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

Constipation is generally defined as difficult defecation characterized by having 3 or less bowel movements in one week, hard or dry stools, sensation of incomplete elimination following a bowel movement, reduced frequency of stool elimination, or pain associated with stool evacuation.

Since there are many reasons why someone could be constipated clinical management of constipation depends on why they are constipated. Transient reasons for constipation include dietary changes, environmental/ daily habit changes, pregnancy, pharmacological side effects, and a painful anorectal condition. There are functional reasons such as persistent lifestyle deficits such as fiber, fluids, and exercise. Medical conditions that are functional in nature and can induce a slow transit include diabetes mellitus, depression, hypothyroidism, MS, spinal cord injury, and Parkinson disease. Dysfunctional defecation could be caused by a tumor, dyssynergia between pelvic floor and anal sphincter muscles, and pelvic organ prolapse. Depending on the cause of the diarrhea? there are many treatments such as lifestyle modifications, laxatives and enemas, management of fecal impaction, digital removal of feces, and alternative therapies such as biofeedback, and sacral neuromodulation.

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?

A focused assessment will consist of assessing the color of the wounds and locate the anatomical sites where there is IAD. IAD can occur in any anatomical location exposed to urine and feces. It is imperative to ask the patient is they have a burning, itching, tingling, or pain. In addition, the focused assessment should include checking for pinpoint satellite lesions (papules or pustules) because that would be indicative of candidiasis, a common secondary infection. Assess if the skin has intact erythema or if the skin is severely eroded. You are missing additional assessment data such as catheter inspection, discussion w pt. about the diarrhea & timing of same, checking for rectal tone/masses & anal wink, tube feeding composition.

b. 1. How will you approach the issue of urinary incontinence on a long-term basis?

The discussion of a long-term treatment such as medication or catheterization should be discussed. True, but this info is too sparse

Darifenacin would be a medication to consider because it works well for patients who have urinary incontinence. In addition, it is also best used with patients who have concurrent fecal incontinence which this patient has as well. Another medication that helps patients with urinary incontinence is solifenacin, as it has a favorable tolerability profile and has no central nervous system effects.

This patient is a good candidate for intermittent self- catheterization because of the history of recent UTI. Long term catheterization should be avoided to prevent any further infections or kidney damage. Other approaches to management include modifying barriers to toilet assess, such as having a bedside commode. Also, lifestyle modifications such as fluid and dietary modifications, toileting programs, bladder retraining with urge suppression strategies, and pelvic floor muscle exercises can be considered.

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?

Trial and void, and intermittent catheterization. Ok

d. 2. How will you approach the issue of fecal incontinence for this person? Will you need to use containment devices? If so, what kind?

We should preform stool studies to ensure patient does not have an infection. Abd xray to ensure patient is not constipated and this is not overflowing diarrhea. A FMS system could be considered (perhaps as we do not discuss the patient's mobility but in reality not as we should be getting this patient up). OK, but you are missing an obvious aspect of this patient's diarrhea + you did not answer the second part of the question.

marked and extensive incontinence associated dermatitis. On assessment you see marked erythema with wet and weepy dermatitis in the perianal and sacral skin.

Since the patient had extensive incontinence associated dermatitis it is important to protect the perianal and sacral skin. I would consider an external fecal collection pouch because it is designed to collect and contain liquid fecal material to quantify the stool and protect the skin. An external fecal collection pouch is the first step in the management of large- volume liquid stool. The external pouching device adheres directly to the perianal skin and should be replaced every 1 to 2 days as needed for leakage. Benefits of the external fecal pouch includes that they are noninvasive with no risk of

damage to the sphincters or rectal tissue. In addition, the pouch protects the perianal skin from breakdown and is a closed system that helps prevent the spread of harmful organisms.

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

The first step in a structured skin care program is cleaning the skin following an incontinence episode. Cleansers for incontinence should be pH balanced, contain surfactants to reduce surface tension, and friction with incontinence skin cleansing practices. If the skin is denuded, plain water can be an acceptable alternative. Water that is lightly delivered by syringe may be better tolerated than a spray cleanser or wipes. The use of standard bath bar soaps is discouraged as they are pH disruptive, drying, and irritating based on their formulation. Good info on cleansingThe second critical step is protecting the skin with a "leave-on" moisture barrier. Pt. has wet weepy dermatitis-not all moisture barriers work on this type of problem – 3. what are your options?

Options for "leave-on" moisture barriers include Baza Protect Moisture Barrier Cream Tube Coloplast and 3m Cavilon Durable Barrier Cream. The Baza Moisture Barrier Cream is a zinc oxide and dimethicone- based moisture barrier used to treat and prevent minor skin irritation due to diaper rash and helps seal out wetness. The 3 m Cavilon Durable Barrier Cream provides a long- lasting protection from bodily fluids from incontinence while it moisturizes the skin.

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?

Diabetes Mellitus can contribute to continence status because poor control of DM can lead to polyuria and precipitate or aggravate incontinence. DM is also associated with increased likelihood of urgency incontinence and diabetic neuropathic bladder. A better control of diabetes can reduce osmotic diuresis, associated polyuria and improve incontinence. Patients can be taught urgency suppression training and bladder training techniques which are techniques that help override the sensation of urgency allowing them to delay voiding until convenient. Methods include rapid pelvic floor contraction at the onset of urgency, sitting on a hard surface, and various distraction techniques. Bladder training also known as bladder drills is a self-guided method of increasing the time between onset of urge to void and the actual time of voiding. Urgency suppression and bladder drills have been shown to be effective in management of OAD and /or urgency incontinence. For years bladder antimuscarinics, including oxybutynin have been the mainstay drug therapy for OAB. But it is falling out of favor due to potential side effects such as xerostomia (dry mouth), constipation and cognitive impairment in older adults. B3 agonist, Mirabegron, is a better option which is effect in both young and older

people, but side effects include a concern for either new-onset or worsening hypertension. Local topical estrogen is also a good option as it has been shown to provide less urgency and frequency. Neuromodulation is another option as it releases electrical signals to alter the involuntary reflexes of the lower respiratory tract which intern inhibits the voiding reflex, reduces involuntary detrusor contractions and assists in patients regaining voluntary control of micturition. OK

4. 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?

Applying an external (condom) catheter is not a sterile procedure and it is a great way to collect a man's urine without being invasive. The CNAs should prepare what they need including the sheet and the ~~condon~~ condom catheter and drainage bag. I would evaluate their understanding by having them demonstrate applying an external condom catheter 3x. on a patient? And what are the actual steps or instructions you would give?

I would first clearly review all directions with the group of CNAs. Then I would have them teach/read back the directions. Then I would demonstrate on a patient and have the CNAs observe. Next, I would ask the CNAs to apply the condom catheter on 3 patients and I would observe. Then I would consider them competent. I would thoroughly review the application instructions of how to place a condom catheter which first includes cleaning your hands with soap and water and applying clean gloves.

Next, the penis should be cleaned with soap and water and dried thoroughly. Lotions, creams, or ointments should not be applied on the penis as it will interfere with applying the catheter. If the patient is uncircumcised, it is important to leave the foreskin in the natural position. If necessary, the hair at the base of the penis should be clipped but not shaved. Next, grip the penis along the shaft and hold the condom catheter at the tip of the penis and smoothly roll the condom onto the penis.

It is significant to allow 1- 2 inches between the tip of the penis and condom catheter to prevent the condom catheter from irritating the tip of the penis. Next, the drainage tube should be attached to the bag at the end of the condom catheter. After, you should wash your hands thoroughly with soap and water. The drainage bag should be held on the side of the bed lower than the patient, not above to prevent any backflow. It is important to note that the condom catheter should be changed every 24 hours.

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?

Abd xray should be ordered to see if she has stool in her bowel.yes, xrays work 5. but what else can you do here?

Our patient is impacted. The patient has passing liquid stool which means they have a hard mass of stool caused from persistent relaxation of the internal sphincter which is causing the fecal leakage which is passing the fecal mass. It is important to note that impactions usually occur at the level of the rectum, but a high impaction can also occur in the ascending or transverse colon. A digital rectal examination should be done because there is likely a fecal mass in the rectum that is too hard and large to evacuate. Digital breakup should be attempted. If a digital breakup is unsuccessful a lubricant solution should be administered rectally to soften the stool. In addition, warm mineral oil enemas can be used to soften the stool and facilitate evacuation.

Her symptoms and chronic constipation/ fecal impaction make it likely that she is experiencing overflow diarrhea. Encourage dietary modifications as the food she is eating is low in fiber and contributing to her symptoms. I would also suggest anorectal manometry and if there is dyssynergia defecation this patient would likely benefit from biofeedback. In addition, this patient would benefit from increased fiber and fluid intake, increased activity.good I would also review all medications and screen for elimination or reduction of constipating medications. Fiber works well because it acts to soften the stool, increase stool bulk, reduce colonic transit time, and promote microbial balance. I would suggest adding an osmotic laxative like, miralax, daily in the AM. This is safe to use daily because osmotic agents work by distending the bowel whereas simulant laxatives activate nerve cells within the bowel wall and are recommended for intermittent use only. Stimulant laxatives for example, dulcolax, are stimulant laxatives that activate nerve cells within the bowel wall and are recommended for intermittent use only. ok

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

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

There are multiple components of a quality improvement project. An in-depth understanding of the problem is paramount in executing successful quality improvement project. The problem, goal, aim, and measures need to be clearly identified. ok

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

I would design a QI project using CAUTI as the subject by first identifying the problem. Ok, but before you start all of this identify that it is a problem w an incidence survey for a

defined period of time (2 quarters, a year, or whatever you determine) so that you can see the problem units. Get a team together so that everyone is on the same page & identify which evidence-based actions you are going to include in a prevention order set or bundle or whatever you call it. The you can educate & track results. We want to decrease/ minimize the occurrence of CAUTIs. The goal would be to decrease the incidence of CAUTIs. The measures needed to clearly identify would be which units or departments we are working with such as the GI unit and nephrology unit. We would implement measurable items. This would include reeducating the nurses on how to properly insert a foley catheter utilizing sterile technique. I would have the nurses demonstrate catheter insertion on a manikin first correctly 3x, sign off on their competence, then have them place a foley catheter for a patient. If this is a policy at your place that is great. Many facilities would not do 3x & then live for a competency as they would not spend the time.

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.

The purpose of the voiding trial is to ensure that it would be safe, and the patient no longer needs an indwelling catheter. If you pass the trial and void test that means you are not retaining urine and able to go on your own. If you are retaining urine an indwelling catheter should be in place~~d~~ because urinary retention can lead to infection and neurological damage.

I would conduct a trial and void test by removing the urinary drainage bag. Fluid will be placed into the bladder through a catheter. The amount of fluid that goes into the bladder will be measured. Once the patient feels a strong enough urge to void the balloon holding the catheter will be deflated and the catheter will be removed. The patient will be asked to void into a container to measure the amount of fluid that empties from your bladder.

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.

The goal of intermittent self-catheterization is to eliminate the urine (if someone has retention) ~~and be able to hold their urine without having incontinence~~. Preserve kidney health and prevent infection. This also promotes more independence rather than an indwelling catheter. And self-catheterization should be done every 4 to 6 hours to keep the bladder volume less than 400-500 mL as a full bladder impedes blood flow and allows bacteria to multiply.

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

Key educational points to include for an individual performing self-catheterization includes urinating the regular way, washing your hands with soap and water, wash your genitals with soap and water or at minimum an antiseptic towelette. Apply a water based-lubricant on the tip and top two inches of the insertion end of the catheter if needed. This is a clean procedure, and everything should be as clean as possible. It is important to slowly slide the catheter until it reaches the bladder and urine starts to flow out of the tube. The catheter should be inserted another inch or two. The catheter should be held in place until the bladder empties.

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

Potential complications that could occur with intermittent self- catheterization include urethral scarring and strictures, urinary tract infection and bladder perforation or spasms.

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

Finasteride works by blocking the body's production of a male hormone that causes the prostate to enlarge. Potential side effects include non-alcoholic fatty liver diseases, insulin resistance, keratoconjunctivitis sicca, kidney dysfunction, and other metabolic dysfunctions. Common side effects of finasteride usage include depression, decreased libido, and ejaculatory/erectile dysfunction

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?

~~Pre-operative teaching of suprapubic catheter insertion would include teaching of a suprapubic catheter insertion includes~~ purpose of procedure, what to expect during insertion, reviewing care of the stoma site including bathing, dressing, securing, changing the catheter and lifestyle modifications.

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

The stoma site should be monitored for skin irritation and urine leakage. The patient should be informed a urethral leakage is also a possibility. It is imperative to ensure good skin care and educate regarding care and complications. The patient should be educated on the frequency for changing an SPC which is based on the time frame to blockage??.

The patient should know that prior to removal the catheter should be clamped, across or down the thigh, down the calf, or against the abdomen. I would review the different types of suprapubic drainage bags that could be worn such as leg-worn, body-worn bag, or night drainage bags. 6. Site care, calling MD, securement of tube

I would educate the patient on site care of the suprapubic catheter. This is imperative to prevent any infection. It is imperative to wash around the catheter twice a day and surrounding area using plain soap and water. It is also important to remove any crusting and you can pat dry. It is important not to use any scented soap or talcum power. It is imperative to change clothing and wash clothes every day.

Reasons to call the MD include hematuria, pain, redness, pus, or swelling at the stoma site. In addition, if a patient did not have any drainage, or if the urine is concentrated or cloudy, the MD should be notified. All of these signs and symptoms are concerning and warrant immediate attention.

Securement of the tube consists of a catheter anchor/ securement device of bifurcation and a Velcro anchor strap.

Kristen, I have highlighted 6 areas where more information needs to be provided. Please just add the information to the above writing in a different color & return via dropbox. Thanks