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1. Define constipation and address its clinical management. ✓

Constipation is when stool remains in the colon. The colon absorbs too much water from the stool, the stool becomes hard and dry and cannot pass through. Constipation is having less than three bowel movements per week. The clinical management of constipation is Encourage the patient to drink two to four extra glasses of water daily and avoid caffeine and drinks containing alcohol. Asking the patient to walk and get enough exercise is essential. Assessing how the patient is sitting when on the commode is also important. Utilizing a stool to raise their feet into a squatting position may assist with bowel elimination. Also, educating the patient that adding fruits, vegetables, whole grains, and high-fiber foods will help decrease the chances of constipation. Adding over-the-counter fiber could be helpful also. These options would be Metamucil, Citrucel, or Benefiber. If true constipation occurs, a stool softener, laxative such as docusate, Milk of Magnesia, or even Mineral oil enemas. If necessary, there are prescription medications such as Amitiza, Trulance, or Linzess. (https://my.clevelandclinic.org/health/diseases/4059-constipation, 2023)

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?

Urinary and fecal incontinence should have their skin regularly assessed to check for signs of IAD and pressure injuries. The assessment would focus on the anatomical locations exposed to urine and feces, such as the anus, vulva, scrotum, labia, groin folds, lower abdomen, thighs, gluteal folds, gluteal cleft, buttocks, and sacrococcygeal region. Must assess for pressure injury development, secondary infection, such as candidiasis, herpes simplex, or pressure, and other factors, including assessing for distribution patterns, blistering, and skin color. It is also necessary to evaluate the type of enteral tube feeding the patient receives, which could cause diarrhea. Reviewing the patient's medications is also essential. The antibiotics utilized to treat the UTI could also contribute to diarrhea. Reviewing the antibiotics and making a change in them could be helpful. Testing the diarrhea for Clostridioides difficile should be completed. The patient has had a recent CVA and is recovering in a long-term acute care facility since the CVA most likely has decreased motility and is at risk for constipation, so a digital rectal examination may be necessary to assess for impaction. Good

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

This patient is suffering from a neurogenic bladder. There is no prevention for neurogenic bladder, but there are ways to assist with managing it. Prior to managing his neurogenic bladder, the provider will most likely order urodynamic studies, possibly a cystoscopy, ultrasound, x-ray, computed tomography scan, or magnetic resonance imaging scan. Educating the patient to make lifestyle changes such as avoiding alcohol and caffeinated drinks. Learning the correct absorbent undergarments, pads, and adult incontinence pads to utilize can be helpful to prevent the patient from being wet and odorous. It will also protect the skin and clothes.

Teaching the patient, the appropriate bed pads are also essential to protect the sheets and mattress. This patient is a new CVA patient, which has affected the left side of his body. Bladder training is necessary for this patient. Intermittent catheterization is one option for him, but he will most likely require assistance to complete the catheterization, because the patient may not have the capability to use the left side of his body to assist himself in performing catheterization. He needs a structured schedule every four hours while awake to decrease the possibility of overflow (Gray, 2022). Next, it is vital for the patient to educate him on pelvic floor therapy and lastly if necessary he may discuss the possibility of the need for botox injections with medications such as oxybutynin, or tolterodine (https://my.clevelandclinic.org/health/diseases/15133-neurogenic-bladder, 2023).

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

An initial and ongoing urodynamic testing can be used to track the progress of regular and consistent bladder emptying with minimal break- through leakage would include urinary flowmetry, bladder cystometrogram and electromyogram, valsalva leak point pressure, urethral pressure profile. Getting the patient onto a scheduled toileting program is essential (Thompson, 2022).

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

First, the provider must complete a comprehensive, collaborative assessment of diarrhea. A thorough evaluation would interview things such as stool odor, color, vital signs, abdominal pain, blood in stool, skin integrity, and much more (Kamp & Heitkemper, 2023). The provider must determine the cause of diarrhea because diarrhea may be causing complications. If it presently is not causing problems, it can cause the patient complications in the long run. Then, the provider will decide how to contain the diarrhea. The patient may suffer from Clostridioides difficile, malabsorption syndrome, or many other disorders in this scenario. Managing his diarrhea involves treating the underlying cause and supplying supportive care to provide fluids and electrolytes, skincare, and contain when needed. The containment of stool typically consists of

disposable absorbent body-worn absorbent products (BWAPs); other products, such as external fecal pouches or internal fecal management systems, are also available. For this patient, diligent skincare hygiene is critical, with regular checking of pads to reduce the risk of skin erosion from fecal enzymes and to utilize BWAPs. An external pouching system would be ideal until the patient can utilize a bedside commode. When able to be assisted in beginning a toileting program, the patient should be supported to begin a scheduled toileting regimen (Kamp & Heitkemper, 2023).

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

Unfortunately, guidelines for incontinence-associated dermatitis (IAD) treatment have not been created, but best practice principles have been established. Figuring out the patient's medications that may be causing a problem and speaking to his provider for alternative possibilities. Creating a toileting schedule can utilize a commode or bedpan and create that into the plan of care, formalizing incontinence as a problem but placing continence as the plan of care goal. For the IAD, cleansing with plain water out of a syringe, then applying a topical barrier, drying the area, and applying a topical antifungal medication such as nystatin or miconazole powder may be utilized to assist with moisture and antifungal control followed by a zinc paste. Remembering an essential part of this patient's care with IAD to keep in mind is pain. Analgesics should also be considered secondary to severe skin injury (Thayer & Nix). OK

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?

Medically, this patient could be prescribed pelvic floor therapy to assist with pelvic therapy. Having a discussion with her provider about medications or incontinence device insertion could be helpful to her. Patients with diabetes are usually also struggling with one or more of these symptoms, such as obesity, nerve damage, compromised immune system, or constipation. So, behavioral strategies that would be helpful to her would be informing her to decrease her caffeine intake, keeping a bladder diary, maintain a healthy weight or join a weight loss program if she is overweight, eat more fiber to avoid constipation. She could keep a bladder diary or set timers reminding herself to retrain her bladder and to regularly utilize the bathroom. Behaviorally, teaching her to decrease her caffeine intake, and when she does use the restroom, she needs to take her time after urinating, wait a minute and try to urinate again prior to getting up. good

4. You are teaching a group of CNAs how to apply an external (condom) catheter. What should be included in this education? How will you evaluate their understanding of what has been taught?

Education for application of a condom catheter is extremely important. If it is not applied correctly, it may cause skin breakdown and leakage. Informing the CNA to avoid the use of condom catheters on spinal bifidia patients or patients with latex allergy or

hypersensitivity to latex. Prior to application the CNA must inspect the penis for inflammation or any breaks in the skin. The application would begin with instruction of washing of their hands with soap and water, then trimming the hairs of the penis shaft and base. The penis should be washed thoroughly with mild soap and water and rinsed. After cleansing the skin needs to be dried well. After drying the skin then they would open the package and unroll the condom catheter. The condom catheter is applied much like a condom. It is then placed on the tip of the penis and rolled over the tip of the penis.

It will carefully and slowly start unrolling down the shaft with the CNAs assistance to the base of the penis. Must instruct the CNA to not place the condom does not rub the tip of the penis because it may cause chafing. The condom catheter should be unrolled as smooth as possible. If the patient is uncircumcised the foreskin must be placed over the head of the penis. After application then gently grip the catheter and squeeze gently to make sure the adhesive inside the condom catheter is adhered properly. Setting up educational testing such as skills stations for CNAs would be a way to make sure they understand what was taught to them. Great idea…consider a skin protectant to the shaft too

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. What are your recommendations?

She has already had her anal wink examined which revealed an intact wink, and her sphincter tone is normal with good voluntary contractility. The most probable problem is fecal incontinence secondary to chronic constipation. There are many tests she may undergo to evaluate this situation such as balloon expulsion test, anal manometry, proctography, colonoscopy, MRI, anal ultrasonography. All these tests evaluate the function of the anus and rectum. These tests will assist with figuring out her fecal incontinence. After having these, depending on the results, they would be able to make a firm plan of care. We are looking for a plan of care from you….just based on her history, **1. what other assessment would you do & what plan would you develop with her before we subject her to all of the above tests?**

Before sending the patient for detailed testing, a thorough assessment is essential. Interviewing the patient about her diet and bowel habits is critical. Evaluating the patient for blood in the stool, unintentional weight loss, and change in stool caliber and asking her if there is a family history of colorectal cancer is vital. She will warrant a definite referral for a workup if any of those symptoms are present. Having her keep a food diary and bowel diary would be a helpful guide, but she is reporting she is not receiving enough fiber in her diet, which could contribute to her constipation. The guidelines from

(the U.S. Department of Health and Human Services and the U.S. Department of Agriculture, 2015) recommend fiber intake daily for women to be at least 25g (Thompson, 2022). Maintaining the proper amount of dietary fiber, hydration, and physical activity is essential for bowel health.

Pelvic floor muscle therapy is also helpful for patients with constipation; it can improve the external and anal sphincter tone (Thompson, 2022). Educating the patient on high-fiber foods and different methods to increase her fiber and informing her of the importance of increasing her fluid intake could also help her fight against her constipation. Another strategy that could be helpful after she has implemented the fiber, increased fluids, increased physical activity, and the pelvic floor muscle therapy would be to add a cup of coffee in the morning to assist with bowel motility. Lastly, she could utilize Psyllium daily. Psyllium would increase colonic transit.

6. The following prompts relate to quality improvement projects and CAUTI:

a.) Describe the components of a quality improvement project.

Quality improvement is important for a successful project. Components would include Identifying the team, evaluating the qualitative and quantitative data. Then, implementing strategies to prevent CAUTI implementation would also include education. Lastly, sustain, if the project is not sustained by ongoing education, follow up it will not continue to improve.

b.) Identify and describe how you would design a QI project using CAUTI as the subject.

The way the QI project would be designed for CAUTI is by first, identifying the team which is vital. The team will consist of leadership, the patient and family, the residents, and the facility staff. Gathering of qualitative data which will supply the subjective data, and quantitative data which will offer the objective data to the project. Hmmm, team is definitely important but first you would identify the need or problem and then I think get a team together. I am not sure the patient and family are part of the team but gathering stats on CAUTI is certainly part of the plan**. 2. Talk briefly about establishing the plan…**

To establish a plan to wash hands before and after handling the urine bag with gloves. Must concentrate on keeping the bag below the patient's waist and off the floor and maintain a closed system, meaning do not break the opening of the catheter. Use an aseptic technique when drawing out the sterile specimen and continue to monitor for the earliest possible removal. Clean the catheter site with soap and water and secure the tubing to the thigh. Of course, the most critical prevention for CAUTI is to try to avoid catheter placement.

Next, implementation is the improvement strategies against CAUTI such as prevention, and then implementing education. Intervention is the checks and balances that the appropriate clinical indication is present for the treatment. Finally, sustaining the

project is essential; this is where implementing tools and modules will assist in maintaining the project.

7. Mr. J.L. had an indwelling catheter placed for urinary retention secondary to an enlarged prostate. He is started on Finasteride (Proscar), 5 mg 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. Explain the purpose of a voiding trial and how you will conduct it.

A voiding trial would be started by deflating the catheter balloon then remove the catheter slowly from the bladder. Then, saline should be instilled into the bladder with the amount recorded that is instilled, the patient should then be assisted to void within one hour and the amount should be recorded that is voided. After patient voids then a post void bladder scan will be performed and the amount remaining if any should be recorded.

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 avoid urinary incontinence and urinary retention. Although this is true **3. What is a more significant goal for ISC?** A significant goal for intermittent self-catheterization is to provide maximal drainage for the patient by providing minimal discomfort for the patient and minimizes complications.

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

Important educational points for self-catheterization are there are many sizes to be aware of, and other supplies necessary are cleansing towelettes and lubricant. Educating the patient on how to order their supplies and who their supply company is essential. The patient should also understand that self-catheterization should occur as often as they were to empty their bladder naturally, usually every 4-6 hours. Education on self-catheterizing in the morning and before bed is essential, as making the patient aware that if they consume more liquids to drink, they may need to catheterize more often to avoid overdistention. Informing the patient, the importance of washing their hands before and after the procedure and how to clean their catheter.

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

Three complications that can occur with intermittent self-catheterization are: urinary tract infections, difficulty with insertion of the catheter **4. What is another complication**, and trauma or bleeding to the urethra.

Urethral strictures, perforation, or spasms.

d. Describe the action of Finasteride (Proscar) and any other teaching points, such as side effects.

Finasteride treats symptoms of benign prostatic hypertrophy; it is a 5-alpha reductase inhibitor that stops testosterone from turning into another hormone called dihydrotestosterone (DHT). When taking Finasteride, teach the patient erectile dysfunction, the possibility of depression or suicidal tendencies, loss of libido or anxiety, and an increased incidence of high-grade prostate cancer in men. Women who are pregnant or potentially going to be pregnant should not handle crushed or broken Finasteride because they can absorb the medication, which can be a risk to the male fetus.

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 should be included in the pre-operative teaching of suprapubic catheter insertion?

Before suprapubic catheter placement, education is essential for the patient. Instruction includes information about sedation/anesthesia, incision size and location, surgical plan, catheter or stomal care and management, complications, ways to prevent them, toileting, ambulation, and recovery time; they also must be evaluated and pulmonary optimization. Discussing the patient's cultural wishes and values is essential. Education on caring for the catheter and ongoing management of the catheter is vital. Having the patient demonstrate what they learned will confirm that they understand. After the teach-back, documenting the teaching will help the surgical team understand what the patient has been taught, and the surgical team will then know what the patient will need to be educated on going forward.

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

Knowing how to manage a suprapubic catheter is essential. First, the patient should wash their hands with soap and water, then collect the supplies they utilize for catheter change, such as the catheter and a towelette for cleaning. The patient will assess the catheter site for pain, redness, or edema, and the patient should avoid using creams, powders, or sprays near the area. Lubricant and a container to collect the urine in will also be necessary. Apply two pairs of sterile gloves in a sterile fashion; the patient must deflate the balloon with a syringe and remove the old catheter. The patient will then remove the top sterile gloves and lubricate the end of the catheter that inserts into the abdomen. Insert the new catheter as far as the other old one was placed, waiting for urine to flow. When urine flows, the patient will inflate the balloon with 5-8ml of sterile water, and then the catheter is attached to the drainage bag. The patient shall use a drain sponge

around the tube and tape the tube to the skin. There should be enough slack in the tube to let the patient stand and walk without the tube pulling.

Thank you for the information here. I just wanted to say that many patients do not change their own suprapubic catheter and it really does depend on the patient and the physician. If the patient is changing it, good clean technique is often utilized even for the SP Cath. Many patients visit their urologist every few months to have the catheter changed.

References

https://my.clevelandclinic.org/health/diseases/4059-constipation, 2023

Kamp, K. & Heitkemper, M. (2022). Motility disorders. In J. Carmel, J. Colwell, M. Goldberg. (Eds.). *Wound, Ostomy, and Continence Nurses Society core curriculum: Ostomy management* (2nd ed., pp. 454-483). Wolters Kluwer.

Kamp, K. & Heitkemper, M. (2022). Motility disorders. Voiding Physiology. In Ermer-Seltun, J. & Engberg S. (Eds*). Wound, Ostomy, and Continence, Nurses Society core curriculum: Continence management* (2nd ed., pp. 454-483). Wolters-Kluwer.

Good job w hanging indent & reference…just a couple of errors. Note that there is no period after the last editor and no period after the (Eds.) but a comma and the 2nd is not superscript.

Kamp, K., & Heitkemper, M. (2022). Motility disorders. In J. M. Ermer-Seltun & S. Engberg (Eds.), *Wound, Ostomy, and Continence Nurses Society core curriculum: Continence management* (2nd ed., pp. 454-483). Wolters Kluwer.

The chapters below have the same errors – wrong book & punctuation. Also, if the ostomy book is used, Margaret Goldberg uses her middle initials – M. T.

Thayer, D. & Nix, D. (2022). Incontinence-associated dermatitis. In J. Carmel, J. Colwell, M. T. Goldberg. (Eds.*). Wound, Ostomy, and Continence Nurses Society core curriculum: Ostomy management* (2nd ed., pp. 364-381). Wolters Kluwer.

Thompson, D. (2022). Management fundamentals for incontinence. In J. Carmel, J. Colwell, M.T. Goldberg. (Eds.*). Wound, Ostomy, and Continence Nurses Society core curriculum: Ostomy management* (2nd ed., pp. 82-110). Wolters Kluwer.