Bladder & Bowel UK
Supporting people with bladder and bowel problems
part of Disabled Living

Children's bladder and bowel care

Level 1 resource pack

Assessing parental tolerance

Parents or carers who are intolerant of the child will focus on the impact on themselves rather than on the child and may use punishment inappropriately. This may result in concerns for the child's welfare.

Questions to ask include:

What concerns you about the wetting/soiling? Supportive parents or carers will express concern for the emotional state and wellbeing of the child, impact on the child's social activities and on their self-esteem. Parents or carers who may be intolerant are more likely to focus on the impact of extra washing and drying the smell and the cost of replacing bedding or clothing.

What are the reasons for the wetting/soiling? Supportive parents or carers may link incontinence to causes outside the child's control, such as deep sleep or family history. Intolerant parents may consider the child to be lazy, doing it on purpose, or doing it to get back at or punish the parents in some way.

What has your child tried to do to stop the wetting/soiling? Supportive parents or carers may talk about attempts made by the child, such as helping to get changed, following instructions from the parents, such as drinking more or less, stopping fizzy drinks. Intolerant parents or carers are more likely to consider the child can be dry or clean when they want to be, not to be bothered or having not tried anything.

How does the wetting/soiling make the parent or carer feel? Parents or carers who are supportive of the child may talk about being empathetic with them and how it is unpleasant for the child. Intolerant parents or carers may express hostility, anger, annoyance or frustration with the child

How do you cope with the wetting/soiling? Parents or carers who are supportive try to find solutions and cope with practicalities. Those who are intolerant may be punishing the child, humiliating them, showing disappointment, making threats, reprimanding or withdrawing privileges.

(Adapted from Nocturnal Enuresis Resource Pack, Charts Questionnaires and Information to Assist Professionals, R Butler, fifth edition, 2006. Pub: ERIC)

It is not unusual for parents and carers to consider the impact on themselves as well as the child. However, the clinician should be observant for any signs that may suggest that there are safeguarding concerns. If these are present, appropriate and timely advice should be sought from the Children's Continence Service, and/or from the safeguarding children department with action taken and documented in accordance with the local policies and procedures on safeguarding children.

Promoting Continence Pathway: NIGHT TIME WETTING

INITIAL ADVICE

If bedwetting has only started in the last few days or weeks consider whether it might be caused by systemic illness.

If the child also has daytime symptoms (e.g. urgency, frequency, daytime wetting), refer to the day time wetting pathway.

- Explain that the bedwetting is not deliberate, nor is it the child's fault and that the child should not be told off or punished
- If possible, explain the causes of bedwetting
- Encourage day time water-based drinks (see fluid advice). Avoid caffeinated, fizzy and energy drinks
- Do not limit fluid intake during the day, unless excessive (see fluid advice)
- Encourage regular daytime toileting (about two hourly)
- Encourage the child to try and pass urine before settling for sleep each night.
- Advise that the child should avoid all food and drink in the last hour before sleep
- Avoid high salt and high protein foods late in the day (these increase urine production)
- If the child is using products (e.g. pyjama pants, nappies) and family circumstances allow, consider a trial of at least two consecutive nights without
- Do not lift/wake the child when parents/carers go to bed. The only times when lifting may be acceptable is in the short term when it is particularly important that the bed stays dry e.g. when on holiday
- If the child wakes themselves during the night, ask parents/carers to encourage them to use the toilet before settling back to sleep
- Discuss ways of reducing the impact of the wetting, such as bed protection, washable or disposable products. E.g. a waterproof sheet on the mattress, or absorbent pants
- Consider access to the toilet at night. If this is difficult try to find ways to make it easier e.g. torch by the bed or potty in the room
- Consider whether the child is able to get out of bed, or has anxieties or fears that may result in difficulties getting up e.g. fear of the dark
- Advise parents/carers to only use rewards for things that are in the child's control. Remember that a child cannot control what happens when they are asleep. Therefore, encouragement and positive comments should be made for dry nights, but rewards (if used) should focus on things that are in the child's control, such as drinking recommended levels and toileting during the day, for toileting before sleep, helping to strip their own bed etc. Do not give rewards for dry nights, but do notice and praise any efforts made by the child
- Monitor progress by keeping a diary of wet and dry nights, of waking after wetting, of waking to use the toilet

FLUID ADVICE

Adequate fluid intake is an important part of treatment for continence problems including day time wetting, night time wetting and constipation and is also important when children are toilet training.

- Caffeinated drinks, including tea, coffee, hot chocolate, energy drinks and cola should be avoided as they may have a diuretic effect and can contribute to bladder overactivity
- Fizzy drinks should be avoided as they can contribute to bladder overactivity
- Children and young people will need extra water-based fluids if they are doing lots of exercise (including sports, playing out and school playtimes), or if the weather or their environment is hot
- Milk is healthy, but is used by the body as a food. It should not be encouraged instead of, or as part of total water-based drinks

Suggested intake of water based drinks per 24 hours according to age and sex:

Age	Sex	Total drinks per day
7-12 months		600 – 900ml
1-3 years	Female	900 – 1000ml
	Male	900 – 1000ml
4–8 years	Female	1200–1400 ml
	Male	1200–1400 ml
9–13 years	Female	1200–2100 ml
	Male	1400–2300 ml
14–18 years	Female	1400–2500 ml
	Male	2100–3200 ml

(Adapted from CG 111 Nocturnal Enuresis NICE 2010 and American dietary requirements, cited in CG 99 Constipation in Children and Young People, NICE 2010)

NB higher intakes of water are required when children are physically active, or the weather or environment is hot.
Overweight children may also require more water.

- Do not restrict fluid intake. If fluid intake is excessive, consider whether the child / young person may have diabetes insipidus
- Children and young people should be encouraged to take full water bottles (500 – 750mls) to school and drink the contents
- Water is the healthiest drink and should be encouraged. However, many children refuse to drink it. If children / young people do not like to drink water, arrangements should be made for them to take a non-see-through bottle to school with diluted fruit squash (preferably sugar-free)

- Schools should be asked to allow the child open access to their drinks bottles and to the toilet, particularly if they are being encouraged to increase their drinking, or have day time continence problems

Strategies to help children increase their fluid intake:

- Positive reinforcement for drinking well, including use of appropriate charts and rewards
- Start with expecting the child to drink only slightly more than they currently are and gradually increase expectations
- Measure out what the child should be having in a day into a clean jug or plastic bottle. Making all their drinks from that can help them visualise how well they are doing. If they have a drink from a carton or bottle, the equivalent quantity of water from the jug or bottle can be poured away. The child should be encouraged to finish their jug or bottle by the end of tea time each day
- Some children manage well if given a full glass and are told to drink half, others do better if given half a glass and are told to finish it
- Build drink times into the family's daily routine
- Make drink times fun: Sitting together with a book or game and refusing to read any more/throw the dice until the child has had a few more sips; using straws or a different glass or cup; adding ice
- If children really dislike or refuse to drink water, offer fruit squashes or diluted fruit juices. Many of these are high in sugar content – sugar free alternatives are best, for children who will not drink water
- Ice lollies and jellies are high in fluid content, but also tend to be high in sugar, so should be used with caution
- Families should be advised to avoid battles over drinks
- The child should be having half their daily intake by dinner time (midday meal) to avoid them having large quantities late in the day, as this may cause or exacerbate night time wetting

DIETARY ADVICE

- Dietary adjustment alone is not an acceptable treatment for chronic constipation, but does play a part in treatment and is part of health promotion
- Children/ young people should be encouraged to eat five or more portions of fruit and vegetables per day
- Children/ young people should not be encouraged to eat large amounts of high fibre foods (such as Weetabix or all bran) as this can exacerbate constipation if fluid intake is inadequate
- Children / young people should not be eating unprocessed bran
- Wholegrain cereals, brown bread and rice can be helpful and are part of a healthy diet
- Children over the age of one year should not be having more than a pint of milk or its equivalent (yoghurts, fromage frais, cheese, custards, rice puddings etc) per day. This can exacerbate constipation, reduce appetite and prevent children from having a balanced, varied diet

N.B. Please always follow any advice from the dietitian and ensure that the child does not have any foods to which they may have intolerances or allergies.

SYMPTOMS OF CONSTIPATION

Constipation in childhood is a common problem. For many it lasts only a few days but it can become chronic in up to a third of children and is a common reason for referral to secondary care. Chronic constipation is usually idiopathic (it happens spontaneously and/or the cause is not known). Symptoms vary between children and it is possible for children to be having a bowel motion most days, but to be constipated if they are only partially emptying the rectum. Other children may only pass loose stools, which means it is not always easy to diagnose constipation in children.

Symptoms of constipation in children are:

- Infrequent bowel motions (less than three times / week in children over 3 years)
- Unpleasant smelling wind or bowels motions
- Excessive flatulence
- Varying texture to bowel motions
- Small, hard or very large poos
- Withholding or appearing to strain
- Soiling or overflow
- Bowel motions in sleep in children over a year in age
- Abdominal pain
- Abdominal distension
- Poor appetite, often improves after a large bowel motion
- Lethargy
- Unhappiness, anger or irritability that improves after a large bowel motion

NB. If the child is presenting as acutely unwell, has faltering growth or gross abdominal distension they should be reviewed by the GP or a paediatrician.

(Constipation in Children and Young People NICE clinical guideline 99, 2010.)

https://www.nice.org.uk/guidance/cg99

Nice has a range of useful resources which are freely available to download:

https://www.nice.org.uk/guidance/cg99/resources

TOILETING ADVICE

- Encourage the child / young person to use the toilet regularly during the day. About two hourly is the correct interval for most. However, if the child / young person is wet more often than this, the interval should be shorter to try and ensure that they remain dry
- Suggest that the child / young person uses the toilet after they have had a drink. When the child is toileting two hourly this can help with fluid intake as well
- Ensure the toilet is easy to access, clean and well stocked with toilet paper etc. This is particularly important at school. Secondary school children may benefit from a toilet pass. Primary school children may need the teacher to know about the continence problem. Having a signal to indicate that the child is going to the toilet may be helpful, rather than them having to wait to ask to go
- Ensure that smaller children have an insert seat and stool, so they are able to sit comfortably, well supported and with their feet on a firm surface
- Ensure that children with mobility difficulties or sensory issues have been referred to an occupational therapist for assessment of their toileting needs
- If the child / young person feel they need to pass urine urgently or suddenly, they may be encouraged to count to five and if the feeling goes away to wait until the next planned toilet visit. If the feeling remains or they are likely to wet if they do not toilet quickly, then they should go straight to the toilet. Open access should be arranged for the toilet at school
- There is no evidence of benefit from trying to put off passing urine for longer than a few seconds if a child has urgency or day time wetting and this should not be encouraged
- Children should be encouraged to remain at the toilet long enough to complete voiding
- Children should be encouraged to sit on the toilet long enough to complete a bowel action. They should be able to sit privately. For children with constipation and soiling, there is often benefit from allowing them access to the disabled toilet in school as this is often more private than the main toilets
- If the child is wetting /soiling at school it would be helpful to them to have spare clothes, wipes and plastic bags for the damp clothes, in their bag to allow changing as needed. Parents/carers should provide these from home and arrange replacements as needed
- Children should be supported to learn to change independently as soon as they have the developmental skills, which is usually from about four years old. If they are wetting/soiling in school, they may need support with learning to change themselves initially, or until their dexterity is sufficiently good to manage alone
- It is not acceptable for schools and nurseries to request parents or carers attend to support their children with personal hygiene
- Guidance is available for schools to help them manage children with medical needs:
  https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/638267/supporting-pupils-at-school-with-medical-conditions.pdf

SKILLS FOR TOILET TRAINING`

Toilet training is one of the earliest self-care skills developed by children and is one of the most important. In traditional societies, most children have attained continence by their second birthdays. In the Western World, the age of toilet training has increased in the last 50 years. There is research that suggests children should start toilet training in their second year.

Working on the skills for toilet training should not be delayed due to disability. Failure to offer support and advice for toilet training to a child with disabilities may be considered discriminatory. When childen remain reliant on contience containment products, rather than toilet training, they may fail to achieve their potential, with associated increased dependence compared to their peers, reduced self-esteem and self-confidence, increased liklihood of abuse and there is more stress for them and their family.

- Ensure the child has a varied diet and adequate fluid intake (see relevant sections of this document)
- Encourage the child to sit on the toilet or potty regularly. The potty may be better for smaller children due to them feeling more secure and having feet well supported on the floor. However, if the toilet is used, smaller children must have an insert seat and stool on which they can rest their feet when sitting, to ensure they are in the correct position to pass urine or open their bowels.
- If the child has any physical or sensory issues, they should have an early referral to the occupational therapist for assessment of their toileting needs.
- Start by sitting the child on a potty, or adapted toilet once a day for short periods of time and gradually increase frequency and time of sitting. Do not sit the child for more than 3-4 minutes.
- Encourage regular drinks (about 2 hourly) and then potty/toilet times after drinks. About 10-15 minutes later is often best if parents/carers can manage this, otherwise straight away.
- Tip solid poos down the toilet and then flush them away, with the child present.
- Change all nappies in the bathroom.
- If the child is mobile ensure they are standing to have their nappy changed. Encourage them to be as involved as possible and tip any solid matter down the toilet, involving the child in flushing the toilet.
- Have an open door policy for toileting so the child sees parents/carers and siblings using the toilet
- Ensure all carers use the same words to describe wee and poo. Avoid using the word ‘dirty’ for poo as this has other meanings
- Discuss the difference between wet and dry
- Consider using stories, videos etc
- Children who have communication, processing or learning difficulties are often helped by the use of picture cue cards
- Encourage the child to learn to help dress and undress themselves.
- Use clothes that are easy for the child to manage
- Encourage the child to say (or sign) when they are wet or have opened their bowels.

- Modern nappies are very efficient at drawing moisture away from the skin, so reduce the child's awareness of passing urine, or opening their bowels.
- Consider using cotton underwear or kitchen towel inside the nappy to raise awareness of when they are wet or dry.
- Ensure the parent/carer has a plan for dealing with wetting or soiling when away from home and has good routines established.
- At a time when the child appears to be progressing and the parent/carer is able to be home for most of a couple of days remove nappies.
- Start using underwear or training pants during the day. There are pads (Dry Like Me) available in most large supermarkets that are designed to support toilet training if parents/carers want to use a pad.
- Praise and reward success, change in the bathroom when needed with minimum fuss and feedback
- Consistency is important and once progress is being made, the parent/carer should be encouraged not to return to nappies during the day.

Children who give no indication of needing to use the toilet:

- Consider using cotton underwear or kitchen towel inside the nappy to raise awareness of when they are wet or dry.
- Consider a trial without nappies for at least a few days. Parents/carers will need to have a strategy for managing on trips out. For children with disabilities, a wetting alarm (the same as a body-worn enuresis alarm) may be helpful. These can be borrowed from the continence service.
- Regular drinks, (about two hourly) followed by regular trips to the toilet/potty can help the child by ensuring they are voiding more often during the day.
- Keeping a record, using a toileting chart (see appendix) for at least three days, of when the child is drinking and when they are passing urine can help parents/carers to see their child's natural pattern and help them to get the child to the potty/toilet at the right time
- Doing all changing in the toilet or bathroom, flushing solid stools down the toilet and sitting the child on the toilet when changing them can all be helpful.
- Using positive reinforcement (praise, reward charts with time based rewards) for targeted behaviours.

('One Step at a Time - A Parent's Guide to Toilet Skills for Children with Special Needs.' Continence Foundation of Australia 2010)
'Toilet training of infants and children 2010 parental attitudes and practices'. A. C. Jursi (The Restraint Project UNSW))

TOILETING ASSESSMENT

Toileting assessment should commence in the child's second year, when there is an identified physical disability of learning difficulty, or as soon as it is identified that there is a delay in toilet training. It should be dynamic process, with a programme put in place to address any issues. The child should be reassessed every one to three months (depending on individual needs), with the family given an individualised programme to follow in the meantime. The amount of support required will depend on the child's needs and the family dynamics, with some families needing frequent review and others minimal intervention.

The first stage of a toileting assessment involves asking the parents/carers to keep a full toileting diary for at least three days using the toileting chart (below). This is important as part of promoting bladder and bowel health, even for children who are unlikely to ever be able to toilet train due to the extent of their disability. Failure to fully assess a child's bladder and bowel health may result in problems being missed, with serious long-term consequences. Any problems detected on assessment, such as constipation, constant dribbling of urine, inability to sit, behaviour problems etc, must be addressed.

- The toileting chart should be printed so that the parents/carers have a copy of the instructions that are on the reverse
- Parents/carers should be advised to keep records for all the child's waking hours for at least three full days. This must be done on days when the child is with the parent/carer all day (i.e. not on school days) and these days do not need to be consecutive. They should also keep records of the child's bowel motions for at least seven consecutive days.
- As modern disposable nappies are so absorbent, it is sometimes difficult to tell the child has voided if they have only passed small amounts of urine. Therefore it is recommended that the child wear cotton pants inside the nappy, or that the parent/carer fold a piece of kitchen towel inside the nappy. It is very obvious when these are wet. The pants or piece of kitchen towel should be changed if they are wet when the nappy is checked, but the nappy does not need to be changed more often than usual.
- The toileting chart should be reviewed when completed to see if:
    - the child is having the recommended intake of drinks,
    - to ensure they are not having excessive milk,
    - to see whether they appear to be having normal bowel actions and
    - to see if they are able to stay dry for more than an hour at a time.
- As promotion of bladder and bowel health is the priority for all children, parents/carers should be offered advice as appropriate from the information received from the toileting chart.
- Where a dietician is involved, they should be consulted prior to advice being given to the parent/carer about diet, fluid or milk intake.

Once the toileting chart is completed and returned the assessment tool for toilet skills assessment chart (see below) must then be completed. This should be done with the child and parent/carer, so that the child can be observed in their normal environment, the parent/carer is involved and advice is given in an appropriate and timely way. Carrying out the assessment will allow skill deficits to be identified,

alongside any underlying pathology. The assessment tool can then be used to inform an individualised toilet skill development programme.

- Sections a) and b) of the toilet skills assessment, must be completed using the toileting charts and information observed by the assessor. Normal formed bowel movements (section (b) 2 and 3) refer to a child passing type 3 -5 stools three times a day to once every three days. Any bowel or bladder problem should be addressed using the relevant pathway or discussed with the continence service.
- Products are not normally provided for children with enuresis (night time wetting- see section (c)), as this is considered a treatable condition. If the child is dry during the day, the enuresis pathway should be followed.
- If a child is opening their bowels (section d) at night and is more than one year old, this is normally an indication of constipation. The constipation pathway should be followed.
- Low scores for the section titled INDEPENDENCE (sections (e), (f), and (g)) do not mean that a child cannot toilet train. Efforts should be made to address the problems:
    - If a child is not sitting, then this should be gradually introduced using incentives and encouragement
    - If a child is not giving any indication of needing to go to the toilet, then sign language, or picture communication may need to be introduced. Individual advice may be sought from the continence service
    - Inability to handle clothes is of itself not a reason for a child to be prevented from toilet training. Assistance should be given to help the child to learn to handle their clothes, where possible. Advice should be provided to parents/carers about using clothes that are easier to adjust, or about appropriate adaptations. The occupational therapist may be able to make suggestions or offer help.
- If it is found that a child never passes urine or opens their bowels on the toilet or potty (sections (h) and (i)) then appropriately timed toileting should be tried. The toileting chart can be used to see if there is any pattern to wetting/soiling, or if these are related to drinks or meals. This information can be used to inform toilet visits. A daytime wetting alarm may increase the child's awareness of when they are voiding
- High scores for section (j) – behaviour problem – does not mean that a child cannot toilet train. Efforts should be made to address the problems. Learning disability services may be able to offer some suggestions.
- If a child is likely to require toileting aids or adaptations (section (l)), that should be addressed early and may require referral to the occupational therapist.
- If a child is not responding to basic commands (section (m)), then changing routines or introducing picture cue cards or social stories may be helpful.
- Diet (section (n)) and fluids (section (o)) should be assessed and any changes required discussed with the family, paying heed to individual children's needs or advice given by a dietician if involved.

The toilet skills assessment should be reviewed and actions should be taken as indicated by the prompts. If these actions are felt to be inappropriate this should be

documented with the reasons in the child's notes. It is not acceptable to ignore highlighted problems. These must be treated where possible and the child then reassessed for their ability to toilet train.

A formal toielt training programme should be put in place once the child is achieving the skills to enable training to take place. These include:

- A maturing bladder that can hold urine for around 1 ½ - 2 hours
- A bowel that is not constipated
- An abilitty to sit on the toilet/potty for sufficient time to complete bladder or bowel empyting (with support or adaptations if required).

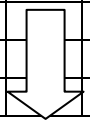
The continence service should be consulted as required. In line with the National Guidance for Provision of Continence Containment Products 2016 (available from Bladder and Bowel UK), products will only be provided to children who are at least four years old and have undertaken full assessment and toilet training trial as above. However, every child will be considered on an individual basis and decisions will be made based on the outcome of assessment.

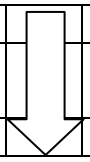
More resources to support toilet training are available online from Bladder and Bowel UK: www.bladderandboweluk.co.uk

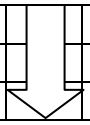
The recommendations here are in line with those in the Guidance for the provision of continence containment products to children and young people: a consensus document (2016) available from http://www.bladderandboweluk.co.uk/wp-content/uploads/2016/12/final-Guidance-Paed-product-provision-doc.pdf

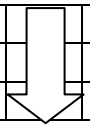
TOILET SKILLS ASSESSMENT

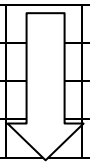
Child's Name: ……	**Date of Birth: ……..** **NHS No: .....**
Initial Assessment completed by: ……	Date of 1st assessment: …… Date of 2nd assessment: ..... Date of 3rd assessment: .....

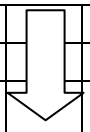
		Assess 1	Assess 2	Assess 3
(a) bladder function – bladder emptied:		√	√	√
1 More than once per hour				
2 Between 1-2 hourly				
3 More than 2 hourly				

(b) Bowel function:				
1 Has more than three bowel actions per day				
2 Does not always have normally formed bowel movements ie is subject to constipation or diarrhoea				
3 Has regular normally formed bowel movements				

(c) If night-time wetting occurs:				
1 Frequently i.e. every night				
2 Occasionally i.e. has occasional dry nights				
3 Never				

(d) If night-time bowel movements:				
1 Occur frequently i.e. every or most nights				
2 Occur occasionally i.e. has some clean nights				
3 Never occurs				

INDEPENDENCE				
(e) Sitting on the toilet:				
1 Afraid or refuses to sit				
2 Sits with distraction or encouragement				
3 Sits briefly with or without toilet adaptation				
4 Sits long enough to complete voiding or a bowel action				

(f) Going to the toilet:				
1 Gives no indication of need to go to the toilet				
2 Gives some indication of need to go to the toilet				
3 Sometimes goes to or indicates need for toilet of own accord				

		Date	Date	Date
(g) Handling clothes at toilet:		√	√	√
1 Cannot handle clothes at all				
2 Attempts or helps to pull pants down				
3 Pulls pants down by self (if physically able)				
4 Pulls clothes up and down without help				

Other components				
(h) Bladder control:				
1 Never or rarely passes urine on toilet/potty				
2 Passes urine on toilet sometimes				
3 Passes urine on toilet every time				
4 Can initiate a void on request				

(i) Bowel control:				
1 Never or rarely opens bowels on toilet/potty				
2 Opens bowels on toilet sometimes				
3 Opens bowels on toilet every time				

(j) Behaviour problem, that interferes with toileting process eg screams when toileted, faecal smearing:				
1 Occurs frequently				
2 Occurs occasionally i.e. less than once a day				
3 Never occurs				

(k) Wears disposable nappies, "pull ups" or similar:				
1 Yes				
2 No				

(l) Toilet:				
1 Requires toileting aids or adaptations				
2 Uses normal toilet/potty				

(m) Response to basic commands, eg "come here":				
1 Never responds to commands				
2 Occasionally responds				
3 Always responds				

(n) Diet:				
1 Refuses/unable to eat any fruit/veg				
2 Will occasionally eat fruit/veg each day				
3 Eats adequate amount (age+5 = grams fibre)				

(o) Fluid intake:				
1 Drinks poor amount < 50ml/kg per day				
2 Drinks 50mls/kg per day < (4-5 drinks)				
3 Drinks 80ml/kg per day (6+) drinks				

PLEASE COMLETE IN BLACK INK

Frequency Volume Chart

Instructions Overleaf

Name: ……..

Date Started: ……

Continence Advisory Service

Tel:

	DAY 1			DAY 2			DAY 3		
	Drinks	**Urine**	**Bowels**	**Drinks**	**Urine**	**Bowels**	**Drinks**	**Urine**	**Bowels**
6 am									
7 am									
8 am									
9 am									
10 am									
11 am									
Midday									
1 pm									
2 pm									
3 pm									
4 pm									
5 pm									
6 pm									
7 pm									
8 pm									
9 pm									
10 pm									
11 pm									
Midnight									
1 am									
2 am									
3 am									
4 am									
5 am									
TOTAL									

INSTRUCTIONS

Please record

1. **Type and amount of all drinks (in mls)**
2. **The amount of urine passed in mls (measure in a jug)**
3. **The time and type of bowel movements, using the Bristol Stool Chart opposite ►**
4. **Any wet beds or wet clothes (write wet in the urine column). If wetting occurs estimate the amount by writing**
   WS for a small amount
   WM for a medium amount
   WL for a large amount
5. **Indicate bedtime by writing B in the urine column**
6. **Indicate time of waking by writing M in the urine column**

BRISTOL STOOL CHART

Type 1. Separate hard lumps, like nuts (hard to pass)

Type 2. Sausage-shaped but lumpy

Type 3. Like a sausage but with cracks on the surface

Type 4. Like a sausage or snake, smooth and soft

Type 5. Soft blobs with clear-cut edges (passed easily)

Type 6. Fluffy pieces with ragged edges, a mushy stool

Type 7. Watery, no solid pieces, entirely liquid

PLEASE COMPLETE IN BLACK INK **TOILETING CHART** **Instructions overleaf** **Name…….** **NHS NO ……...** **Date started…….**	**Continence Advisory Service** **Tel:**	

	Day 1			Day 2			Day 3		
	Drinks	**Urine**	**Bowels**	**Drinks**	**Urine**	**Bowels**	**Drinks**	**Urine**	**Bowels**
6 am									
7 am									
8 am									
9 am									
10 am									
11 am									
Midday									
1pm									
2pm									
3pm									
4pm									
5pm									
6pm									
7pm									
8pm									
9pm									
10pm									
11pm									
Midnight									
1 am									
2 am									
3 am									
4 am									
5 am									
TOTAL									

It is important that you complete this chart as part of the assessment of your child's bladder and bowel health and their ability to toilet train.

INSTRUCTIONS

Please record

1. Type and amount of all drinks (in mls)
2.
3. Check your child's nappy every hour, when they are awake, and record whether wet (W) or dry (D). This can be difficult with modern "super absorbent" nappies. We suggest that you put something inside the nappy, so that you can easily tell whether your child is wet or dry. Folded kitchen roll works well; if the kitchen roll is wet, change it, but the nappy can stay on until it will not hold any more urine

4. If your child uses the toilet or potty successfully, put (T) in the urine column

5. Record poos in the bowel column

Try and carry on for as many days as you can. Please continue for at least four days.

Bristol Stool Chart

Type 1. Separate hard lumps, like nuts (hard to pass)

Type 2. Sausage-shaped but lumpy

Type 3. Like a sausage but with cracks on the surface

Type 4. Like a sausage or snake, smooth and soft

Type 5. Soft blobs with clear-cut edges (passed easily)

Type 6. Fluffy pieces with ragged edges, a mushy stool

Type 7. Watery, no solid pieces, entirely liquid