Desmopressin response

The response should be assessed at 4 weeks

- If there is a response (which may include smaller wet patches, fewer wetting episodes per night and fewer wet nights) it can be continued for 3 months.
- If there is no response or only a partial response consider advising that Desmopressin is taken 1- 2 hours before bedtime instead of at bedtime if they can comply with fluid retention. If not then stop Desmopressin
- If partial or no response to Desmopressin consider referral to doctor for further review and assessment of factors associated with poor response .e.g. overactive bladder, underlying disease or social and emotional factors

Consider alarm treatment as an alternative to continuing drug treatment for children and young people who have recurrences of bedwetting, if an alarm is now appropriate and desirable.

Perform regular medication reviews for children and young people on repeated courses of drug treatment for bedwetting.

Desmopressin partial response

- Consider continuing treatment for bedwetting that has partially responded to Desmopressin combined with anitmuscarinic medication, as bedwetting may further improve for up to 6 months.
- Consider repeated courses of Desmopressin combined with anitmuscarinic medication for bedwetting that recurs repeatedly after successful treatment with Desmopressin combined with anitmuscarinic medication

7.1 Letter: Desmo Course

Dear Dr.

Re:

As you know, ……. has nocturnal enuresis and has been attending the Community Enuresis Clinic. During a recent visit, Doctor/Nurse discussed the use of Desmopressin.

I would be grateful if you would consider prescribing a course of Desmopressin (Desmotabs – 200 micrograms / DesmoMelt – 120 micrograms), at a starting dose of 1 tablet/melt at bedtime.

Advice has been given that if, after a week of usage, there is no effect from the 1 tablet / melt starting dose, this can be increased to 2 tablets / melts or 1 x 240 micrograms melt.

The need for limiting fluids from 1 hour before until 8 hours after administering the medication has been emphasised.

I have asked his/her parent/guardian to contact the surgery.

The child will be reviewed regularly and 4 weeks after commencing treatment.

Thank you for your help.

Yours sincerely,

7.2 Letter: Desmo Holiday

Dear Dr.

Re:

As you know, ……. has nocturnal enuresis and has been attending the Community Enuresis Clinic. During a recent visit, Doctor/Nurse discussed the use of Desmopressin for holidays, school trips etc.

…… is about to go and stay away from home, and I would be grateful if you would consider prescribing a course of Desmopressin (Desmotabs – 200 micrograms / DesmoMelt – 120 micrograms) to cover this trip, at a starting dose of 1 tablet / melt at bedtime, starting 2 or 3 days before and continuing for the duration of the trip.

Advice has been given that if, after a week of usage, there is no effect from the 1 tablet / melt starting dose, this can be increased to 2 tablets / melts or 1 x 240 micrograms melt.

The need for limiting fluids from 1 hour before until 8 hours after administering the medication has been emphasised.

I have asked his/her parent/guardian to contact the surgery.

The child will be reviewed regularly and 4 weeks after commencing treatment

Thank you for your help.

Taking DesmoMelt*
Patient Information

About primary nocturnal enuresis

Primary Nocturnal Enuresis (PNE) is the name given to the condition in which your child has always wet the bed. It can happen when your child's natural control of night time urine production doesn't develop quickly enough.

What is DesmoMelt?

DesmoMelt is a medicine prescribed for children with PNE.

The body controls urine production with a substance called vasopressin, which acts on the kidneys to reduce the production of urine so that it takes longer to fill the bladder. Children with PNE may not yet have developed the ability to make enough vasopressin at night.

The active ingredient in DesmoMelt is called desmopressin, and it is very similar to natural vasopressin. So, by prescribing DesmoMelt your doctor is helping to normalise your child's night time urine production.

Why treat now?

Bed wetting can be a traumatic and humiliating experience for a child and may lead to lowered self-esteem. As children get older and interact more with other children and adults they can become very distressed by continued wet nights. It can also lead to frustration and stress for parents too.

By treating quickly without undue delay, you and your doctor can help restore normality to a child's life and future development.

Taking DesmoMelt

DesmoMelt is taken by placing it under the tongue. Your doctor will tell you how long your child should continue taking DesmoMelt.

Do not adjust the dose yourself. Tell your doctor if you think the effect is too weak or too strong.

Fluid intake must be limited to a minimum from one hour before until 8 hours after taking DesmoMelt, because it works by holding back water in the body overnight. Although it is very rare, too much fluid in the body can lead to problems that may need medical attention. If you experience an unusually bad or prolonged headache contact your doctor, nurse or pharmacist.

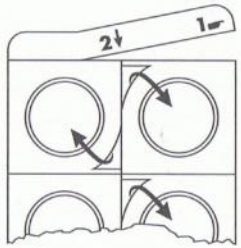
What can I expect?

Some children experience dry nights very soon after starting DesmoMelt. If there is no improvement the doctor may adjust the dose. Treatment is normally reviewed every three months. Those who do well with DesmoMelt will normally continue for some time before their natural ability to control night time urine production 'catches up'.

Successful treatment may improve the quality of the child's life.

Opening instructions for DesmoMelt blister pack

1. Completely remove the end tab of a blister strip by tearing along the perforations, starting from the corner with the hand symbol.



2. Now remove one blister from the strip by tearing along the perforations.

3. Remove the foil on each blister, starting at the corner with the printed arrow, by peeling off the foil in the direction of the arrow.

4. Carefully take a melt out of its blister. Place the melt under the tongue and allow it to dissolve.

5. If a melt breaks into more than two pieces while you are taking it out of its blister, do not take the broken pieces. Take a melt from another blister.

FERRING
PHARMACEUTICALS

This leaflet is produced as a service to medicine by Ferring Pharmaceuticals Ltd
The Courtyard, Waterside Drive, Langley, Berkshire SL3 6EZ Tel: 01753 214800

Date of preparation: December 2005. DE/572/09/05

7.3 Schedule of withdrawal

Background: children taking medication, such as Desmopressin, are highly likely to relapse to bed wetting if medication is withdrawn suddenly. This chart schedules a gradual reduction of medication, which has been shown to be effective in reducing the extent of relapse. Studies have shown that the programme enables 70-75% of children to remain dry after the removal of Desmopressin.

Method:

- The withdrawal programme may be started after a **period of being dry** although it is wise to negotiate this time with the child and parents
- The **eight week programme** phases out the medication. On nights marked 'MED' the medication is given at the usual dose. On nights left blank, no medication is given. This is the window of opportunity to determine if the child can remain dry without medication.
- Dry nights are filled in by colouring the box. If the phasing out of medication appears too rapid, slow it down. On wet nights, the 'dry' box is not coloured
- For each night the child ticks (S) if he/she sleeps through or (W) if he/she wakes to use the toilet
- It is important to watch for achievement of dry nights on 'non medication' nights. The **important feedback** is:
    - The child has been dry without medication – this should '**loosen' the link** in the child's mind between being dry and medication
    - The child is developing **'internal mechanisms' to stay dry** – either by producing vasopressin (if he/she sleeps through) or is waking to full bladder sensations (if he/she wakes to void)
- Week 9 and 10 are monitored to check the degree of success when the child is off medication

7.4 Desmopressin Schedule of Withdrawal

📖PIL 116 – Desmopressin Schedule of Withdrawal

8. SPECIALIST ENURESIS CLINICS

See NICE pathway – Further treatments of nocturnal enuresis in children and young people algorithm (Enuresis Policy Appendix 4.6)

- Children or young people with nocturnal enuresis in whom the alarm and or Desmopressin has not been successful should be discussed with the community paediatrician for consideration of further assessment and treatment.
- Children with daytime symptoms that have not responded to advice about fluids and regular voiding should be discussed with the community paediatrician for consideration of further assessment and treatment.

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Anitmuscarinic medication

- Consider Desmopressin combined with anitmuscarinic medication for children and young people who have been assessed by a healthcare professional with expertise in the management of bedwetting that has not responded to an alarm and/or Desmopressin and have any of the following:
    - Bedwetting that has partially responded to Desmopressin alone
    - Bedwetting that has not responded to Desmopressin alone
    - Bedwetting that has not responded to an alarm combined with Desmopressin
    - Who have been assessed by a healthcare professional with expertise in prescribing this combination and have daytime symptoms and bedwetting.
- Do not use anitmuscarinic medication:
    - Alone for children and young people with bedwetting without daytime symptoms
    - Combined with imipramine.
- Not all anitmuscarinic medications have a UK marketing authorisation for treating bedwetting in children and young people. If a drug without a marketing authorisation for this indication is prescribed, informed consent should be obtained and documented
- Inform the child and young person and parents or carers:
    - That success rates are difficult to predict, but more children and young people are drier with a combination of Desmopressin and anitmuscarinic medication than with Desmopressin alone
    - That the combination can be taken together at bedtime
    - That treatment should be continued for 3 months
    - That repeated courses can be used.

Imipramine treatment

- Imipramine is not recommended.

9. Follow up Letters

9.1 Letter: Follow Up Letter – to GP

Dear *GP*

Re : *Name – (dob)*
Address

The above named child was referred to the Enuresis Service.

They did not attend the 1st appointment. No further appointment will be sent.

9.2 Letter: Discharge Letter to GP– ENU3

Dear GP

Re: Name – (dob)
Address
School

The above named child has been attending the Enuresis Clinic.

He/She has failed to attend for two follow up appointments or has cancelled several appointments in close succession, and therefore has been discharged.

9.3 Letter: Discharge Letter to GP – ENU4

Dear GP

Re: Name – (dob)
Address
School

The above named child has been attending the Enuresis Clinic.

He/She is now reliably dry and therefore has been discharged.

9.4 Letter: Discharge Letter to GP – ENU5

Dear GP

Re: Name – (dob)
Address
School

The above named child has been attending the Enuresis Clinic.

He/She is resting from treatment and the parents have been asked to contact us in about 6 months if further intervention is required.

9.5 Letter: Follow up after DNA – ENU6

Dear Parent/Guardian,

……had an appointment at the Enuresis Clinic

on……..which was not attended.

Due to the demand for appointments at the Enuresis Clinic, we need to know whether you require a further appointment. To do this please contacts the Child Health Team within 14 days of the date of this letter. If we do not hear from you we will assume that you no longer wish to attend this clinic.

If your child has an enuresis alarm, Please contact us at the earliest opportunity to arrange to return your alarm. **Alternatively you could return the alarm to the enuresis clinic your child attended or to your child's school. Please ensure the alarm is addressed to the School Nurse and marked with your child's name, date of birth and address as soon as possible.**

9.6 Letter: Follow up After DNA 1st Appointment Letter – for parents ENU 7

Dear Parent/Guardian,

We are sorry we did not see…….for his/her first appointment at the enuresis (bedwetting clinic) on:…….

A second appointment is not automatically offered. If you wish to make a further appointment, please contact the Child Health Team within 14 days of the date of this letter. If we do not hear from you we will assume that you no longer wish to attend this clinic and your child will be will discharged from the clinic.

9.7 🗎 Letter: Follow up After Cancellation letter – for parents ENU 8

Dear

ENURESIS CLINIC - (BED WETTING CLINIC)

An appointment has been arranged for ..... to attend the Enuresis Clinic at ..... on ..... at .....

When you arrive, please wait in the main waiting room.

If you are unable to attend this appointment, please let us know as soon as possible by ringing (01743 - 450800), otherwise a further appointment will not be offered.

If I can be of any assistance to you prior to your appointment, please contact the above clinic telephone number.

9.8 Post Treatment Evaluation Form

Background:

The **Guidelines on Minimum Standards of Practice** suggests that parents /guardians be asked to record their opinion of the enuresis service.

Method:

- This form is designed for parents to complete and will provide information on most areas regarded as important to the delivery of the service
- Information can be summarised from a number of responses (and reported annually)
- In line with the **Guidelines on Minimum Standards of Practice,** the information should be used to improve the service in response to the evaluation

Shropshire Community Health NHS
NHS Trust

School Nursing Office
Osewstry Health Cdentre
Thomas Savin Road
Oswestry
Shropshire SY11 1GA

Telephone: 01691 663610

Post treatment evaluation form

What do you think of the service?

In our concern to develop and continually improve our ways of working, we routinely seek the opinion of those who have used the service. We would be grateful for you views on the service you have received and ask you to complete the following questions by ticking the response you feel to be most appropriate. Any further comments would be welcome in the spaces provided. All information given will be treated in the strictest confidence.

Q1 Was being referred to the enuresis service easy?

Yes ☐ *No* ☐

If no, please state any difficulties: _____ _____ ____

Q2 Were you provided with any information about the service before your first appointment?

Yes ☐ *No* ☐

Q3 Was this information helpful

Yes ☐ *No* ☐

If not, how could it be improved? _____ _____ ____

Q4 Was this information easy to understand

Yes ☐ *No* ☐

If not, how could it be improved? _____ _____ ____

Q5 What was the waiting time between being referred and being seen by the service?

1-2 wks	*2-4 wks*	*4-8 wks*	*8-12 wks*	*12-16 wks*	*more than 16 wks*
☐	☐	☐	☐	☐	☐

Q6 About appointments:

	Always	*Often*	*Sometimes*	*Never*
Were the appointment times made at a suitable time for you?	☐	☐	☐	☐
At the clinic, were you seen on time?	☐	☐	☐	☐

Q7 Was the time between appointments about right or too long?

About right ☐ *Too long* ☐

Q8 Please use the rating scale to record how you feel, where 1 is dissatisfied, and 5 is very satisfied

	1	2	3	4	5
Was the problem understood by your clinician?	☐	☐	☐	☐	☐
Were you given sufficient time in the sessions?	☐	☐	☐	☐	☐
Were your concerns and doubts listened to?	☐	☐	☐	☐	☐
Do you feel the treatment suggested was appropriate for your child?	☐	☐	☐	☐	☐
Did you feel involved in making choices about which treatment to use?	☐	☐	☐	☐	☐
Were you provided with instructions about treatment?	☐	☐	☐	☐	☐
Were the instructions easy to understand?	☐	☐	☐	☐	☐
Were you happy with the way progress was monitored using the charts?	☐	☐	☐	☐	☐
Was the treatment programme effective?	☐	☐	☐	☐	☐
Did your child respond as quickly as you had hoped to the treatment?	☐	☐	☐	☐	☐
If you used an alarm, were you satisfied with the instructions given?	☐	☐	☐	☐	☐

Q9 Were you provided with a contact number to ring in case you required help between appointments?

Yes	*No*
☐	☐

Q10 If you used an alarm, did you have any of the following faults:

	Often	*Sometimes*	*Rarely*	*Never*
Battery run down?	☐	☐	☐	☐
Complete breakdown?	☐	☐	☐	☐
Triggering to perspiration?	☐	☐	☐	☐

Q11 Please list any complaints you have about the service:

Q12 Please offer any suggestions below for improving the service:

THANK YOU

Angela Scull
School Nurse – Enuresis Lead

Thank you for taking the time to complete this questionnaire. Please return (using the envelope provided) to: Simon Savage, Clinical Audit Facilitator, Oak Lodge, William Farr House, Mytton Oak Road, Shrewsbury, SY3 8XL FREEPOST RRZR-SZAA-BUBZ

10. REFERENCES / ADDITIONAL INFORMATION / RESEARCH

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Nocturnal enuresis NICE clinical guideline 111

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Related NICE guidance

Constipation in children and young people NICE clinical guideline 99 (2010)

When to suspect child maltreatment. NICE clinical guideline 89 (2009)

Medicine adherence: involving patients in decisions about prescribed medicines and supporting adherence. NICE clinical guideline 76 (2009)

Urinary tract infection NICE clinical guideline 54

Type 1 diabetes NICE clinical guideline 15

Useful Websites

ERIC (Education and Resources for Improving Child-hood Continence) is dedicated to improving support for children and families affected by continence problems.
ERIC has recently launched a resource for schools with a special section for school nurses: 'Why me?'
Helpline for professionals, parents and children: 0845 370 8008
www.eric.org.uk

Water is Cool in School Campaign aims to improve the quality of provision and access to fresh drinking water for children in UK primary and secondary schools.
Tel: 01793 544 800
www.wateriscoolinschools.org.uk

Bog Standard is a campaign to promote better toilets for pupils:
Tel: 0117 960 3060
www.bog-standard.org

PromoCon aims to promote continence and product awareness, by providing impartial advice and information about products, equipment and services.
Helpline: 0161 832 2001
www.promocon.co.uk

Department of Health National Service Framework for Children, Young People and Maternity Services. Continence - One in a series of exemplar journeys (patient pathways), illustrating key themes in the National Service Framework for Children, Young People and Maternity Services. Gateway reference: 8797 (2 October 2007)
www.dh.gov.uk/childrensnsf

Childhood constipation.com, an information resource for parents, carers, health professionals and children.
www.childhoodconstipation.com

11. Handouts & Forms Referred to in this Document

11.1 Patient Handouts

PIL102 – Drinks Chart.
PIL103 – Drinks Chart (empty Glasses)
PIL 105 – Colour in the Clown
PIL 106 – Walk Tall Like a Giraffe
PIL 112 – Waking Profile Chart
PIL 113 –Enuresis Alarm
PIL 115 –Alarm Progress Chart
PIL 116 – Desmopressin Schedule of Withdrawal
PIL100 – Nocturnal Enuresis – A Guide for Parents
PIL101 – Choose your Poo
PIL103 – Bladder retraining Handout
PIL107 – Monitoring Chart – 7 Years +
PIL108 – 11 Steps to Bladder Control
PIL108 – Diagram of Urinary System
PIL110– The Three Systems Checklist
PIL111– Measuring Voided Volume 1
PIL118– Measuring Voided Volume 2

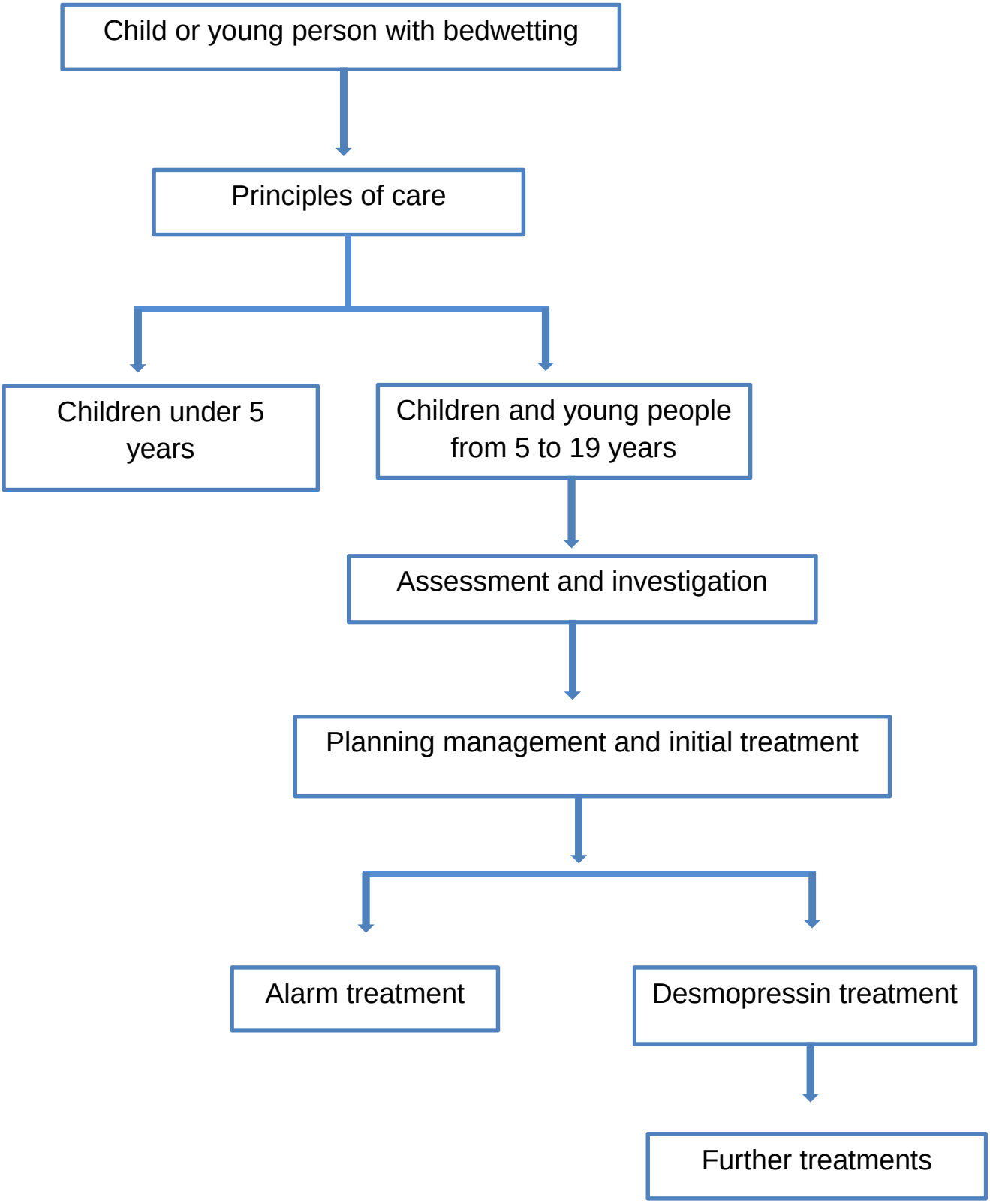
11.2 Clinical Patient Documents

SN100 – Enuresis Clinic Referral Form
SN102 Enuresis Assessment Form
SN 104 – Enuresis Alarm Loan Form

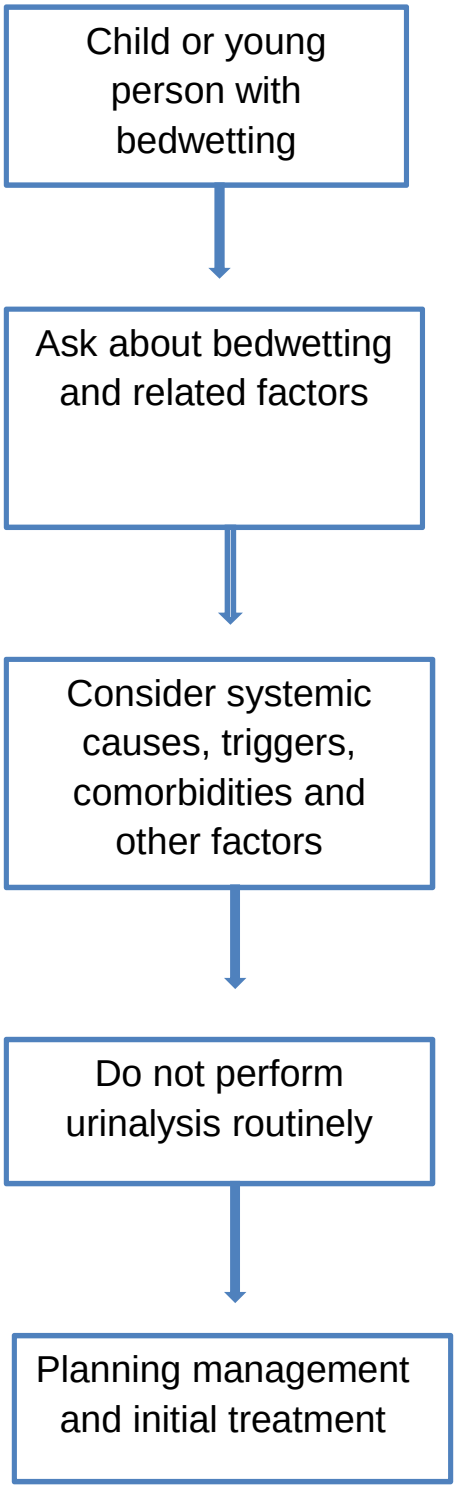
11.3 Forms Relating to Administration of the Service

Z101 – New Patient Appointment Sheet
Z102 – Clinic Administration / Appointment Sheet
Z104 – Clinic Resources Order Form

4.1 Bedwetting (nocturnal enuresis) in children and young people overview

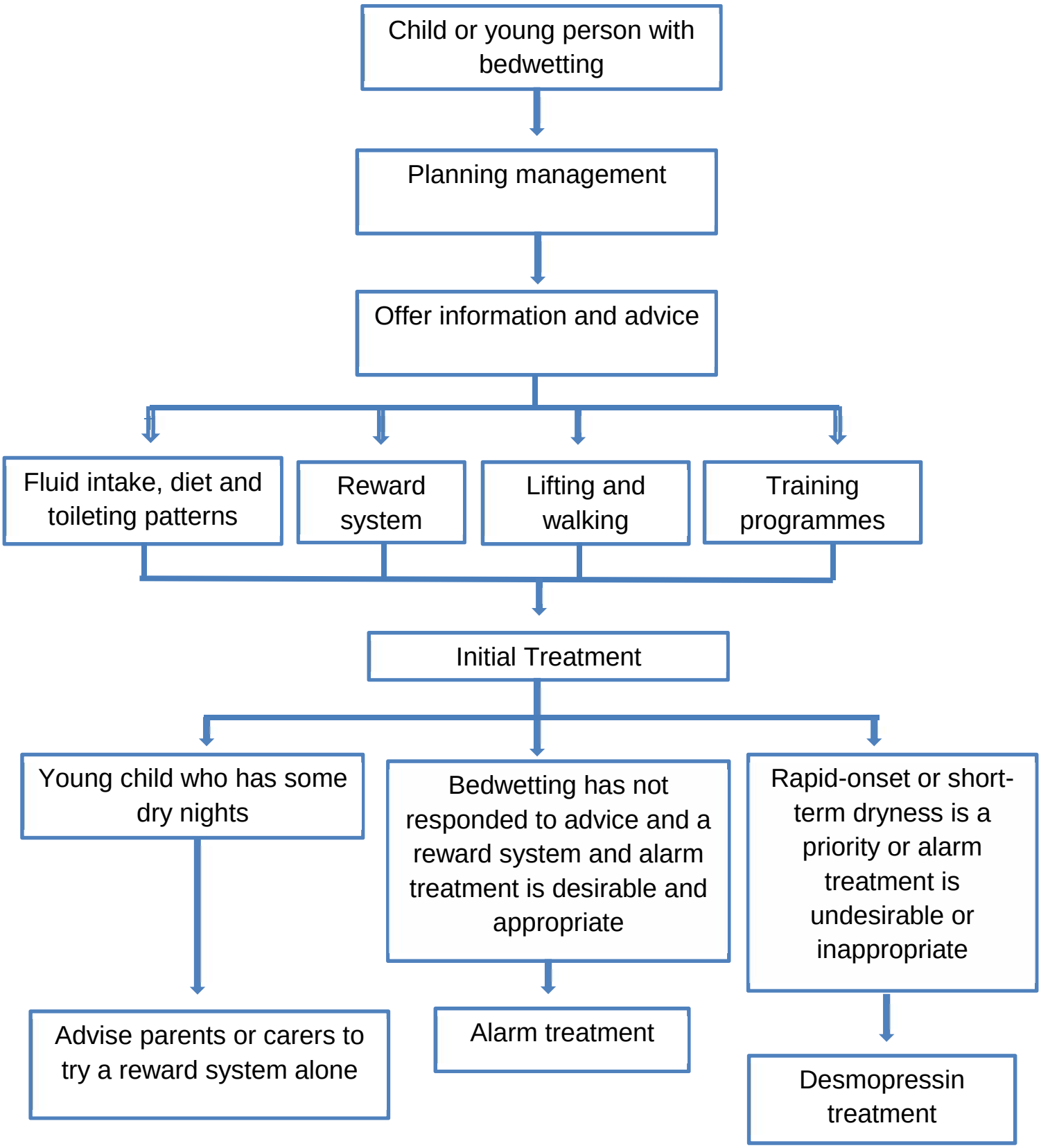


4.2 Assessment and investigation of nocturnal enuresis in children and young people

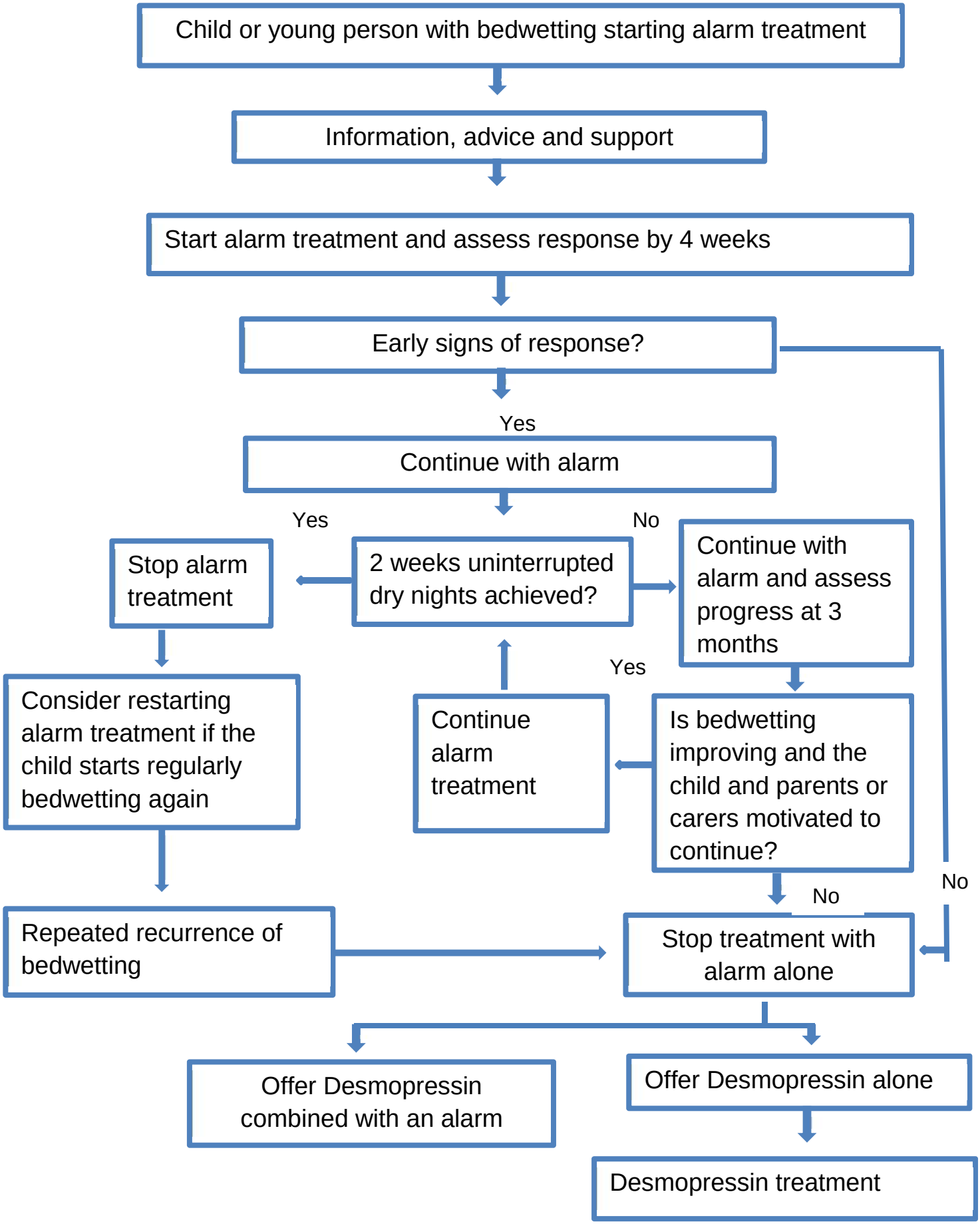


4.3 Planning management and initial treatment of nocturnal enuresis

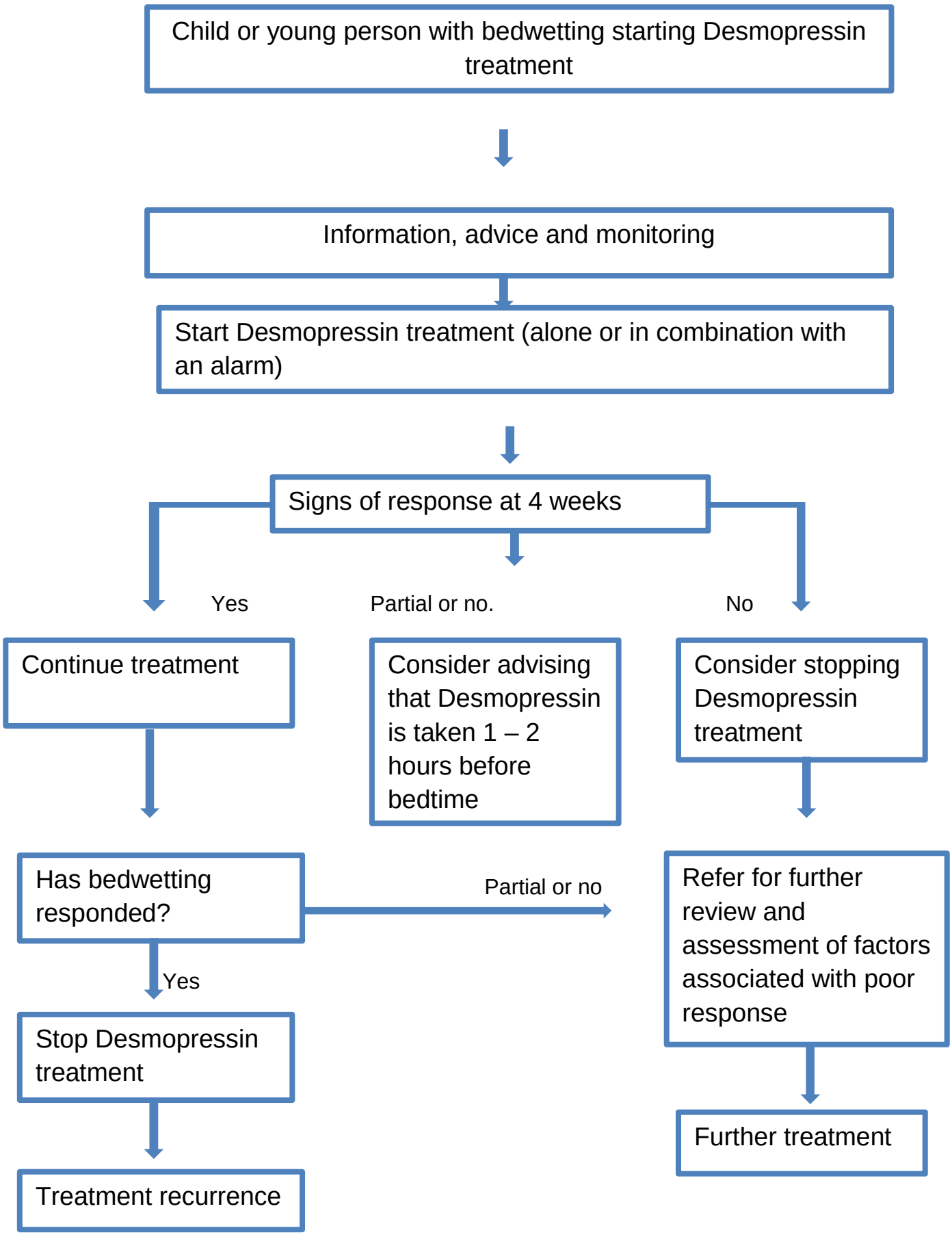
In children and young people



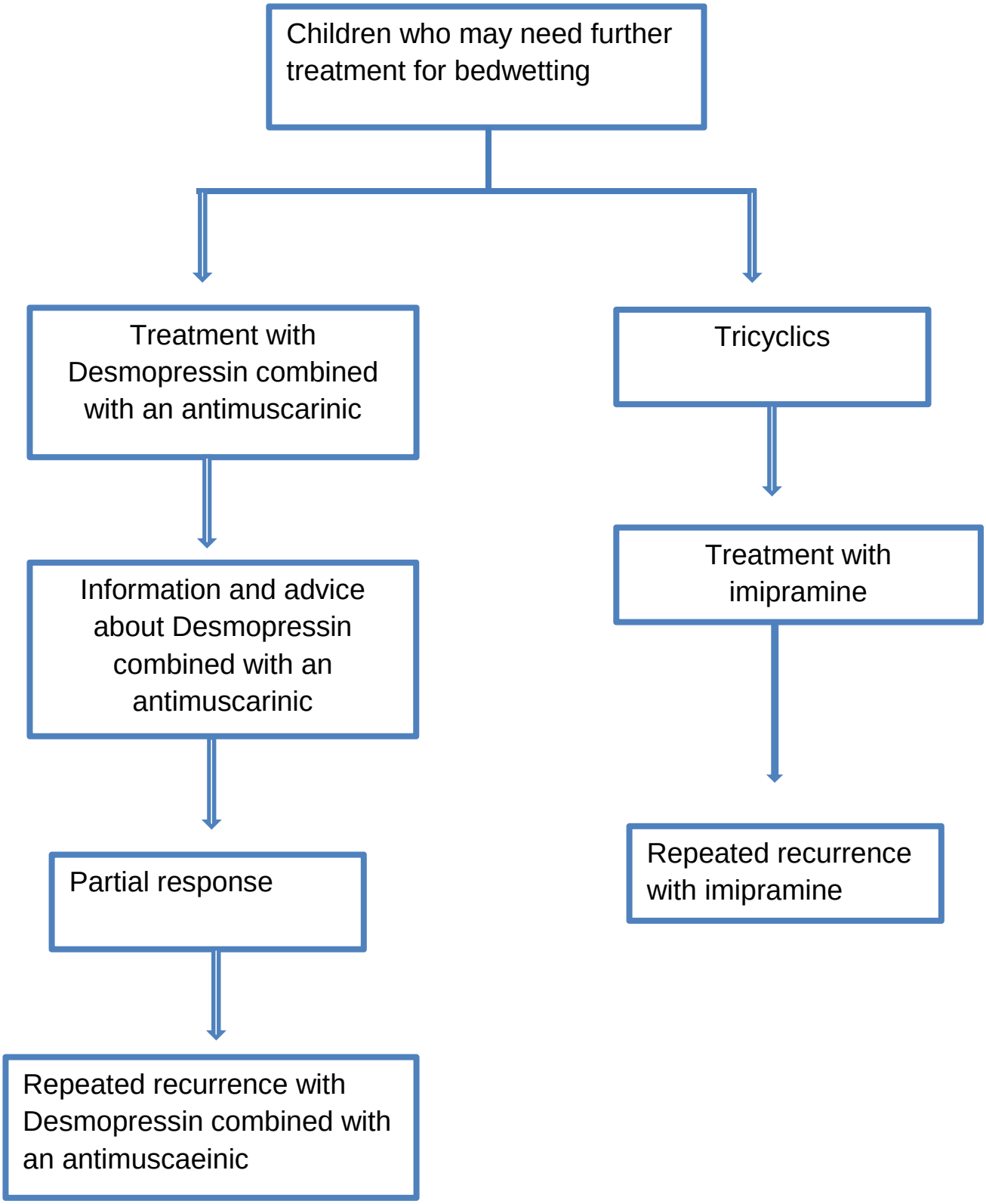
4.4 Alarm treatment for nocturnal enuresis in children and young people



4.5 Desmopressin treatment for nocturnal enuresis in children and young people



Further treatment for nocturnal enuresis in children and young people



First Name: _____

Last Name: _____

Date of Birth: _____

NHS Number: _ _ _ _ _ _ _ _ _ _

Shropshire Community Health NHS
NHS Trust

Enuresis Assessment Form

Page:

Childs' Details:

Name of Parent or Guardian:	Relation to Child:
Telephone Numbers:	School:
Date and Source of Referral:	Religion: Ethnicity:
Date of First Appointment:	Venue of First Appointment:

Nocturnal:

Average Weekly Frequency:	×1	×2	×3	×4	×5	×6	×7
Nightly Frequency:		Once ☐		Several ☐			
Patch Size:		Large ☐		Small ☐			Variable ☐
Occurs away from home:		Yes ☐		No ☐			
Approximate time/s:							
Wakes in wet bed:		Yes ☐		No ☐			
Longest Dry period:				When:			
Type of Enuresis:		Primary ☐		Secondary ☐			

Daytime:

Daytime Accidents:	Yes ☐	No ☐		
Extent:	Damp ☐	Patch ☐		Puddle ☐
Timing of daytime accidents:				
Daytime urgency:	Yes ☐	No ☐		
Number of daytime voids:	Less than 4 (infrequent) ☐	4 – 7 (normal) ☐		More than 7 (frequency) ☐
Daytime symptoms only in some situations (venues; pre/post void; with exercise, giggling, coughing etc.):	Yes ☐	No ☐	Detail:	
Avoidance of toilets at school or elsewhere:	Yes ☐	No ☐	Detail:	
Flow / stream:	Normal ☐	Abnormal ☐	*If Abnormal discuss with Community Paediatrician*	
Abdominal straining when passing urine:	Yes ☐	No ☐	*If Yes discuss with Community Paediatrician - possible outflow obstruction*	
Incomplete Emptying:	Yes ☐	No ☐		
Age dry by day:				

n/a = Not Applicable n/k = Not Known n/r = Not Required

First Name: _____

Last Name: _____

Date of Birth: _____

NHS Number: _ _ _ _ _ _ _ _ _ _

Shropshire Community Health NHS
NHS Trust

Enuresis Assessment Form

Page:

Family History:

Family History of Enuresis: Yes ☐ No ☐

Who: Age resolved:

General Health of Family:

Stressful Events: e.g. separation / house moves

Family Composition:

Other Problems:

Constipation: Yes ☐ No ☐ Bristol Stool Chart No:

Soiling: Yes ☐ No ☐

Previous UTI: Yes ☐ No ☐ Age of 1st infection:

Number of episodes: Outcome of Any Previous Investigations:

(UTI = Urinary Tract Infection)

General:

Own room: Yes ☐ No ☐

Type of Bed: Single ☐ Cabin ☐ Top Bunk ☐ Other ☐

Access to Toilet:

Wakes for Toilet at Night (dry bed): Yes ☐ No ☐

Bed Time: Sleep Time:

Wakes by Self in Morning: Yes ☐ No ☐ Time:

Cold at Night: Yes ☐ No ☐

Fluids (name / type / amount):

Breakfast:

Before school:

Mid morning:

Lunch time:

Mid afternoon:

Home time:

Tea time:

Supper time:

Fluid Intake: Good ☐ Poor ☐

Previous Treatments:

Nappies ☐ Lifting ☐ Fluid restriction ☐ Charts / Rewards ☐ Alarm ☐ Drugs ☐

n/a = Not Applicable n/k = Not Known n/r = Not Required

First Name: _____

Last Name: _____

Date of Birth: _____

NHS Number: _ _ _ _ _ _ _ _ _ _

Shropshire Community Health NHS
NHS Trust

Enuresis Assessment Form

Page:

Medical History:		
Birth History:		
Is the child / young person fully immunised?	Yes ☐	No ☐
Actions:		
Past Medical History:		
Medication:		
Physical examination undertaken by referring Doctor / GP:	Yes ☐*	No ☐
*See Referral Letter Dated……for Full Details		
Developmental milestones:	Normal ☐	Delayed ☐
Any concerns about walking / leg weakness:	Yes ☐	No ☐
Any concerns about growth or weight:	Yes ☐	No ☐
SEN:	Yes ☐	No ☐
Behavioural problems	Yes ☐	No ☐
Emotional problems:	Yes ☐	No ☐
Other agencies involved (past / current)	Yes ☐	No ☐
* If Yes above Detail:		

n/a = Not Applicable n/k = Not Known n/r = Not Required

First Name: _____

Last Name: _____

Date of Birth: _____

NHS Number: _ _ _ _ _ _ _ _ _ _

Shropshire Community Health NHS
NHS Trust

Enuresis Assessment Form

Page:

Urinalysis:		
Do not perform urinalysis routinely, unless the child or young person has: • Started bedwetting recently (in the last few days or weeks) • Daytime symptoms • Any signs of ill health • A history, symptoms or signs suggestive of a urinary tract infection • A history, symptoms or signs suggestive of diabetes mellitus (immediate referral needed – NICE clinical guideline 15		
Parents Advised to Contact GP for Urinalysis / MSU:	Yes ☐	No ☐
Reason:		
Reported Results:		
Source:	Date:	
Action Plan / Initial Management: *patient centred supported by NICE clinical guideline 111 (2010), NICE quality standard 70 (2014) and Shropshire's enuresis policy & care pathway (2015)*		
Priorities (short / long term):		
Child / young person's view (main problem):		
Effect of bedwetting on child / young person:		
Effect of bedwetting on family:		
Fluid intake:		
Fluids to avoid:		
Toileting patterns:		
Reward system:		
Verbal / written / other information (ERIC / Solihull Approach / Bristol stool chart / PromoCon / IMPACT / DNA Policy):		
Planned Follow Up:		
Contact details given to Parent / Carer Yes ☐		
Signature:	Print:	
Date:	Designation:	

n/a = Not Applicable n/k = Not Known n/r = Not Required

First Name: _____

Last Name: _____

Date of Birth: _____

NHS Number: _ _ _ _ _ _ _ _ _ _

Shropshire Community Health NHS
NHS Trust

Enuresis Action and Management Plan

Page:

Details of Contact:	
Today's Date and Time: Others Present:	Venue of Contact:
Date of Last Contact:	Type of Last Contact: clinic / telephone / school / other
Primary Reason for Contact:	
Progress / Discussions: *patient centred supported by NICE clinical guideline 111 (2010), NICE quality standard 70 (2014) and Shropshire's enuresis policy & care pathway (2015)*	
Enuresis (when did it start):	
Daytime symptoms:	
Constipation:	
Fluid intake:	
Fluids to avoid:	
Toileting patterns:	
Reward system:	

Current Treatment:	Fluids / Toileting / Reward system Yes ☐ No ☐ N/A ☐	Alarm: Yes ☐ No ☐ N/A ☐	Desmopressin: Yes ☐ No ☐ N/A ☐

The bedwetting has not responded to treatment if the child / young person has not achieved 14 consecutive dry nights or a 90% improvement in the number of wet nights per week

Has the child / young person responded to treatment? Yes ☐ No ☐ N/A ☐

n/a = Not Applicable n/k = Not Known n/r = Not Required

First Name: _____

Last Name: _____

Date of Birth: _____

NHS Number: _ _ _ _ _ _ _ _ _ _

Shropshire Community Health NHS
NHS Trust

Enuresis Action and Management Plan

Page:

Nice Clinical Guidance 111 (2010) states that if bedwetting has not responded to advice on fluids, toileting and an appropriate reward system then an alarm system or Desmopressin medication should be offered as first line treatment if desirable and appropriate

Is an Alarm / Desmopressin appropriate at this consultation?	Yes ☐	No ☐	N/A ☐
If no please document reason:			
Satisfactory progress made with fluids / toileting / reward system:	Yes ☐	No ☐	
Not yet tried appropriate fluids / toileting / reward system:	Yes ☐	No ☐	
Parent /Carer expressing anger or blame:	Yes ☐	No ☐	
Short term dryness is the priority:	Yes ☐	No ☐	
Alarm / Desmopressin considered otherwise inappropriate:	Yes ☐	No ☐	
Infrequent bedwetting (<1-2 wet beds per week):	Yes ☐	No ☐	

Summary:

Priorities (short / long term):

Child / young persons view (main problem):

Impact of bedwetting on child / young person – Scale 0-10 (0=no affect, 10=serious affect):

Impact of bedwetting on family – Scale 0-10 (0=no affect, 10=serious affect):

Action / Management Plan: *patient centred supported by NICE clinical guideline 111 (2010), NICE quality standard 70 (2014) and Shropshire's enuresis policy & care pathway (2015)*

Fluids:

Toileting:

Treatment options:	Fluids / Toileting / Reward system Yes ☐ No ☐	Alarm: Yes ☐ No ☐	Desmopressin: Yes ☐ No ☐

Verbal / written / other information (ERIC / Solihull Approach / Bristol stool chart / PromoCon / IMPACT / DNA Policy):

Planned Follow Up:

Assess early response to Alarm or Desmopressin by 4 weeks (NICE 2010)

Contact details given to Parent / Carer Yes ☐

Date / time:	Venue: clinic / telephone contact / school / other

Contact / refer: GP / CCN / Continence service / Dietician / Psychology / Enuresis service / Community Paediatrician

Signature:	Print:
Date:	Designation:

n/a = Not Applicable n/k = Not Known n/r = Not Require

THE BRISTOL STOOL FORM SCALE (for children)

choose your POO!

type 1		looks like: **rabbit droppings** Separate hard lumps, like nuts (hard to pass)
type 2		looks like: **bunch of grapes** Sausage-shaped but lumpy
type 3		looks like: **corn on cob** Like a sausage but with cracks on its surface
type 4		looks like: **sausage** Like a sausage or snake, smooth and soft
type 5		looks like: **chicken nuggets** Soft blobs with clear-cut edges (passed easily)
type 6		looks like: **porridge** Fluffy pieces with ragged edges, a mushy stool
type 7		looks like: **gravy** Watery, no solid pieces ENTIRELY LIQUID

Concept by Professor DCA Candy and Emma Davey, based on the Bristol Stool Form Scale produced by Dr KW Heaton, Reader in Medicine at the University of Bristol.

MOVICOL® Paediatric Plain

macrogol 3350, sodium bicarbonate, sodium chloride, potassium chloride

Monitoring Progress

Name:_____

	Dry		Wet	
Date	slept through ✓	woke to toilet (time) ✓	woke after wet (time) ✓	slept through ✓

Please bring this chart along to your next appointment on…….

Any problems please ring……

From Butler, RJ. (2006) **Nocturnal Enuresis Resource Pack;** E

Drinks Chart

Name……..... Your next appointment is.....

For each day, please write on the chart:

- The number of drinks in the day (150-200ml / mug sized drinks)
- The type of drink you had during the 1 ½ leading up to bedtime
- In the morning please record if you were dry or wet (and if the patch was small (S), medium (M) or large (L). Your parents will record if you were dry or wet when they went to bed

Date	No. of drinks	Time of last drink (pm)	Type of drink	Dry / Wet at parents bedtime	Dry / Wet in morning S / M / L
				Dry / Wet	
				Dry / Wet	
				Dry / Wet	
				Dry / Wet	
				Dry / Wet	
				Dry / Wet	
				Dry / Wet	
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				Dry / Wet	
				Dry / Wet	
				Dry / Wet	

Any problems please ring……

Measuring Voided Volume 1

Aim:

- To assess the child's maximum voided volume (the amount of urine a bladder holds at it's fullest capacity – functional bladder capacity)

Method:

- The child is asked to pass urine (wee) into a measuring jug once a day and record on the chart the amount of urine passed

It is important to ask the child to pass urine (wee)

- When they feel the need to wee (not when asked to wee by a parent)
- At any time during the day except the first wee on a morning

Uses:

- The largest measure is taken as an estimate of functional bladder capacity
- This needs to be compared with the expected functional bladder capacity, which can be estimated to be (in mls):

  (Child's Age +1) × 30

Over the next 2-3 weeks, we would like to find out how much your bladder holds.
To do this we need you to wee into a measuring jug when you **really feel you need a wee**

Make sure:

- **Not** to measure the first wee on a morning
- Take only **one** measure a day
- **Record** the measure on this chart

Date	Bladder Capacity

Date	Bladder Capacity

11 Steps to Bladder Control

During the Day

1 **Increase fluid intake**
150-200 ml / 6-8 mug sized drinks spaced throughout the day

2 **Go to the toilet for a wee regularly**
About every 2 hours, or when you have a drink

3 **Measure and monitor how much you wee**
Good voiding volume in mls is: (age+1) × 30

1 ½ Hours before Bed

4 **Have a small drink**
Note if any drinks increase a vulnerability to bedwetting

Just before sleep

5 **Make sure your bladder is empty**

6 **Switch off any bedroom lights or TV**

7 **Make sure you are warm in bed**

8 **Think to yourself 'I'll be dry tonight' or 'I'll wake up for a wee if I need one'**

During the night

9 **No lifting**
If parents wish to toilet your child, make sure he/she is awake

10 **If you wake up, really try to get up and use the toilet**
Have a torch at hand if the toilet is difficult to get to

After dry nights

11 *Make a note of:*
Whether you woke to toilet in the night (*arousability*)
or
Slept through (*release of vasopressin*)

From Butler, RJ. (2006) **Nocturnal Enuresis Resource Pack;** ERIC 5th Edition

WALK TALL LIKE A GIRAFFE

Name .....

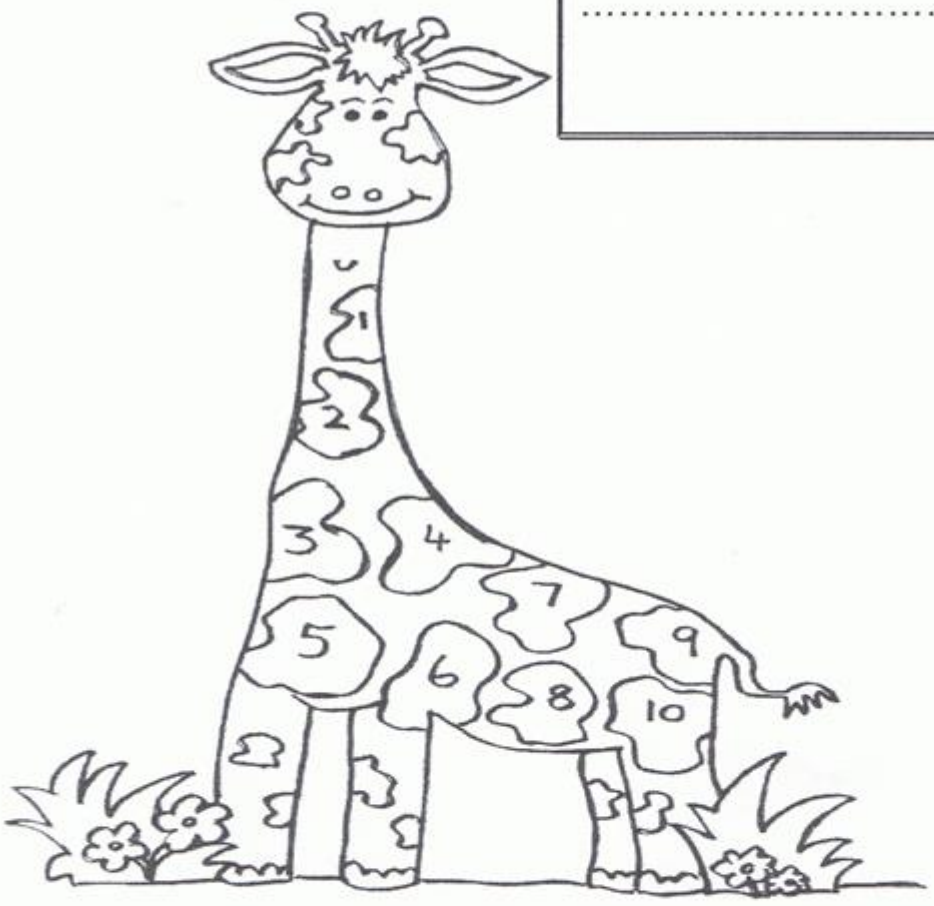
I can colour in a patch for:

.....

.....

my reward for 10 patches will be:

.....



Please bring this chart along to your next appointment

From Butler, R.J. (2006) **Nocturnal Enuresis Resource Pack;** *ERIC* 5th Edition

The Three Systems Checklist

Name:_____

Over the last two weeks how often have you

Daytime

- **Had a sense of urgency** **often** **rarely**
  (sudden need to dash to the toilet)
- **Frequent toileting** **often** **rarely**
  (more than 7 times a day)
- **Passes small volumes of wee** **often** **rarely**
  (with small maximum voided volumes)

Night-time

- **Woken up soon after wetting** **often** **rarely**
  (or during actual wetting)
- **Wet soon after going to sleep** **often** **rarely**
  (within 3 hours of sleeping)
- **Had large wet patches** **often** **rarely**
  (the bed is soaked)

⇩ ⇩

Suggests bladder over-activity

Suggests lack of vasopressin release

Maximum voided volume / functional bladder capacity:

Best…….

Range……

Expected (mls): (Child's age +1) × 30

From Butler, RJ. (2006) **Nocturnal Enuresis Resource Pack;** ERIC 5th Edition

COLOUR IN THE CLOWN

Name .....

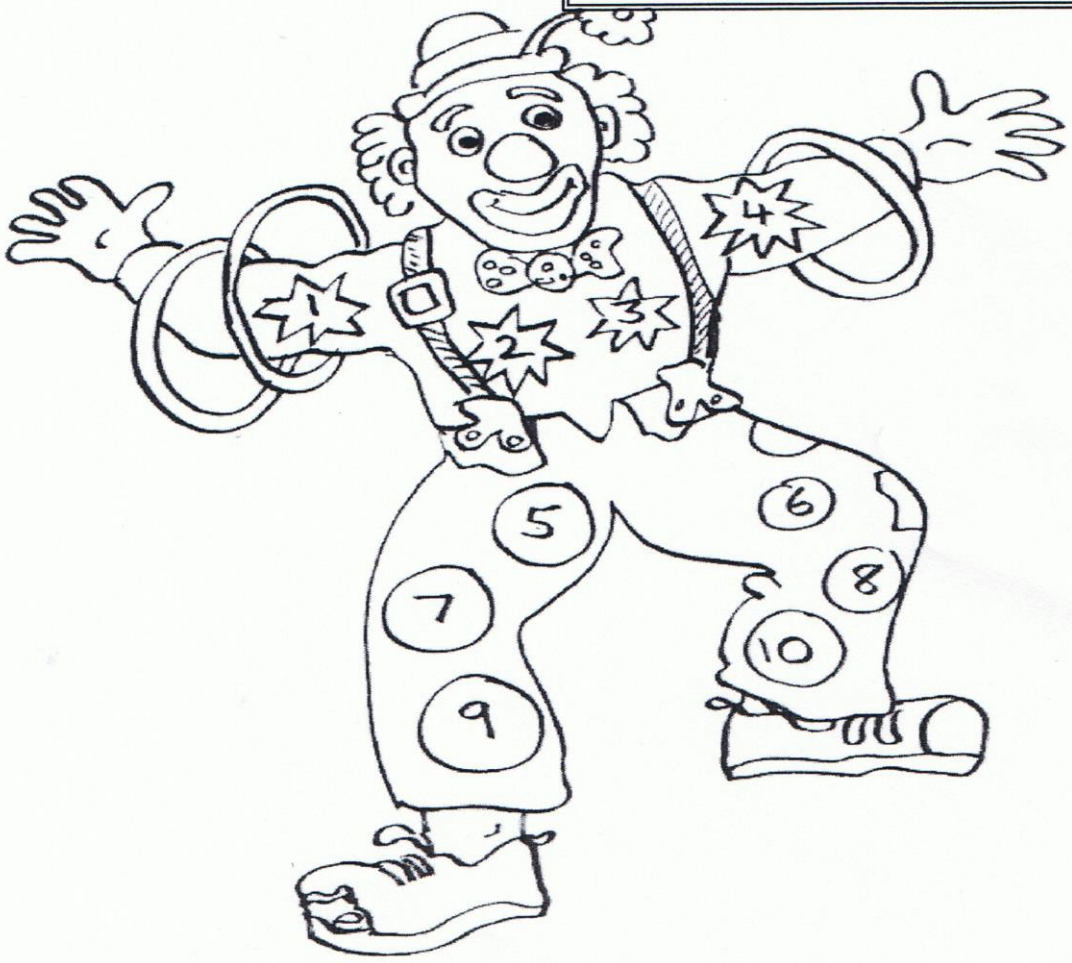
I can colour in a spot or a star for:

.....

.....

my reward for 10 spots and stars will be:

.....



Please bring this chart along to your next appointment

From Butler, R.J. (2006) **Nocturnal Enuresis Resource Pack;** *ERIC* 5th Edition

Waking Profile Chart

How often do you wake up for

	Never	Sometimes	Often
To go for a wee			
Needing a wee but go back to sleep			
When you are excited			
When you are poorly			
When you are upset or worried			
When you are too hot or too cold			
To loud noises			
To strange sounds			
To an alarm clock			
If mum or dad tries to wake you			
When you are wet			

Please bring this chart along to your next appointment on:_____

Any problems please ring:_____

Alarm Progress Chart

Name:_____

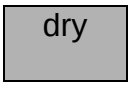
Date	Dry ✓	Self Waking ✓	Time of alarm	Woke to alarm Y / N	Size of wet patch S / M / L	Comments

Please bring this chart along to your next appointment on…….

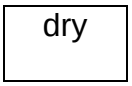
Desmopressin Schedule of Withdrawal

For each night complete the following

If DRY, shade in the box

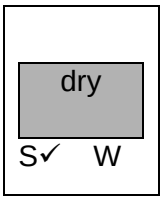


If WET, leave the box blank

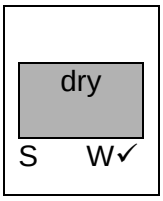


If you SLEEP THROUGH THE NIGHT tick S S✓

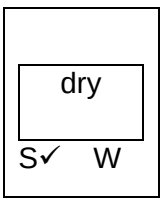
If you WAKE UP TO USE THE TOILET tick W W✓



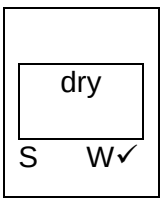
Means you slept through the night and remained dry



Means you woke in the night to use the toilet and remained dry



Means you slept through the night and found you were wet when you woke up in the morning



Means you woke in the night to use the toilet but also had a wet bed.

Desmopressin Schedule of Withdrawal

Name:_____

1	MED dry S W	dry S W	MED dry S W	MED dry S W	dry S W	MED dry S W	dry S W
2	MED dry S W	MED dry S W	dry S W	MED dry S W	dry S W	dry S W	MED dry S W
3	dry S W	MED dry S W	dry S W	dry S W	MED dry S W	dry S W	MED dry S W
4	MED dry S W	dry S W	MED dry S W	dry S W	dry S W	MED dry S W	dry S W
5	dry S W	MED dry S W	dry S W	dry S W	MED dry S W	dry S W	dry S W
6	dry S W	MED dry S W	dry S W	dry S W	dry S W	MED dry S W	dry S W
7	dry S W	dry S W	MED dry S W	dry S W	dry S W	dry S W	MED dry S W
8	dry S W	dry S W	dry S W	MED dry S W	dry S W	dry S W	dry S W
9	dry S W	dry S W	dry S W	dry S W	dry S W	dry S W	dry S W
10	dry S W	dry S W	dry S W	dry S W	dry S W	dry S W	dry S W

Measuring Voided Volume 2

Name…… Date started……

For each day:

Drinks column: write in all drinks taken day and night.

Urine column: write in all urine passed both day and night. If you can't measure because you are out or child is at school put a tick to show visit to toilet. If bed is wet write S = small, M = medium and L = large against the time of day.

Get your child to help you complete the chart each day. Try and do the chart for as many days as you can. We would like you to do at least four days

Please see back of chart for tips on completing.

	Day 1		Day 2		Day 3		Day 4		Day 5		Day 6		Day 7	
	Drinks	Urine	Drinks	Urine	Drinks	Urine	Drinks	Urine	Drinks	Urine	Drinks	Urine	Drinks	Urine
7am														
8am														
9am														
10am														
11am														
12md														
1pm														
2pm														
3pm														
4pm														
5pm														
6pm														
7pm														
8pm														
9pm														
10pm														
11pm														
12mn														
1am														
2am														
3am														
4am														
5am														
6am														

Volumes **For clinic use only**

Day														
Night														

Measuring intake and output

This information is an important part of your child's assessment and helps us to work out how best to treat them. Try and do the chart for as many days as you can. We would like you to do the chart at least four days. Ideally we would like some of the days at home and some at school. The more days that you can do, the better. It's best to start the chart at the weekend, when you are going to be with your child for most of the time. Get your child to help you complete the chart each day

Measuring urine

Use a suitable plastic measuring jug to measure urine at home. If it is not possible to measure urine, for example if you are out or the child is at school just tick to record trip to toilet against the time.
At night record if wet and write S – small, M – medium or L-large
If wearing nappy or pull up you can weigh the dry nappy and then weigh again in morning. Please weigh in grams. The difference in weight = no. of mls passed overnight.
For example: Nappy dry weight = 300gm
Nappy wet weight = 750gm Difference in weight = 450gm = 450mls.

It is very useful for us to know how much urine your child passes at night. If your child does not normally wear a nappy / pull up at night, you may consider them using one for two or three nights for this assessment.

Measuring drinks

Try to measure all drinks in mls. If this is difficult to do each time, measure how much the child/young person's usual cup/glass holds or drinking bottle if taken into school, write down that amount at the bottom of the chart and then record drinks as tick against the time. Be as accurate as you can.

Name:_____

Date of Birth:_____

NHS No:_____

Shropshire Community Health NHS
NHS Trust

Team Equipment on Loan

Date of issue……

Issuing clinic……

Contact number……

1. The enuresis equipment on loan is the property of Shropshire Community Health NHS Trust and must not be given or loaned by me to anyone else
2. I agree to use the equipment in the manner set out in the instructions or guidelines given to me
3. I agree to keep the equipment in good condition to the best of my ability
4. I agree to inform the enuresis clinic of any change of address
5. Shropshire Community Health NHS Trust cannot accept any liability for any damage caused while the equipment is in use
6. I agree to pay for a replacement alarm if I lose or damage the one loaned to me
7. The need for continued loan of the equipment will be reviewed
8. I agree to bring the equipment to each appointment for maintenance and to return it if a replacement is provided
9. Replacement batteries are available and must be replaced by clinic staff
10. **I agree to return the equipment to the enuresis clinic at the end of the treatment period – approximately 16 weeks**

I have had the above conditions explained to me and agree to abide by them

Signed……Print……

Items issued and serial number……

Issued by……Date……

Returned to……Date……

Once complete please photocopy and store original in child's records, and a copy to be given to parents.

Clinic Date & Venue	Nurse / Doctor Running Session

Services for Children and Young People
Enuresis Clinic Appointments

Time	Surname	Forename	Dob	New Referral	Nurse Referral (R) Discussion (D)	Seen by Doctor (D) Nurse (N)	Other Outcome			Alarm Issued	Alarm Returned	Discharge	F/up & Time	Letter Code
							DNA	Can FAM	Can PCT	Type & No	Type & No			

Letter Codes: 1 –GP: attended 1st appointment: **2 –** GP: DNA 1st appointment: **3** – GP: DNA x 2: **4 –** GP: discharged dry: **5** – GP discharged resting: **6** – Parents: DNA review: **7** – Parents: DNA 1st: **8** – Parents: cancelled review

Time	Surname	Forename	Dob	New Referral	Nurse Referral (R) Discussion (D)	Seen by Doctor (D) Nurse (N)	Other Outcome			Alarm Issued	Alarm Returned	Discharge	F/up & Time	Letter Code
							DNA	Can FAM	Can PCT	Type & No	Type & No			

Extras (including telephone contacts)

Name:_____

Date of Birth:_____

NHS No:_____

Shropshire Community Health NHS
NHS Trust

Enuresis Clinic Referral Form

For Children 5 Years & Older (Priority will be given to 7 years upwards)

Address	Telephone Number
	GP
Post Code:	School
Additional contact details	

Clinics held at

	First Choice	Second Choice
Bridgnorth CHC	☐	☐
Ludlow Hospital	☐	☐
Oswestry PCC	☐	☐
Shrewsbury Haughmond View	☐	☐
Whitchurch Hospital	☐	☐
Donnington Clinic	☐	☐
Stirchley CHC	☐	☐
Wellington CHC	☐	☐

Night time wetting ☐Yes ☐No ☐Primary / ☐Secondary

Daytime Symptoms
Wetting ☐Yes ☐No
Urgency ☐Yes ☐No
Frequency ☐Yes ☐No

Constipation ☐Yes ☐No
Previous UTI ☐Yes ☐No
Educational Needs ☐Yes ☐No
Child Protection Register ☐Yes ☐No

Soiling: ☐Yes ☐No

Diagnosed behavioural problems: _____

_____

Current Medication / Drugs / Comments: _____

_____

_____

_____

Referred by:	Signed;
Designation:	Date:
Contact details	

Return to: Enuresis Services - Targeted Team
Shropshire Community Health NHS Trust
Children & Families Services
Coral House, 11 Longbow Close, Harlescott Lane, Shrewsbury.
Tel (01743) 450800

Bladder and Bowel Diary

The following leaflet aims to help parents/carers keep a record of their child's bladder and bowel functions.
Within this leaflet, you will find a bladder diary and a bowel diary to assist you and us in assessing how your child's bladder and bowels are working

My child's bladder: Why should we keep a bladder diary?
Keeping a bladder diary helps us to make an assessment of how your child's bladder is working and gives us an idea of:
• The amount your child drinks
• The amount of urine your child's bladder can hold
• How often your child passes urine.

How to complete the bladder diary
• Fill in the bladder diary as carefully as possible for two convenient days (preferably not school days).
• For each day record what and how much your child drinks (in millilitres or cups) and when they drink it.
• Use a jug to measure the amount of urine your child passes. Record the amount on the chart and the approximate time.
• If your child leaks urine, tick the column marked 'wet' and indicate the time of day.
• Record any day and night-time wetting on the **seven day bowel diary** on page 4.

Each time your child passes urine please describe how urgently your child had to get to the toilet. You should enter the most appropriate letter from the following list:
A. My child felt no need to empty their bladder, but did so for other reasons
B. My child could have postponed voiding (emptying their bladder) as long as necessary without fear of wetting him/herself.
C. My child could have postponed voiding for a short while, without fear of wetting him/herself.
D. My child could not postpone voiding, and had to rush to the toilet in order to avoid wetting him/herself.
E. My child leaked before he/she arrived at the toilet.

Below is an example of how to complete the bladder diary:

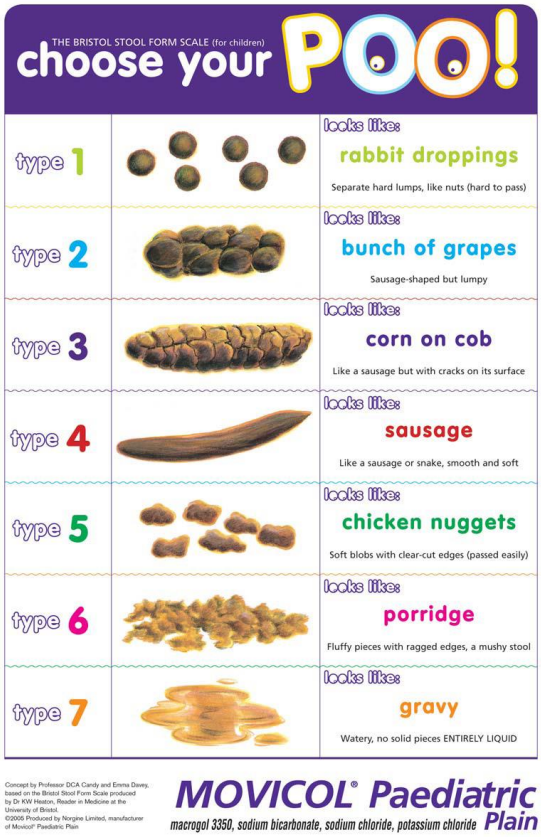
Time	**Day 1**				**Day 2**			
Approx	**In (drink)**	**Out (urine)**	**Wet**	**Urgency**	**In (drink)**	**Out (urine)**	**Wet**	**Urgency**
07:00		120mls	√ night	B		80mls	√ night	B
08:00	1 cup milk				1 cup orange			
09:00	150mls water							
10:00		90mls 45mls		C C				
11:00						30mls		A

Bladder diary:

Time	Day 1				Day 2			
Approx	**In (drink)**	**Out (urine)**	**Wet**	**Urgency**	**In (drink)**	**Out (urine)**	**Wet**	**Urgency**
06:00								
07:00								
08:00								
09:00								
10:00								
11:00								
12:00								
13:00								
14:00								
15:00								
16:00								
17:00								
18:00								
19:00								
20:00								
21:00								
22:00								

My child's bowel: Why should we keep a bowel diary?
Keeping a bowel diary helps us to assess how often your child opens their bowels and whether there are any problems with constipation.

How to complete the bowel diary
• Fill in the bowel diary carefully for seven days.
• For each day please indicate with a tick if your child opened their bowels and record the approximate time.
• Indicate with a tick if there was any discomfort, and describe the degree of discomfort if there was any.
• Record what the stool looked like (shape and texture). Base your answer on the different types listed in the Bristol stool chart (see below)
• Indicate with a tick if there was any soiling or if any bowel accidents occurred.
• Tick the appropriate box if this was accompanied by any day or night-time urinary wetting accidents



Below is an example of a bowel diary that has been completed:

Day	Bowels open	Time	Discomfort	Stool type	Soiling	Any wetting during the day	Any bedwetting
1	√	6pm		3			
2						√	√
3	√	8am	√ Mild	1			
4	√	4pm		2			

Bowel Diary:

Day	Bowels open	Time	Discomfort	Stool type	Soiling	Any wetting during the day	Any bedwetting
1							
2							
3							
4							
5							
6							
7							

Remember to bring your bladder and bowel diaries with you to your next appointment

Any wetting day or night please note: **S** – small, **M** – medium or **L** – large

If you child is wearing a nappy or pull up you can weigh the dry nappy and then weigh again in morning. Please weigh in grams. The difference in weight = no. of mls passed overnight.
For example: Nappy dry weight = 300gm
Nappy wet weight = 750g
Difference in weight = 450gm (=450mls)

If you require any further assistance with using the diaries or if you have any questions, please ring……...

Useful sources of information

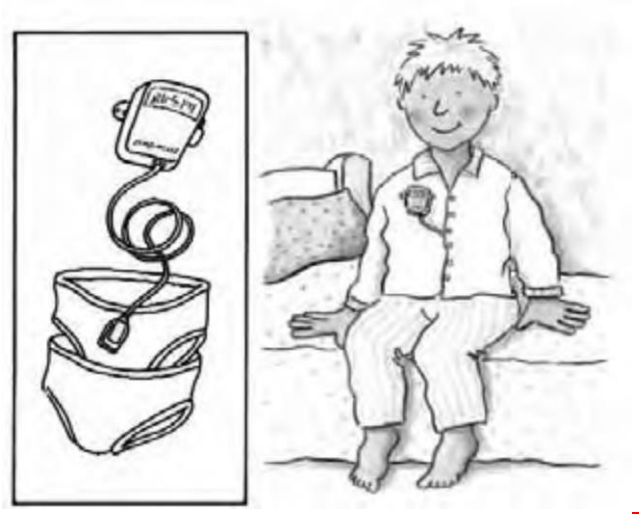
ERIC: http://www.eric.org.uk
PromoCon: http://www.disabledliving.co.uk/PromoCon
NICE enuresis guidance: www.nice.org.uk/guidance/cg111

Adapted from Guy's and St Thomas' NHS Foundation Trust bladder and bowel diary 2012

Malem Body Enuresis Alarm Instructions for Use

- Insert sensor clip into alarm socket making sure the Easy-Clip© Sensor is lifted up
- Carefully attach the alarm to the nightwear close to the shoulder and thread the cord inside the top. For small children loop and tie the cord to shorten length
- For Easy-Clip© Sensor, lift the sensor clip lever. Attach to the outside of close fitting underwear at the location most likely to get wet first, by inserting material inside sensor jaws at the front and closing the lever

Lowering the lever without dry material in the jaws will trigger the alarm and prevent the alarm from resetting. Lift the lever and press the reset button on the side of the alarm



Cleaning

Alarm unit: wipe clean using mild detergent or skin disinfectant. Use a damp cloth and dry thoroughly. NEVER IMMERSE IN WATER

Easy-Clip© Sensor: lift lever and regularly clean in soapy water, rinse and shake dry

Malem Bed-Mat Enuresis Alarm Instructions for Use

- Place a clean and dry Bed-Mat correct side up over the mattress in the area which is normally wetted
- Cover Bed-Mat with a clean dry cotton sheet and make up the bed in the usual way. Avoid nylon/polyester sheets as they can cause 'false' alarms due to increased perspiration
- Attach the Bed-Mat wire to the alarm sensor and place the alarm next to the bed (vibrating alarms can be placed under the pillow)
- When the alarm is activated, try and stop any more urine from being released and go to the toilet to completely empty the bladder
- The alarm sound can only be stopped when the Bed-Mat wire is unlocked form the alarm and the rest button is pressed

The Bed-Mat must be wiped clean with detergent and dried the replaced on a freshly made bed, as before, for reuse

Rapid waking on hearing the alarm is vital for success so better results are obtained if parents help to wake the child when the alarm starts especially during the first few nights

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Rapid waking on hearing the alarm is vital for success so better results are obtained if parents help to wake the child when the alarm starts especially during the first few nights

Enuresis Alarm

Why do I need an alarm ?

- ★ It is an **effective** way of overcoming bedwetting
- ★ It acts as a **reminder** to wake when your bladder is full.
- ★ It is important to **wake quickly** when the alarm is triggered.

Drinks

- ★ Have a **small drink**
- ★ **Practice** by lying on your bed, imagine your bladder is full and get up to use the loo.
- ★ **Set up** the alarm.
- ★ Switch off your light.

Beat the alarm

- ★ Before you fall asleep, **think** 'I'll wake up for a wee if i need one".
- ★ And **say to yourself** 'I'll wake up if the alarm goes off"

If the alarm triggers

- ★ Switch it off as quickly as you can.
- ★ **Unplug** the wire
- ★ Visit the loo to finish off weeing
- ★ Change the wet sheets.

Record your progress on the cart:

- ★ If you had a **dry** night
- ★ If **you woke** for a wee
- ★ The **time** the alarm was triggered
- ★ If the alarm **woke** you up
- ★ The **size** of the wet patch.

Check your progress:

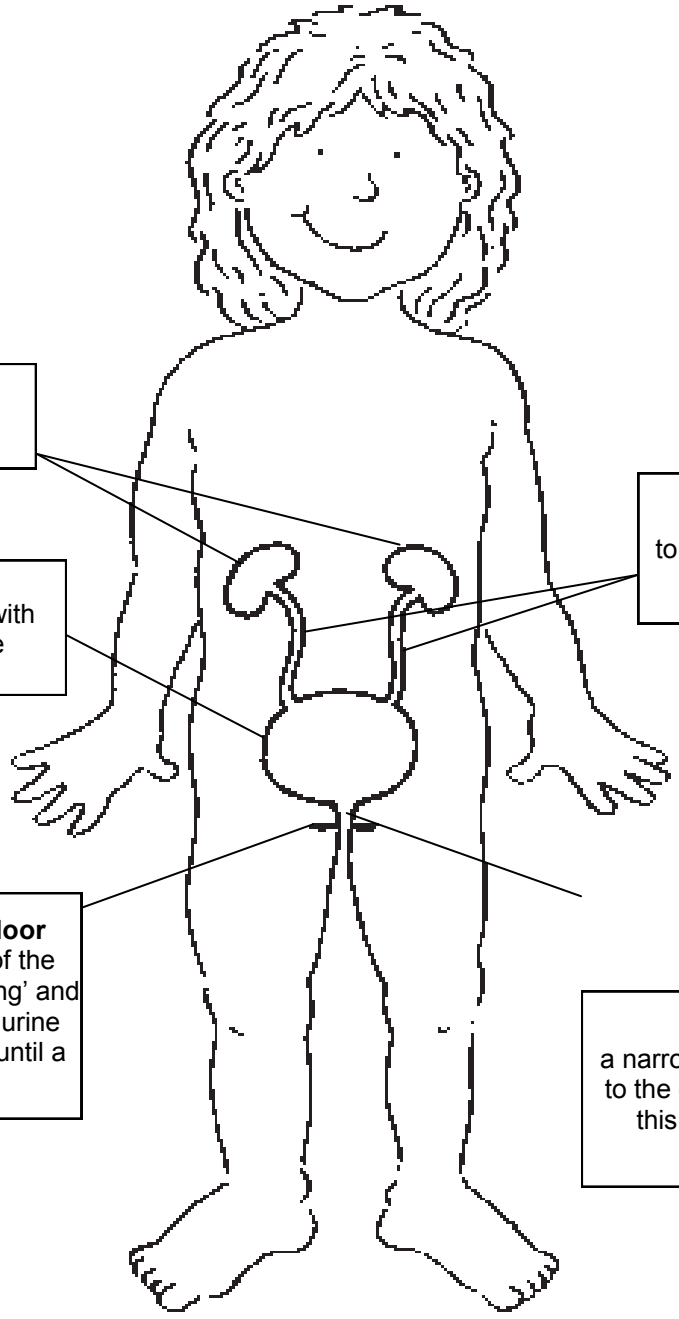
You should find -

- ★ Less urgency
- ★ Increased bladder capacity
- ★ More DRY nights

Any difficulties:

Please ring:_____

Diagram of the Urinary System and Explanation



Kidneys
which produce urine

Ureters
to carry urine from kidneys to bladder.

Bladder
an expandable 'bag' with walls of thin muscle

Muscles of the Pelvic Floor
Help to control the outlet of the bladder. By consciously 'lifting' and squeezing these muscles, urine can be kept in the bladder until a toilet is found

Urethra
a narrow tube which carires urine to the outside of the body, in bys this tube is longer and runs through the penis.

The bladder is like a stretchy bag. Its muscle walls relax, to allow it to gradually fill with urine from the kidneys (and therefore become larger), and to contract and squeeze out its contents. Everyone's bladder has a usual maximum level of filling before contractions start - and this varies in volume from person to person. When the maximum level is reached, the bladder sends messages to the brain via the nervous system, resulting in feelings of discomfort or fullness. It is this that tells children that they need to go to the toilet. When the toilet is reached (or wetting occurs!), the contractions squeeze the urine out, emptying the bladder. The achievement of diurnal and nocturnal continence is a developmental milestone; it will be different for every child and occur at different ages. Most children become dry by day and by night between 2 and 4 years of age, the majority becoming dry by day before they achieve night-time continence. For some children, when this development is delayed it can have devastating effects on their psychological and social development.

_____ Drinks Chart

Aim to have 6-7 drinks of 150—200mls each day and a very small drink before bedtime
Colour in the glass when you have finished your drink.

Date Started	**Waking Up** (150—200mls)	**Breakfast** (150—200mls)	**Mid Morning** (150– 200mls)	**Lunch Time** 150—200mls)	**Mid Afternoon** (150—200mls)	**After School** (150—200mls)	**Tea Time** (150—200mls)	**Before Bedtime** (50—100mls)	Total
Monday									
Tuesday									
Wednesday									
Thursday									
Friday									
Saturday									
Sunday									