**Continence Care**

**Bladder and Bowel diary**

Please record as accurately as you can the amount you drink and the amount of urine you pass. Every time you pass urine you will need to catch it in a container which has volumes marked on it (e.g. a plastic jug). Hand the completed form to your health care professional as this information is needed to help plan your care. Further guidance on completing this diary is on the back of this diary.

**Instructions**

**How to complete this diary:** (If possible please complete the following information)

**Time**: Indicate the time you woke and slept. When you have a drink or pass urine, write down the volume in the appropriate column against the relevant time (as near to the hour as is possible)

**Drinks:** Record the **amount** and **type** of drink when consumed. E.g. 200ml milk

**Urine passed:** Record the amount of urine you passed ideally in millilitres (ml) using a measuring jug. If you passed urine but couldn’t measure it, put a tick in this column. If you leaked urine at any time write **leak** here.

**Bowels open:** Put a tick in this column at the time you open your bowels. If you are incontinent with your bowel write if you changed your pad or clothes.

**Changed pads/clothes:** If you change a **pad** put a tick in this column.

**Change pads/Clothes:**  If you do not wear pads but had to change your **underwear/clothing** then put a **C** in this column.

If you have had to change **both** your pad and clothing/underwear then please indicate this in the column with a tick and a **C**

[](http://d111vui60acwyt.cloudfront.net/product_photos/3169638/Profile(1)_original.jpg) A cup usually holds around 150ml

[](http://www.backgroundsy.com/file/preview/red-cup.jpg)

A mug normally holds 250ml

**Patient Name: NHS no: Date of Birth:**Click or tap here to enter text.

**Day 1**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Time** | **Drink** | **Urine passed** | **Bowels open** | **Changed pad/ clothes** |
| 6 am |  |  |  |  |
| 7 am |  |  |  |  |
| 8 am |  |  |  |  |
| 9 am |  |  |  |  |
| 10am |  |  |  |  |
| 11am |  |  |  |  |
| 12md |  |  |  |  |
| 1 pm |  |  |  |  |
| 2 pm |  |  |  |  |
| 3 pm |  |  |  |  |
| 4 pm |  |  |  |  |
| 5 pm |  |  |  |  |
| 6 pm |  |  |  |  |
| 7 pm |  |  |  |  |
| 8 pm |  |  |  |  |
| 9 pm |  |  |  |  |
| 10pm |  |  |  |  |
| 11pm |  |  |  |  |
| 12mn |  |  |  |  |
| 1 am |  |  |  |  |
| 2 am |  |  |  |  |
| 3 am |  |  |  |  |
| 4 am |  |  |  |  |
| 5 am |  |  |  |  |
| Total |  |  |  |  |

**Patient Name: NHS no: Date of Birth:**Click or tap here to enter text.

**Day 2**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Time** | **Drink** | **Urine passed** | **Bowels open** | **Changed pad/ clothes** |
| 6am |  |  |  |  |
| 7 am |  |  |  |  |
| 8 am |  |  |  |  |
| 9 am |  |  |  |  |
| 10am |  |  |  |  |
| 11am |  |  |  |  |
| 12md |  |  |  |  |
| 1 pm |  |  |  |  |
| 2 pm |  |  |  |  |
| 3 pm |  |  |  |  |
| 4 pm |  |  |  |  |
| 5 pm |  |  |  |  |
| 6 pm |  |  |  |  |
| 7 pm |  |  |  |  |
| 8 pm |  |  |  |  |
| 9 pm |  |  |  |  |
| 10pm |  |  |  |  |
| 11pm |  |  |  |  |
| 12mn |  |  |  |  |
| 1 am |  |  |  |  |
| 2 am |  |  |  |  |
| 3 am |  |  |  |  |
| 4 am |  |  |  |  |
| 5 am |  |  |  |  |
| Total |  |  |  |  |

**Patient Name: NHS no: Date of Birth:**Click or tap here to enter text.

**Day 3**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Time** | **Drink** | **Urine passed** | **Bowels open** | **Changed pad/ clothes** |
| 6 am |  |  |  |  |
| 7 am |  |  |  |  |
| 8 am |  |  |  |  |
| 9 am |  |  |  |  |
| 10am |  |  |  |  |
| 11am |  |  |  |  |
| 12md |  |  |  |  |
| 1 pm |  |  |  |  |
| 2 pm |  |  |  |  |
| 3 pm |  |  |  |  |
| 4 pm |  |  |  |  |
| 5 pm |  |  |  |  |
| 6 pm |  |  |  |  |
| 7 pm |  |  |  |  |
| 8 pm |  |  |  |  |
| 9 pm |  |  |  |  |
| 10pm |  |  |  |  |
| 11pm |  |  |  |  |
| 12mn |  |  |  |  |
| 1 am |  |  |  |  |
| 2 am |  |  |  |  |
| 3 am |  |  |  |  |
| 4 am |  |  |  |  |
| 5 am |  |  |  |  |
| Total |  |  |  |  |

**Patient Symptom Questionnaire** (Bladder-PSQ Urinary)

(Adapted from Kings Health Questionnaire)

**DATE OF COMPLETION: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **QUESTION/SCORE** | **Very good (1)** | **Good (2)** | **Poor (3)** | **Very poor(4)** | **Not assessed (0)** |
| How would you describe your health at present |  |  |  |  |  |
| **INCONTINENCE IMPACT** | **Not at all (1)** | **A little (2)** | **Moderately (3)** | **A lot (4)** | **Not assessed (0)** |
| How much do you think that your bladder problem affects your life |  |  |  |  |  |
| **ROLE LIMITATIONS** | **Not at all (1)** | **A little (2)** | **Moderately (3)** | **A lot (4)** | **Not assessed (0)** |
| Does your bladder problem affect your household tasks (cleaning, shopping etc) |  |  |  |  |  |
| Does your bladder problem affect your job or daily activities outside the home |  |  |  |  |  |
| **PHYSICAL/SOCIAL LIMITATIONS** | **Not at all (1)** | **A little (2)** | **Moderately (3)** | **A lot (4)** | **Not assessed (0)** |
| Does your bladder problem affect your physical activities (sports, running, gym) |  |  |  |  |  |
| Does your bladder problem affect your ability to travel |  |  |  |  |  |
| Does your bladder problem limit your social life |  |  |  |  |  |
| Does your bladder problem limit your ability to see and visit friends |  |  |  |  |  |
| **PERSONAL RELATIONSHIPS** | **Not at all (1)** | **A little (2)** | **Moderately (3)** | **A lot (4)** | **Not assessed (0)** |
| Does your bladder problem affect your relationship with your partner |  |  |  |  |  |
| Does your bladder problem affect your family life |  |  |  |  |  |
| Does your bladder affect your sex life |  |  |  |  |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **EMOTIONS** | **Not at all (1)** | **A little (2)** | **Moderately (3)** | **A lot (4)** | **Not assessed (0)** |
| Does your bladder problem make you feel depressed |  |  |  |  |  |
| Does your bladder problem make you feel anxious or nervous |  |  |  |  |  |
| Does your bladder problem make you feel bad about yourself |  |  |  |  |  |
| **SLEEP/ENERGY** | **Never (1)** | **Sometimes (2)** | **Often (3)** | **All the time (4)** | **Not Assessed (0)** |
| Does your bladder problem affect your sleep |  |  |  |  |  |
| Does your bladder problem make you feel worn out and tired |  |  |  |  |  |
| **DO YOU DO ANY OF THE FOLLOWING (if so how much)** | **Never (1)** | **Sometimes (2)** | **Often (3)** | **All the time (4)** | **Not Assessed (0)** |
| Wear pads to keep dry |  |  |  |  |  |
| Be careful of how much fluid you drink |  |  |  |  |  |
| Change your underclothes because they got wet |  |  |  |  |  |
| Worry that you smell |  |  |  |  |  |
| **BLADDER SYMPTOMS - Over Active Bladder (OAB)** | **Never (1)** | **Sometimes (2)** | **Often (3)** | **All the time (4)** | **Not Assessed (0)** |
| Frequency: Going to the toilet very often |  |  |  |  |  |
| Nocturia: Getting up at night to pass urine |  |  |  |  |  |
| Urgency: Strong and difficult to control desire to pass urine |  |  |  |  |  |
| Urge Incontinence: Urinary leakage associated with a strong desire to pass urine |  |  |  |  |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **STRESS INCONTINENCE - (SUI)** | **Never**  **(1)** | **Sometimes (2)** | **Often**  **(3)** | **All the time (4)** | **Not Assessed (0)** |
| Stress Incontinence: Urinary leakage associated with physical activity (coughing, laughing, getting out of chair/bed etc.) |  |  |  |  |  |
| Nocturnal Enuresis: Wetting the bed at night |  |  |  |  |  |
| Leakage is only ever a small amount |  |  |  |  |  |
| Intercourse Incontinence: Urinary Leakage associated with sexual intercourse |  |  |  |  |  |
| Waterworks infections |  |  |  |  |  |
| Bladder pain |  |  |  |  |  |
| **NEUROPATHIC INCONTINENCE (The following questions are statements )** | **Never (1)** | **Sometimes (2)** | **Often (3)** | **All the time (4)** | **Not Assessed (0)** |
| I leak urine continuously |  |  |  |  |  |
| I pass urine without knowing |  |  |  |  |  |
| I have no control of my bladder |  |  |  |  |  |
| **VOIDING DIFFICULTY** | **Never (1)** | **Sometimes (2)** | **Often (3)** | **All the time (4)** | **Not Assessed (0)** |
| I can feel when I need to pass urine |  |  |  |  |  |
| I have difficulty starting to pass urine |  |  |  |  |  |
| My urine stream is slow |  |  |  |  |  |
| When I pass urine, it is like a spray |  |  |  |  |  |
| I have to strain to pass urine |  |  |  |  |  |
| I feel my bladder doesn’t empty properly |  |  |  |  |  |
| I dribbled urine after I have passed urine |  |  |  |  |  |
| **FUNCTIONAL/ COGNITIVE** | **Never (1)** | **Sometimes (2)** | **Often (3)** | **All the time (4)** | **Not Assessed (0)** |
| I have difficulty getting to the toilet |  |  |  |  |  |
| I wait for my carers to assist me to the toilet |  |  |  |  |  |
| I find it difficult to adjust my clothing |  |  |  |  |  |
| I need to be reminded to go to the toilet |  |  |  |  |  |
| My skin is sore ‘down below’ |  |  |  |  |  |
| **COMMENTS & TOTAL SCORE** |  | | | | |

**Patient Symptom Questionnaire** (Bowel - PSQ Bowel)

**The following questions are statements –answer YES if it applies to you. NO if it does not & SOMETIMES if you occasionally have these symptoms**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **QUESTION** | **No**  **(1)** | **Sometimes (2)** | **Yes (3)** | **Not assessed (0)** |
| **CONSTIPATION PATHWAY** |  |  |  |  |
| My stools are hard and lumpy |  |  |  |  |
| I have to strain to have my bowels open |  |  |  |  |
| It hurts me when I pass stools |  |  |  |  |
| I open my bowels less than 3 times per week |  |  |  |  |
| I feel I do not empty my bowels completely |  |  |  |  |
| I use my hand/finger to help me pass a motion |  |  |  |  |
| **LOSS OF OR REDUCED BOWEL CONTROL (FI)** | | | | |
| I cannot wait when I want to have my bowels open |  |  |  |  |
| I open my bowels more than 3 times a day |  |  |  |  |
| I cannot always control my wind |  |  |  |  |
| I pass a solid (formed) motion when I do not mean to |  |  |  |  |
| I pass a soft motion when I do not mean too |  |  |  |  |
| I stain my underwear |  |  |  |  |
| I don’t always know when I want to open my bowels |  |  |  |  |
| **OTHER PROBLEMS** | | | | |
| My anus is sore |  |  |  |  |
| Mucus leaks from my back passage |  |  |  |  |
| I notice blood when I pass a motion |  |  |  |  |
| My anus itches/irritates |  |  |  |  |
| I have abdominal pain |  |  |  |  |
| I have abdominal cramps |  |  |  |  |
| **TOTAL SCORE & COMMENTS** |  | | | |

**CONTINENCE CARE – BOWEL DIARY**

Name: NHS No: Date of birth: Click or tap here to enter text.

This diary provides very important information about how your bowels function. This information will help your nurse and doctor plan the most suitable treatment for you. It also helps them measure how successful any help has been. Please complete it as fully as possible. Please write any comments or additional information overleaf.

|  |  |
| --- | --- |
| **Bristol Stool Scale:** | Every time you open your bowels refer to the Bristol Stool Scale card you have been given then write the appropriate number **1, 2, 3, 4, 5, 6 or 7** in this column against the correct time. |
| **Amount:** | Write the amount in this column against the correct time as: **S** small**, M** medium**, L** large. |
| **Soiled:** | If you have marked your clothes or pad write **S** in this column against the correct time. |
| **Pad change:** | If you have changed your pad write **P** in this column against the correct time |
| **Where:** | Write **T**=(Toilet) **C**=(commode) **B**=(bed) **P**(pad) in this column against the correct time. |

**What helps you to open your bowels?** Please tick the appropriate box.

## Laxatives Enemas Suppositories Hand or finger

**DATE: …………………… DATE: ………………………**

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Time** | **Bristol**  **Stool**  **Scale** | Amount **passed** | **Soiled**  **or pad**  **change** | **Where** |  | **Time** | **Bristol**  **Stool**  **Scale** | **Amount** | **Soiled**  **or pad**  **change** | **Where** |
|  |  |  |  |  |  |  |  |  |  |  |
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**DATE: …………………… DATE: ………………………**

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Time** | **Bristol**  **Stool**  **Scale** | Amount **passed** | **Soiled**  **or pad**  **change** | **Where** |  | **Time** | **Bristol**  **Stool**  **Scale** | **Amount** | **Soiled**  **or pad**  **change** | **Where** |
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