Student name and date: Janet Barylski 8/16/23

Instructor Signature/Date:

1. Define **constipation** and address its clinical management.

Constipation is defined as “difficult defecation characterized by one or more of the following: hard or dry stools; reduced frequency of stool elimination; sensation of incomplete evacuation following a bowel movement, or pain or straining with stool elimination” (Wound, Ostomy, and Continence Nurses Society, 2022, pp. 563-564).

Clinical management will depend on the cause of constipation. A holistic assessment of the patient’s diet, medications, health history, and lifestyle are key to successful management of constipation. All these factors will affect the stool characteristics and selection of an appropriate treatment. The different characteristics of constipation will help you determine contributing factors. A helpful tool when asking patients about their stool is the Bristol Stool Scale. This scale provides an objective visualization of patient bowel movements without a subjective interpretation.

Once the characteristics of their bowels are confirmed, we can determine if it is a moisture issue, a motility issue, both, or something else. Typically, you need a bulking agent such as fiber or a softening agent such as water/liquids. People often underestimate the amount of water they are supposed to drink; 30mL/kg of body weight a day for a healthy person without contraindications such as kidney, renal, or mobility issues (Lonergan Callan & Francis, 2022). Creativity is a must as treatment for constipation should be individualized based on each person’s situation.

Bulk-forming fiber will add bulk to loose/watery stools. You can bulk up the stool with fiber supplements or by including high fiber foods such as fruits, vegetables, or whole grains in your diet. Fiber will help maintain our bowels. Bulking up the stool will stimulate peristalsis. One may also need to avoid high fat, processed foods, and dairy that cause constipation, and dairy to maintain a constipation-free outcome. If dietary changes are not a good option, then there are oral fiber supplements. Fiber is good for maintenance of constipation because not only does it bulk up stool, but some fibers also draw water into the lumen to help soften stools. Getting enough water with fiber is important so you do not add bulk without enough fluids available to soften the stool. The risk of not having enough water with your fiber is more constipation. Osmotic medications, such as Dulcolax, will also bring fluid into the lumen for hard and/or dry stools. There are combination products known as stimulants with osmotics available. Medications, such as opioids or antibiotics, can also cause constipation. Thus, a bowel regimen for patients on opioids is important. Antibiotics disrupt the balance of flora in the intestines. Eating yogurt, or taking oral probiotic supplements, will add probiotics to the GI tract to help restore intestinal flora and address issues of bowel dysregulation.

If you have a sluggish bowel from issues that put our bowels to sleep such as opioids, surgery, pregnancy, or sedentary lifestyle, you could use senna. Senna is a stimulant that is available in tea form, pill form and liquid form for occasional constipation and will facilitate peristalsis. It is important to make sure the patient does not have an impacted bowel before oral products are taken and it is important to make sure there is not a risk for bleeding before rectal products are administered.

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?
   Moisture management.

b. How will you approach the issue of urinary incontinence on a long-term basis?
   I would assess the foley, make sure it positioned and inflated properly, and see if it can/should be changed. Sometimes this will stop the leaking. I would also place a pad under the area of insertion to help absorb moisture. Proper hygiene of the patient's skin and foley care would be reviewed/implemented. I would wipe the skin with a 3-in-1 wipe, such as 3M all in one that contains a cleanser, protectant, and restorer for the skin with each incontinence episode. Change the foley if necessary to a smaller size, assess for s/s of infection, make sure the patient is not impacted or constipated, add fluids and irrigation if the urine is concentrated, and consider oral medication for bladder spasms such as oxybutynin or mirabegron. After interventions, properly document problems, interventions, and outcome.

   The question 'is this IUC really appropriate' needs to be addressed. With the goal of removing the IUC as soon as appropriate. The condition of the skin takes priority and moisture needs to be controlled. Without knowing the reason for the IUC, it is hard to pinpoint the best treatment approach. Therefore, I would aim to find a resolution to the foley leakage. If leakage persists, I will see if it was appropriate to remove the foley and perform CIC, bladder scans, etc. to allow the skin to heal and manage the bladder.

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?
Cystometry, bladder scans

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 skin needs to be protected from the feces. Cleanse the skin with a pH balanced no sting cleanser, dust the area with stoma powder, seal with no-sting liquid skin barrier, and apply an external fecal pouch to be changed every 1-2 days and as needed until IAD resolves or diarrhea resolves. If appropriate, an oral anti-diarrheal may be appropriate. I would also explore changing his tube feeding formula or the rate of the feed.

e. What skin care measures will be needed to correct this problem?
Skin care measures above the ordinary skin care are needed. This patient needs a moisture barrier. Gently cleansing with a pH balanced cleanser with surfactant or 3-in-1 cleansing wipe will minimize skin trauma during cleansing. The skin also needs to be protected from friction, shear, and pressure to prevent the IAD from becoming a pressure injury. The patient will need a turn schedule if he is not already on one.

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?

With regard to medical management, risk factors for incontinence include, but are not limited to, obesity, lifestyle, diet, alcohol, medications, pregnancy, menopause, and choric diseases (Sazsteinlt Wooldridge, 2022). She's a diabetic. Hyperglycemia will cause increased urination and sudden urgency. A review of her blood sugars, diet, and any available labs will be needed. She also gave birth to 3 children which weakens the pelvic floor. Weak pelvic floor muscles and weakened supporting structures around the urethra (i.e.: vaginal wall) result in stress incontinence. This patient may benefit from pessaries and vaginal inserts. Medically, I would seek an order for urodynamic testing, collect a UA & C&S (with orders),

Behavioral strategies include Kegel exercises, bladder training, dietary modifications such as eliminating diet soda and caffeine, and managing diabetes. "…low physical exercise levels and a high-carbohydrate diet, in conjunction with obesity and diabetes, were associated with doubling the risk of OAB" (Sazsteinlt Wooldridge, 2022). Adequate fluid intake will help decrease concentrated urine. Concentrated urine is considered a

bladder irritant. Kegel exercises are the first-line intervention in this case. Vaginal cones are also an exercise option to help strengthen pelvic related muscles. Bladder training will include timed toileting that increases the duration between toileting over time. This will lessen urgency. An education session to see what she has been doing or isn't doing related to those factors needs to occur. If these interventions are not successful, she may need a referral for surgical intervention.

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?

Wash your hands before beginning. Assess for latex allergy and retracted penis. You need at least 1" of persistent non-retracted penile shaft to apply external condom catheters. There are special catheters, such as silicone-based catheters and non-sheath glans adherent devices, for individuals with latex allergies or a retracted penis. There are also ECDs that come with an adhesive strip. Use the manufacturer's sizing device to measure the base of the penis and ensure you have selected the appropriate size for a snug fit, one that is not tight or loose. Inspect the penis (glans and shaft) for edema and impaired skin integrity. If abnormalities are present, do not apply the ECD and report findings to nurse. Once everything is assessed and acceptable, we are ready to apply the ECD. It is important to apply condom catheter correctly to avoid penile trauma, impaired penile skin integrity, and leakage.

- Wash hands and apply gloves
- Clean and dry the skin.
- Apply liquid skin barrier and allow to dry.
- Apply skin adhesive per manufacturer recommendation. Do not apply extra adhesive to the penis. If non-adhesive product is being used, apply per manufacturer directions (ie: external fixation strip).
- The ECD is applied like a condom. Roll the ECD down over the shaft, leaving ½" open space at the top for best urine flow.
- Wash hands when finished.

The condom catheter should stay on 1-2 days. You will know that the condom catheter is applied correctly when the wear time is appropriate, leak free with adequate urine flow, and fits comfortably. It will also be easy to remove with no skin damage.

I will assess the learning of the CNA by return demonstration with a model or a patient. They will also need to verbalize what happens when the condom catheter is not put on correctly.

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?

The first thing to do is rule out the presence of a fecal impaction. The presence/absence of fecal impaction is going to determine treatment recommendations. A complete bowel assessment needs to be done (auscultation, palpation, any distention) with a digital rectal exam. If impaction is present, attempt to break it up. If it is too hard and/or too large to do this, a warm mineral oil enema given rectally can be given to soften stool and facilitate evacuation. This can be repeated daily for 2-3 days. Digital removal of feces is a last resort. Instead, try to break up the stool. If the warm mineral oil enemas do not work, you can try a 1:1 mixture of molasses and milk warmed up to thoroughly mix them together and then cooled to instill rectally. The patient will hold this enema solution (60-90mL instilled at a time) for 30 minutes. This is repeated until the mass can be broken up and removed. After the mass is removed, the colon needs to be cleansed with suppositories or enemas. Oral laxatives can be given if they are medically appropriate. Considerations include renal failure, heart failure, and if abdominal distention or obstruction, such as a high impaction, are still present. Patients with renal failure are prone to constipation due to the ESRD medications. Not all laxatives are appropriate for them. Avoid Milk of Magnesia, Magnesium Citrate solutions, and Fleet Phosphosoda laxatives. Safe laxatives are Lactulose, GoLytely, Bisacodyl, Senna, and Miralax. Consider putting renal patients on a routine bowel regimen. For cardiac patients, avoid laxatives with calcium, chloride, potassium, magnesium and sodium as they may cause electrolyte disturbances that affect the heart. Bisacodyl would be an example of a safe laxative. If an impaction is present, you must give a laxative distal to the impaction (via rectum).

There are several things in the case that indicate she may have a fecal impaction such as liquid stool, which will go around the impaction and come out as diarrhea; her diet is high in constipating foods such as starches, dairy products, and meats; she has a history of impaction; she is straining with bowel movements, and she most likely has decreased activity levels based on her age. Bowel movements should be no less than every 2-3 days without straining. She is still straining, despite OTC laxatives. Her anal wink is intact. The lack of sensation may be due to prolonged rectal distention. As stated, this has been going of for a week and will need aggressive intervention.

With regard to management, the cause of the impaction needs to be addressed. Is her medical history indicative of comorbid diseases that cause constipation? Is she on medications that cause constipation? The immediate things that can help with constipation are dietary changes such as adding, as tolerated or medically appropriate, fluids, fiber, cereals, grains, beans, seeds, nuts, and more investigation as to what fruits and vegetables she can tolerate (applesauce, soft vegetables, etc). Insoluble and soluble fiber are important. Insoluble fiber adds bulk to the stool to stimulate peristalsis. Soluble fiber draws water into the bowel lumen to keep the stool soft. She can take oral fiber or get fiber sources in her diet. She, or someone who is able, could keep a bowel diary using the Bristol Stool Scale to describe the stool for consistency. She will need a follow up

visit and education on reporting same or worsening of symptoms immediately. Orders for imaging need to be obtained as well.

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

a.) Describe the **components** of a quality improvement project.
Quality improvement projects need to identify and quantify the problem, describe the outcome(s), and create a solution for a measurable goal. It involves collaboration with staff and leadership to determine the problems and factors that may be attributing to them, a review of hospital records to identify and quantify deficits and adverse events so one can create appropriate interventions that improve quality of care.
- Identify the problem
- Determine the goal
- Establish interventions
- Monitor/measure the implementation of those interventions.
- Analyze the data by comparing the pre and post occurrences
- Prove the 'bottom line' to present the outcome

b.) Identify and describe how you would **design** a QI project using CAUTI as the subject.
Comprise a team of members who have knowledge and expertise related to understanding and correcting the problem. For CAUTI, you would want someone from infectious disease, quality and patient safety, unit nurse managers, nurse educators, and urologists. Develop a workflow that can be tracked so you can perform your analysis. You can track the type of patient, the reason for insertion, the duration of insertion, the number of times foley care was performed, who developed an infection, documentation, and outcomes. Everything will populate in a best practice workflow for monitoring and analysis. Implement protocol to facilitate use of this workflow. Establish bladder management protocols to reduce foley insertions, best practice for foley insertion, best practice to collect urine specimens, and protocol for accountability for nursing and physicians. Devise a way to educate the staff on these protocols. Provide education and implement your changes. Track your data and find out where the gaps in quality are. Is it infection control? Is it unnecessary insertion? Is it duration of insertion? Should we develop a foley insertion team? Is it lack of foley care? Implement computer prompts for tasks such as foley care, foley removal, etc.

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 is performed to assess the ability of the bladder to effectively empty without a catheter.

- The urine collection bag is removed from the catheter
- Room temperature saline is instilled into the bladder through the catheter. The amount of fluid instilled is measured.
- The fluid is instilled into the bladder until the patient verbalizes a strong enough urge to void.
- Once the urge to void is strong enough, the indwelling catheter balloon is deflated and the catheter is removed.
- The patient is then asked to void into a container that can measure the amount of output.
- The amount voided versus the amount instilled is the PVR. The PVR is reported to the physician.

8. 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.
CIC is for patients experiencing urinary retention with or without urinary incontinence to be able to manage their bladder.

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

- Schedule CIC for every 4-6hrs while awake
- If leakage occurs in between voiding times, perform CIC
- Keep voiding journal
- Wash hands before beginning CIC
- Location of the urethral meatus
- Gently insert catheter until urine returns
- Maneuvers to facilitate complete emptying of bladder such as palpation
- If patient resides at home, also teach the caregiver CIC
- Wash hands when finished

c. Identify at least three complications that can occur with intermittent self-catheterization.
1) difficulty inserting the catheter; 2) UTI; 3) urethra trauma and/or bleeding

d. Describe the action of Finasteride (Proscar) and any other teaching points, such as side effects.
Finasteride blocks the action of 5-alpha-reductase which allows testosterone to increase. As a result, the prostate shrinks. These effects only last when the medication is being taken.

Teaching points regarding common side effects are decreased interest in sex, trouble getting an erection, trouble having an orgasm, abnormal ejaculation, breast tenderness/swelling. Serious side effects to report to the physician are breast pain/lumps, nipple discharge, any other breast change, blood in your semen, testicular pain, or depression (https://www.facebook.com/Drugscom, n.d.).

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?

The procedure will be done in the surgical area. The procedure should take approximately 20 minutes. They will palpate the distended bladder and mark the site. The site will be verified by imaging of the bladder and pelvic area to ensure that it is an acceptable location (i.e.: no bowel loop interference). You may have local or general anesthesia, so you do not feel as much pain. They use a small catheter device to make an incision just above the pubic bone and guide the catheter through the abdominal wall into the bladder, sometimes with ultrasound. The balloon of the catheter is inflated to hold it in the bladder and a cannula remains in place after the catheter is removed. The cannula will be sutured in place with one or possibly more sutures. It remains there for up to a month so scar tissue can form a hole between the bladder and the outside of the body. The site is covered with a dressing to help prevent infection. Pain, swelling, and discomfort from the procedure should resolve within two weeks. You can manage any pain with NSAIDs such as ibuprofen during that time. Avoid lifting and activities.

Typically, the initial catheter change is done by the urologist once a scar is formed. The nurse does not change the catheter until the scar tissue is formed. When the catheter is changed, the replacement catheter needs to be on hand so it can be immediately inserted.

Complications could include blood in the urine that is usually transient, skin irritation, infections (cellulitis, abscess, UTIs), and kidney stones which may develop later. Call the physician if you experience any of the following:

- Fever greater than 100.5F/38C
- Urine leaking around SPC
- Pain or feeling of fullness in abdomen
- Hematuria
- Little to no urine in collection bag or the bag is filling up quickly

- SPC comes out
- Stitches fall out
- Skin changes (rash, itching, redness, etc.)
- Cloudy and/or foul-smelling urine
- Grit in your urine

Drink at least 8-12 cups of water a day (if medically appropriate). Avoid activity for the first 1-2 weeks.

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

- Wash your hands before and after handling the catheter.
- Remove the dressing daily. Check the catheter site and dressing for s/s infection (pain, swelling, redness, sores, pus, odor). Change the dressing more often if needed (falls off, becomes dirty, or saturated with drainage).
- Do not pull on the catheter tube; keep tube secured to leg with anchor
- Gently hold the base of the catheter and wipe with mild soap and water going away from the body. Do the same with water to rinse off the soap and water.
- Gently wash the area around the catheter with mild soap and water and pat dry
- Don't apply powders, creams, or sprays to the area
- Flush the foley at least 1x/day to prevent blood clots
- Place fenestrated gauze around the area and secure with tape
- You can shower. Avoid baths, hot tubs, or swimming pools. Do not let the shower beat directly on the site.

- Make sure collection bag is below the waist so urine does not backflow into the bladder.
- Keep the tubing from kinking
- Move tubing around if it is not draining.
- Keep the bag off the floor (can set it in a clean pan/basin on the floor)

- Change catheter every 4-6 weeks
- Use supplies ordered by physician (foley kit, dressing, syringe, collection bag, waste bag, soap and water, 4x4s).
- Remove dressing as stated above.
- Clean hands and apply gloves.
- Deflate balloon on old catheter with syringe and remove it slowly, noticing how far it was inserted.
- Remove gloves, clean hands, apply sterile gloves
- Clean around the site with sterile solution
- Lube the insertion point of new catheter with K-Y Jelly or surgilube. Do not use Vaseline.
- Insert new catheter to the same length the old catheter was inserted with drainage tip resting in sterile tray
- Wait for urine to flow (may be a few minutes at most)
- Inflate balloon using 5-8mL of sterile water

- Attach drainage bag
- Secure foley to thigh using anchor leaving some slack in the line so the catheter does not get pulled on or held taunt against opening.

References

Finasteride uses, Side Effects & Warnings. Drugs.com. (n.d.). https://www.drugs.com/mtm/finasteride.html#side-effects

Lonergan Callan, L. & Francis, K. (2022). Fecal Incontinence: Pathology, assessment, and management. In J.M. Ermer-Seltun & S. Engberg (Eds.), *Wound, Ostomy, and Continence Nurses Society core curriculum: Continence management* (2nd ed., pp. 111-133). Wolters Kluwer.

Sazsteinlt Wooldridge, L. (2022). Overactive bladder/urgency UI: pathology, presentation, diagnosis, and management. In J.M. Ermer-Seltun & S. Engberg (Eds.), *Wound, Ostomy, and Continence Nurses Society core curriculum: Continence management* (2nd ed., pp.). Wolters Kluwer.

Wound, Ostomy, and Continence Nurses Society. (2022) Constipation. In *Wound, Ostomy, and Continence Nurses Society core curriculum: Continence management* (2nd ed., pp. 563-564). Wolters Kluwer.