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Instructor Signature/Date:

1. Define simple constipation and address its clinical management.

Simple constipation is usually a transient constipation problem, usually related to dietary or environmental issues. Common dietary causes are eating a diet low in fiber and high in simple carbohydrates. Environmental issues may include a lack of exercising, immobility or changes in routines.

The clinical management for simple constipation is to have the patient increase their fiber and fluid, increase their activity level and try to defecate as soon as possible, when the urge comes on. Fiber intake should be 14g/1,000 calories. Fluid intake should be between 1500 and 2000ml a day. If these are ineffective, laxatives and enemas may be needed.

2. You are asked to see a male patient with marked and extensive incontinence associated dermatitis. On assessment you see marked erythema with wet and weepy dermatitis in the perianal and sacral skin. The patient has a recent history of acute CVA affecting the left side of his body complicated by pneumonia and a UTI, and is currently recovering in a long-term acute care facility. Swallow tests for this individual have demonstrated difficulty swallowing; a temporary gastrostomy tube is in place for feedings until oral feedings can safely resume. Diarrhea episodes began a week ago involving 5-6 episodes of liquid stool daily. A Foley catheter is in place with leakage of urine around the catheter.

a. What will your focused assessment consist of?

The focused assessment will consist of assessing general health, history, mental status, skin assessment and current mobility status. It's important know why the catheter was placed and how long it has been in place. This will help in identifying when and if it can be removed. The assessment should also include what treatments were initiated when the FI began. This is important because treatment options vary depending on the potential reasons the patient has developed diarrhea.

a. How will you approach the issue of urinary incontinence on a long-term basis?

Many patients will experience resolution of incontinence symptoms within 12 months following a CVA. However, with the foley catheter currently leaking, the need for it should be reevaluated. If the foley catheter continues to be needed, then possible causes of leakage should be

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considered. A way to assess if he continue to need the foley, it to try a voiding trial. If it is still needed, possible causes of leakage include blockage of the drainage holes, kinked or crushed catheter tubing or blood clots. If the reason is not known or can't be resolved, a new catheter should be inserted. If it continues to leak, assess for signs of renal calculi (grit/gravel in urine). If this is suspected, the patient should be referred to a urologist for possible intervention. If it continues to leak and renal calculi is not suspected, it could be related to an overactive bladder. A 7 day trial of an antimuscarinics can be tried. If no improvement, then a urology referral should be considered.

If the catheter is not needed, but the patient continues to be incontinent, then other interventions should be considered to protect the skin, such as a condom catheter. As the skin heals, behavior training may be appropriate, such as scheduled toileting and the patient should drink plenty of fluid. Concentrated urine can irritate the bladder. Pharmacotherapy may also be necessary. This would include an antimuscarinics, if detrusor overactivity is suspected. After 6 months, if the patient is showing signs of improving, they should take a drug holiday. If no improvement is noted, the patient should be placed back on the medication and a drug holiday can be tried again in another 3-6 months.

- b. What initial and ongoing urodynamic testing can be used to track the progress of regular and consistent bladder emptying with minimal breakthrough leakage?

Bladder scanning, after the patient has voided, can track consistent bladder emptying.

- d. How will you approach the issue of fecal incontinence for this person? Will you need to use containment devices? If so, what kind?

The diarrhea may be related to the gtube feedings, so may not be persistent. If the diarrhea persists, the type/rate of feeding may need to be altered. This can be done in collaboration with the dietician. In the meantime, due to the frequency of the stools and the condition of the perianal skin, an internal bowel management system may be the best choice. This can be placed until the stool thickens, slows down or the perianal skin heals.

- e. What skin care measures will be needed to correct this problem?

Skin measures that are needed include cleansing the perianal and sacral area with a perineal skin cleanser with any signs of leakage of fecal or urine. If the patient has a internal bowel management system in place, so small leaking may still, so choosing a product with zinc oxide and

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petrolatum may be a better choice than just zinc oxide, so that the skin does not get further damage from trying to rub the zinc oxide off of soiled skin. The area of the sacrum is at an increased risk of further breakdown due to the condition of the skin, so extra care in offloading this area should be accomplished. The patient should be instructed to turn frequently (q2h when lying/ q1h while sitting) or assisted in doing so, if unable to do himself. A foam dressing should be applied to the sacrum to help prevent further breakdown and should be changed q7days or if soiled. It should be pulled back every shift to check skin integrity.

3. A female patient reports she has had progressively worsening urine leakage for the last three years. She is a type II diabetic and has three grown children. The pattern of incontinence includes symptoms of stress and urgency. Given her medical history and symptoms, what type of medical management might be helpful to her? What behavioral strategies can you recommend that may reduce the incontinence episodes? Any additional recommendations?

Her symptoms suggest mixed urinary incontinence. Patients with mixed UI have sphincter dysfunction and bladder overactivity. To manage her symptoms, she will need to improve her pelvic muscle strength and sphincter function and reduce bladder irritability. Given her medical history of DM, it's important for her to manage her blood sugar levels. Hyperglycemia can cause the body to produce excessive volumes of urine, that can overwhelm the bladder and sphincter. This can produce a sudden urge to urinate, which can lead to leakage. If she had vaginal births, she may have weak or damaged muscles, so performing pelvic floor muscle training would be the first line of treatment. Other recommendations would be lifestyle interventions, such as weight loss (if appropriate), avoiding alcohol, caffeine, smoking and carbonated beverages. The patient should drink an adequate amount of fluid and avoid constipation. For urgency, she could start by attempting urgency suppression strategies and bladder training. This is done by rapidly contracting her pelvic floor on the onset of urgency and trying distraction techniques to slowly increase the time between voiding.

4. What strategies will you use to teach a group of nurses' aides to improve the use of condom catheters?

Strategies, to improve the use of condom catheters, include cleansing the penis with soap and water and dry, prior to placing the sheath. It is important that any adhesives, from prior applications, are removed and that there is nothing left on the skin surface that will interfere with the new adhesive material. Long pubic hairs should be trimmed, prior to application, so they won't get caught in the adhesive. A barrier film wipe should be applied to the skin and allowed to completely dry, prior to placing new sheath. This will protect the skin. [It's important to select the proper size condom catheter for the patient and place it correctly. Selecting the wrong size or](#)

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incorrect use, can lead to penile trauma, impaired skin integrity and leakage. Please ask for assistance, if you have not used the condom catheter before or are unfamiliar with its use. A sizing guide usually accompanies the condom catheter. Measure according to instructions. If in between sizes, go with the bigger size. When applying the new sheath, there should be no gaps between the glans penis and drainage tube, but not so much that the kinking or twisting can occur. This will help avoid trauma to the glans penis. After applying the condom catheter, if any unrolled section is noted, cut this unrolled section off to avoid constriction. Notify the nurse, if any signs of tissue damage are noted. When removing the condom catheter, the penis should be bathed in warm soapy water while rolling off the device. This will aid the adhesive in coming off and avoid trauma. If any signs of trauma, hematuria or a change in the urine color are noted, notify the nurse right away.

5. A 76 year old woman presents with a history of chronic constipation with fecal impaction and leakage of liquid stool. On assessment she denies any sensation of rectal fullness; her anal wink is intact, and her sphincter tone is normal with good voluntary contractility. She eats mostly starches, dairy products, and meats. She does not eat fruits and vegetables because they bother her stomach. She has used OTC laxatives to induce bowel movements with increasing frequency over the last few years. She reports current use of laxatives as being once a week and frequency of bowel movements as one or twice a week “with straining.” The leakage began just this week, and she is very upset about it. She says she will “do whatever you recommend” to get her bowels working right again.

a. What are your recommendations?

I would recommend discontinuing the use of the OTC laxative, The patient should be educated on other food sources of fiber. A list can be provided, so that she can choose items that she likes or willing to try. She should increase her fiber intake to 14grams per 1,000 calories consumed and try to increase her fluid intake to 1500-2000ml a day. The patient should be educated on the optimal position for defecating, which is in a squatting position. If using a standard toilet, it may be helpful to place a stool under her feet, so that her knees are higher than her hips. A food diary and stool chart may help determine if her food choices may be contributing to her constipation. These will be provided for her to fill out prior to our next meeting.

To help alleviate the current impaction, an oil-retention enema should be administered, and the stool mass broken up. She should be given MiraLAX to be taken daily until normal bowel movements are achieved. A daily stool softener can then be prescribed to prevent future reoccurrences.

5. Describe the components of a quality improvement project using CAUTI as the subject with the goal to decrease an institution's CAUTI rate.

The first step in starting a quality improvement project to reduce CAUTI rates would be to define the problem. The problem in this case is that CAUTIs are one of the most common hospital acquired infections and many of these infections are preventable.

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These infections are costly to the organization, cause discomfort to the patient and increase hospital stays.

The second step would be to define the goal or what you want to accomplish. A goal in this case could be to reduce the number of indwelling catheters being placed unnecessarily.

The third step is to measure the data. Collect information on the reasons catheters are being placed and the CAUTI rate. Perform a root cause analysis to identify the reasons for the CAUTIs

The fourth step is to analyze the data and come up improvements that can be made to reduce the number of catheters being inserted unnecessarily, as well as what the data determined was the cause of the CAUTIs. Such improvement could be staff education (proper insertion techniques, appropriate vs inappropriate use of indwelling catheters and prompt removal of catheters, when no longer needed). Staff can also be educated on alternatives to indwelling catheters, such as female external catheters and male condom catheters.

The fifth step is find the best way to implement the quality improvement measures.

The final step is to evaluate that the quality improvements, put in place ,were effective in meeting the goal.

******You have identified strategies for reducing CAUTI. The question is asking you to identify and describe the QI process. CAUTI was given as a topic for application.***

7. Mr. J.L. had an indwelling catheter placed for urinary retention secondary to an enlarged prostate. He is started on Finasteride (Proscar), 5 mgm once a day to decrease the size of his prostate. Mr. J. L. visits the urologist for a 2 month follow-up for removal of his indwelling catheter and a voiding trial.

a. What is meant by a voiding trial?

There are two types of voiding trials, active and passive. Passive voiding trial is when the catheter is removed, and the patient is monitored over the next 6 hours for voiding. If the patient fails to void in the 6 hours post removal, a bladder scan is performed. The results are reported to the physician to decide on an in and out catheter or to replace the indwelling catheter.

Active voiding trial is when 250-400 ml of saline is instilled via the lumen of the foley catheter by slow push and then the catheter is removed. The amount of saline is recorded. The patient is then assisted to void and should void within an hour. If pain or extreme fullness is noted or the patient is unable to void within the hour, the physician is notified, and a decision is made on how to proceed.

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The PVR is 425 cc, and the urologist orders clean intermittent catheterization rather than indwelling catheter use. The Finasteride is continued.

- a. State the goal of intermittent self-catheterization.

The goal of intermittent self-catheterization is to provide regular emptying of the bladder until voiding resumes (for retention). [The intervals should be enough to keep the bladder volume below 450-500m ml.](#)

- b. Describe education points to include for an individual performing self-catheterization.

Education points should include proper technique to perform the self-catheterization, how often, signs and symptoms of a UTI and when to call a health care professional. Proper and safe disposal, cleaning with soap and water and how to store, if reusing

- c. Identify at least three complications that can occur with intermittent self-catheterization.

1. Urinary Tract Infection

Using proper aseptic technique on insertion of catheter and avoiding overfilling of bladder by frequently catharizing are important prevention strategies.

2. Trauma

To avoid trauma, that patient should be taught to lubricate the catheter prior to insertion and to avoid inserting with pressure. If the patient has no or limited sensation, the patient should be observed, so that education can be provided if too much force is being used. Evidence of trauma is hematuria. The use of hydrophilic-coated or gel-coated catheters also help reduce trauma.

3. Urethral Strictures

This is a less frequent complication, but usually occurs with long term use of intermittent catheterization or with traumatic catheterization. Ways to help prevent this complication include education on proper catheterization, maintaining a healthy lifestyle, and preventing constipation.

- d. Describe the action of Finasteride (Proscar) and any side effect Mr. J. L. should be made aware of.

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Finasteride is a 5-alpha reductase inhibitor. It prevents the conversion of testosterone to DHT in the body. DHT stimulates prostate growth, which can lead to retention or other urinary problems.

Mr. J.L. should know that Finasteride has side effects that include reduced libido, erectile dysfunction, breast tenderness and/or breast enlargement.

9. Mr. P.V., 26 years old, has a neurogenic bladder secondary to an accident 3 years ago. He has been managed with an indwelling catheter (ISC was not workable for him secondary to ureteric reflux), is wheelchair bound and sexually active. He is finding intercourse uncomfortable secondary to the indwelling catheter and has discussed insertion of a suprapubic catheter with the urologist. Suprapubic tube (SP) insertion is scheduled for next week.

- a. What teaching points will Mr. V. need to know preoperatively?

Mr. V should know that the procedure is painful, so may require parenteral analgesia with or without sedation. Patient teaching should also include how the procedure is performed and any complications that can occur. The procedure is performed by cleansing the area around the insertion site, A catheter is inserted approximately 5 cm above they pubic symphysis. The catheter is preceded by a needle and guide wire to create the opening. The needle and guide wire are removed. Once the catheter is in place, a balloon is then inflated to keep the catheter in position. Potential complication includes hematuria (usually transient), cellulitis and abscess formation, catheter blockage, urinary calculi, UTI, and dermatitis at the stoma site.

- b. Discuss care of the suprapubic tube post-operatively including cleansing, dressing, securing of the catheter, changing of catheter, and etc.

Post op care of the catheter include keeping the insertion site clean. No dressing is needed once the site heals. The site should be cleansed daily with mild soap and water daily. Place a new gauze at insertion site, if it hasn't healed yet. Wash your hands prior to handling your catheter. Do not use any lotions or powders around the insertion site. Use a catheter support to properly position the catheter, so that there is no tension during rest or activity. The best place to secure is on the abdomen. The catheter should not have any kinks and always keep the drainage bag below the level of the bladder. You can shower with the bag in place. The catheter should be changed every 30 days, but possibly can go longer periods of time, if no problems exist, but should be evaluated after 30 days. The catheter should be changed sooner, if needed, to prevent any complications. Clean the bag every day after removing it from the catheter. Use another container while you clean the bag. To clean the bag, use the following steps:

1. Wash your hands

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2. Disconnect the bag from the catheter and place a clean bag on the catheter
3. Run clear water through the system
4. Irrigate the bag and tubing with either a bleach or vinegar solution for 30 seconds
 - a. 1 part bleach to 10 parts water
 - b. 1 part vinegar to 3 parts water
5. Drain the bag and then air dry

Notify your physician if any of the following occurs. .

- Your catheter becomes blocked and urine does not collect in the drainage bag.
- Your catheter leaks.
- You have blood or pus in your urine.
- You have pain in your back just below your rib cage. This is called flank pain.
- You have a fever, chills, or body aches.
- You have groin or belly pain.
- Your urine is cloudy or smells bad.
- You have pain, increasing redness, or bleeding around the catheter.
- You have swelling around the catheter or in your belly.

Reviewed 9/7/2021 Kelly Jaszarowski

Overall, well done. There are two questions needing further attention. One was unanswered. These are marked with asterisks.