CHILDREN'S HEALTH & WELLBEING FACTSHEET

Potty and Toilet Training Tips

A calm, inclusive guide to bladder and bowel learning without shame or pressure

The short version

Learning to use a potty or toilet is a developmental process, not a test of obedience or parenting. Children learn body signals, holding and releasing, clothing, wiping, flushing and handwashing at different rates. Begin preparation early, use predictable practice and respond to accidents calmly. Check for constipation before and during training because painful or retained poo can disrupt both bowel and bladder control. Children with additional needs deserve the same opportunity, adapted to their communication, sensory, physical and developmental needs.

Toileting is a collection of skills

Body awareness	Noticing a full bladder or bowel, recognising wetness or soiling, and linking sensations with what happens next.
Movement and position	Reaching the toilet, getting on safely, sitting steadily and relaxing with feet supported.
Communication	Telling, signing, showing a symbol or using another agreed signal before, during or after the need to go.
Sequence	Clothes down, sit, wee or poo, wipe, clothes up, flush and wash hands. Each step can be taught separately.
Emotional safety	Feeling secure in the bathroom, trusting adults and learning that accidents are ordinary information rather than something shameful.

Preparing to begin

There is no single perfect age. NHS guidance encourages parents to notice emerging skills and begin when family life can support consistent practice. Preparation can start before nappies are removed.

Possible signs	Stays dry for a period, notices wet or dirty nappies, shows awareness before or during a wee or poo, can sit with support, follows familiar routines or shows interest in the toilet.
Not all signs are essential	Children with communication, physical or developmental differences may not show typical signs. Do not wait indefinitely for every skill; assess what support would make participation possible.
Check the poo	Before stopping nappies, aim for soft, comfortable stools at least every other day. Hard pellets, very large stools, pain, withholding or soiling can suggest constipation.
Choose a manageable period	Avoid starting during major upheaval if possible, but do not search for a completely stress-free week. Agree a consistent plan across home and childcare.
Prepare equipment	Choose a stable potty or toilet reducer, a firm footstool, easy clothing, spare clothes, handwashing equipment and waterproof protection where useful.

Potty or toilet?

Potty	May feel secure and is easy to access. Feet rest on the floor, which supports a helpful pooing position.
Toilet	Can avoid a later transition. Use a secure reducer seat and footstool so the child is not balancing or dangling their legs.

A helpful pooing position

Support the feet, let knees sit slightly higher than hips, lean forward gently and relax the tummy. A child who feels unstable may tighten rather than release.

A practical daytime plan

1. Make it familiar	Use simple words for wee, poo and body parts. Let the child see the bathroom routine, read a short book or practise sitting briefly while clothed.
2. Learn the pattern	For several days, note when nappies are wet or dirty and when the child shows cues. This helps identify likely times rather than asking constantly.
3. Introduce planned sits	Offer relaxed sits after waking, after meals, before leaving home and at other likely times. Keep them short and predictable.
4. Move to pants	When beginning active training, use ordinary pants or clothing that helps the child notice wetness, unless a clinical plan says otherwise. Keep nappies for sleep initially.
5. Respond to cues	Use a calm prompt such as 'Your body looks ready for the toilet.' Avoid repeatedly asking whether they need to go when they habitually say no.
6. Review and adapt	Notice timing, stool consistency, fluids, sensory barriers and skill gaps. Change one part of the plan rather than abandoning it after several accidents.

Encouragement that supports learning

- praise the action: sitting, trying, telling or helping to clean up
- keep rewards immediate, simple and non-food based
- celebrate progress without creating performance pressure
- use a small sticker or visual marker for the agreed action
- let the child choose pants, a step or a bathroom book
- use the same short words and sequence across caregivers

Avoid punishment

Never shame, scold, tease, force prolonged sitting or withdraw affection after an accident. Punishment does not speed neurological or bowel development and can increase fear and withholding.

Constipation can hide behind accidents

Constipation is common around toilet training and may cause wee accidents, bedwetting, painful pooing and overflow soiling. A child can pass some poo every day and still have retained stool.

Possible signs	Fewer than three poos a week, hard pellets, very large stools, pain, bleeding after a hard poo, tummy pain, poor appetite, withholding postures, skid marks or runny overflow around retained poo.
Withholding	A child may stiffen, tiptoe, cross legs, hide or appear to strain when actually trying not to poo. Previous pain can create a cycle of fear and retention.
Why diet alone may not work	NICE advises that dietary measures alone are not first-line treatment for established idiopathic constipation. Laxatives plus non-punitive toileting, suitable fluids and a balanced diet may be required.
Treatment takes time	Clearing retained stool and re-establishing regular bowel function can take months. Soiling may temporarily increase. Continue prescribed treatment and taper only with professional advice.
During training	NICE says children already using laxatives should generally remain on them until toilet training is well established. Do not stop abruptly because stools look better for a few days.

Support bowel health

- offer enough suitable drinks through the day
- encourage everyday movement
- keep a brief stool and soiling diary
- include varied fruit, vegetables and fibre appropriate to age
- use supported toilet sits after meals
- ask about nursery or school toilet worries

Seek advice early

Speak to a health visitor, pharmacist, GP or continence professional if constipation is suspected. Painful pooing is much easier to address before fear and withholding become established.

Accidents, regression and resistance

Frequent accidents	Check timing, fluid pattern, constipation, clothing, access, distraction and whether prompts are too early or too late. Accidents are information, not deliberate misbehaviour.
Refuses to sit	Consider fear, cold seats, flushing noise, unstable feet, smell, pain or loss of control. Rebuild comfort in tiny steps rather than physically forcing the child.
Only poos in a nappy	This often reflects security or fear. Keep poo soft, allow a gradual bridge—such as wearing the nappy in the bathroom, then sitting on the toilet—and seek specialist advice if stuck.
Holds all day	Some children avoid unfamiliar or school toilets. Review privacy, cleanliness, sensory issues, bullying, rules about asking and access to a suitable toilet.
Regression	Temporary setbacks can follow illness, constipation, a new sibling, moving, school changes or stress. A sudden persistent change also warrants consideration of infection, diabetes or another health problem.
Smearing	May relate to constipation, sensory seeking, communication, distress or access difficulties. Respond calmly, protect hygiene and dignity, and seek a whole-child assessment rather than punishing.

After an accident

Say	'Your clothes are wet. Let's get you comfortable.' Keep language factual and kind.
Do	Help the child change, place waste safely, clean skin gently and involve them in a manageable step without turning cleanup into punishment.
Notice	Record the time and likely trigger if patterns matter, then return to the day. Avoid retelling the accident to others in front of the child.

Night-time dryness and bedwetting

Night-time dryness depends on bladder capacity, night-time urine production and the ability to wake. It often develops later than daytime control. Many children under 5 wet the bed, and bedwetting can run in families.

Do	Provide enough water during the day, support regular toilet visits—often 4 to 7 times daily—and include a toilet visit before sleep. Make the route safe and easy at night.
Protect sleep and dignity	Use waterproof bedding, accessible spare clothes and a discreet routine. Reward helpful actions, not dry nights that the child cannot consciously control.
Do not	Do not punish, routinely restrict daytime drinks, or repeatedly lift a sleeping child as the only strategy. Lifting may manage laundry but does not teach waking to bladder signals.
When to ask for help	Speak to a GP or school nurse if bedwetting persists and is concerning, if the child is 5 or older and wants support, or if wetting restarts after more than 6 dry months.
Possible treatments	After assessment and treatment of constipation or other causes, options may include a bedwetting alarm or prescribed medicine. Choice depends on age, motivation, family circumstances and urgency.

Check for other symptoms

Prompt assessment is important for unusual thirst, passing large amounts of urine, weight loss, pain or burning, fever, weak urinary stream, continuous dribbling, recurrent urine infections, snoring or severe daytime sleepiness, leg weakness or altered sensation.

Daytime wetting

Daytime accidents beyond the early learning stage may relate to constipation, overactive bladder, holding, infection, fluid patterns, developmental needs or another condition. Do not simply tell a child to try harder; assess the pattern and seek continence advice when persistent.

Children with additional needs

Disability, neurodivergence or developmental delay does not automatically mean a child cannot learn toileting skills. The route may be longer, more structured or require equipment and specialist support.

Communication	Use the child's communication system: objects, photographs, symbols, signing, visual sequences or a consistent word. Teach the signal for toilet and for help.
Sensory needs	Consider lighting, echo, hand dryers, flushing, smells, seat temperature, clothing texture and the feeling of wiping. Change one barrier at a time.
Interoception	Some children notice body signals late or experience them differently. Scheduled opportunities and pattern tracking may be more useful than waiting for them to ask.
Physical access	Seek occupational therapy or continence advice about seating, transfer, rails, steps, clothing and safe access. A stable posture matters for emptying.
Learning	Break the sequence into small steps, teach one skill at a time, repeat consistently and allow more processing time. Progress may be uneven.
Trauma and anxiety	Use consent, privacy and predictable care. Children with painful procedures or adverse experiences may need specialist psychological and continence support.

Do not wait for a diagnostic label

Support should be based on the child's current needs. Parents, early years staff, school, health and therapy professionals can begin reasonable adaptations while wider assessment is pending.

Dignity and safeguarding

- explain what will happen before intimate care
- protect privacy without isolating the child
- never use toileting difficulty to humiliate
- use agreed language and seek the child's cooperation
- follow setting policies and record significant concerns
- respond appropriately to pain, fear or disclosures

Nursery, school and community settings

Agree one plan	Share the child's words, schedule, cues, constipation treatment, prompts, rewards, changing routine and what to record. Consistency is helpful, but the plan must fit each setting.
Easy access	The child may need permission to leave promptly, a private or accessible toilet, spare clothes, wipes, disposal arrangements, foot support or adult assistance.
Medical needs	Where a bowel, bladder or other medical condition affects school, parents can ask to see the policy for supporting pupils with medical conditions and agree an Individual Healthcare Plan where appropriate.
Disability	Education providers must not discriminate and have duties to make reasonable adjustments for disabled pupils. Toileting support should not be withheld solely because a child is not independent.
Bullying and privacy	Wetness, odour, protective products or changing can expose a child to teasing. Staff should protect confidentiality, act on bullying and avoid public reminders.
Trips and clubs	Plan toilet stops, accessible facilities, medicine, spare clothing and disposal so the child can participate rather than being left out.

Useful information to share

- usual toilet times and cues
- level of help with clothing and wiping
- how accidents should be handled
- current constipation or continence treatment
- communication and sensory adaptations
- who to contact and when

A child should not be punished for a health need

Repeated wetting, soiling or delayed independence may be linked to disability or a medical condition. Responses should be supportive, proportionate and consistent with safeguarding and equality duties.

When to request assessment

Bowel concerns	Persistent constipation, painful or bloody stools, marked abdominal swelling, vomiting, poor growth, ongoing overflow soiling or constipation beginning very early in infancy.
Urinary concerns	Pain, fever, recurrent infections, very frequent or urgent urination, unusually strong thirst, weight loss, continuous dribbling, weak stream or difficulty passing urine.
Developmental or neurological	Loss of previously gained skills, new weakness, altered walking, back or leg symptoms, numbness, or significant delays affecting the toileting plan.
Emotional and safeguarding	Severe fear, distress, abrupt change after an event, concerning behaviour, pain with intimate care or any disclosure that raises a safeguarding concern.
Persistent difficulty	No progress despite a consistent adapted plan, daytime wetting or soiling affecting school and confidence, or bedwetting that concerns a child aged 5 or older.

Urgent help

Seek urgent clinical advice for a child who is very unwell, cannot pass urine, has severe abdominal pain or swelling, persistent vomiting, significant dehydration, blood in urine, high fever with urinary symptoms, new weakness or loss of bladder/bowel control. Call 999 for a life-threatening emergency.

Who may help

- health visitor, school nurse, GP or paediatrician
- paediatric dietitian when nutrition is complex
- physiotherapist when posture or mobility is relevant
- urology, gastroenterology or other specialist team
- children's bladder and bowel or continence service
- occupational therapist for access and sensory needs
- psychologist for severe anxiety or trauma
- SENCO and education support

NHS, private and complementary support

NHS route	Health visitors, school nurses and GPs can assess constipation, urinary symptoms, development and general health and refer to paediatrics or local bladder and bowel services. Availability and referral routes vary.
Private route	Families may choose a private paediatrician, paediatric continence service, gastroenterologist, urologist, dietitian, occupational therapist or psychologist. Private support may be quicker, but the provider must match the child's actual problem.
Using both	Share bowel diaries, reports, medicine plans and school arrangements. Clarify who monitors prescriptions, growth, investigations and follow-up.
Complementary care	Relaxation and parent-wellbeing support may be used alongside proper care. Do not replace prescribed laxatives with detoxes, herbal remedies, restrictive diets or unproven manipulation, and do not give a child supplements or essential oils without suitable advice.

Choosing a private professional

- verify GMC or HCPC registration where applicable and relevant paediatric experience
- check CQC registration where the clinic or service is required to be regulated
- ask whether constipation, bladder function, development, medication and safeguarding are assessed
- request written goals, review points, fees and communication with school or NHS professionals
- be cautious of guaranteed rapid toilet training, blame-based programmes or sales-led supplement plans

Parents can seek a second opinion

Persistent continence problems deserve proper attention. Families can use an appropriate private service if NHS access is delayed, while still using urgent and primary care when medically necessary.

How Health Matters UK can support your family

Health Matters UK provides personalised health education and practical wellbeing support. We can listen to the full family experience, help organise patterns and trusted information, and support a calm home plan while appropriate NHS or private professionals assess medical or developmental concerns. We do not diagnose bowel or bladder conditions, prescribe or change laxatives or continence medicines, perform intimate assessments, or replace regulated clinical and education services.

Map the pattern	Create a simple record of drinks, wees, poos, stool consistency, accidents, cues, pain, withholding and settings without turning the child into a project.
Prepare	Organise concerns and questions for a health visitor, GP, continence service, school or private appointment and identify red flags that need quicker help.
Build routines	Develop realistic toilet opportunities, visual steps, clothing choices, praise and accident responses that suit the household and child's needs.
Coordinate	Help parents communicate the agreed routine to nursery, school, relatives and activity providers and ask for appropriate adjustments.
Support the parent	Reduce guilt and isolation, recognise the workload of laundry and intimate care, and protect family relationships while progress takes time.

Your calm-start checklist

- poo is soft, comfortable and regular
- clothing is quick and manageable
- all adults use the same short routine
- accidents are handled neutrally
- additional needs are accommodated
- potty or toilet is stable with feet supported
- likely times and body cues have been observed
- praise focuses on actions, not perfect dryness
- nursery or school arrangements are agreed
- persistent symptoms receive proper assessment

A realistic next step

Choose one useful change today: check stool consistency, add a footstool, record the usual poo time, simplify clothing or agree the same words with childcare. Small consistent changes are more useful than a stressful weekend deadline.

Children's health matters to us

Every child deserves dignity, patience and the opportunity to learn at their own pace. Every parent deserves support rather than blame. Health Matters UK helps families use clear evidence, practical routines and compassionate communication while recognising when specialist help is needed.

Important information

This factsheet provides general education and does not replace individual medical, continence, developmental or therapeutic assessment. Do not start, stop or alter prescribed laxatives or bladder medicines without the responsible clinician. Seek urgent care for serious symptoms or rapid deterioration.

Evidence and review

Prepared in line with Health Matters UK's Evidence & Editorial Standards using current NHS, NICE, Department for Education, UK Government and ERIC resources. External organisations remain responsible for their guidance. Local services and education arrangements vary.

• NHS Best Start in Life. Potty training your child, updated 2026. nhs.uk/best-start-in-life/toddler/potty-training-your-child/

• NHS. Constipation in children; Bedwetting in children. nhs.uk

• NICE. Constipation in children and young people: diagnosis and management (CG99). nice.org.uk/guidance/cg99

• Department for Education and OHID. Help for early years providers: Toilet training. help-for-early-years-providers.education.gov.uk

• ERIC, The Children's Bowel & Bladder Charity. Toileting and additional-needs resources, 2026. eric.org.uk

• UK Government. Supporting pupils with medical conditions and disability rights in education. gov.uk

• Care Quality Commission and Professional Standards Authority. Checking services and practitioners. cqc.org.uk; professionalstandards.org.uk

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