Continence Case Studies: Continence Management

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1. Define constipation and address its clinical management.
    a. Constipation is described as having an issue with passing stool, having fewer than 3 stools per week or having a difficult time passing the stool and having a feeling of incomplete defecation. Impaction of stool can result in urethral obstruction and bladder outlet obstruction. Clinical management is to begin a medicinal bowel regimen, increasing fiber to the diet, increasing exercise if possible, drinking enough fluids, using the toilet when there is an urge to pass stool. Laxatives and enemas can be used to produce a bowel movement through stool bulking, osmosis and restarting the action of peristalsis. Biofeedback and sacral neuromodulation can be instituted if the aforementioned methods prove ineffective, lastly surgery can be utilized to remove the blockage if necessary.

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?
        i. My focused assessment will consist a visual assessment for distention then an evaluation of constipation. Palpating and percussing the abdomen, if dullness is heard there may be stool in that section of the abdomen. The patient is new to tube feeding, and is having leaking around the foley which can indicate that the pressure is being placed within from fecal matter. If there have been several episodes of liquid stool daily I would also consider constipation or a blockage of some type. Some tube feedings lack fiber, as well if there is no water flushes it can difficult for stool to pass. A rectal exam should be completed to assess for tone and anal wink to check for neurological issues.

    b. How will you approach the issue of urinary incontinence on a long-term basis?
        i. Urinary incontinence should be reassessed on a routine basis, i.e. biweekly or as per long term acute care facilities' policy. This should be completed by a trial of void, and bladder scanning q6. If the patient is not voiding on their own then intermittent catheterization should be considered. Behavioral modification and lifestyle changes are a good step to seek effect change. Pelvic floor exercises timed voiding schedules and physical therapy can help. If no changes have been made with the incontinence, condom catheters or other urine wicking products could be helpful. Good hygiene and skin care should be utilized for this patient to prevent skin breakdown.

    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?
        i. Postvoid residual measurement would be an initial and ongoing urodynamic test to track the progress of bladder emptying. A postvoid residual of 5-6 oz. or more is a sign that the bladder is not emptying completely. For a patient with a CVA history, incomplete bladder emptying can be common. Also a simple cystometry

could be utilized here, assessing the pressure on the bladder during the filling phase and the bladder's capacity. The sensation of bladder filling can be assessed at this time to determine if the patient has urgency or stress incontinence.

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

ii. For this patient I will approach the issue of fecal incontinence by ensuring there is fiber in the diet, supplemental due to their dependence on tube feeding for nutrition. Enough water in the tube feeding order to help lubricate the digestive tract. Lastly, ensure that there is no concern for bowel obstruction with consultation of the GI team. If there is no concern for bowel obstruction and there is rectal tone, I would consider a rectal tube for this patient as the perianal skin has MASD and a fecal pouch would not adhere to this skin properly and ultimately cause more damage to the skin.

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

i. For this patient with marked erythema, wet and weepy dermatitis in the perianal and sacral skin I would consider Triad wound paste or a moisture barrier cream, perhaps mixed together so that the skin has a barrier to the frequent stools as well as a thick wound paste to allow the

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?

a. Given that this patient has at three known pregnancies, her symptoms of stress and urgency incontinence could be assisted with pelvic floor exercise. A physical therapist specializing in this type of exercise could be helpful to this patient. I would recommend Kegel exercises as well as a toileting schedule, retraining the muscles to work intentionally.

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?

a. Always begin any care with washing your hands and placing gloves on. What should be included in the education is to cleanse the penis and groin with a PH balanced perineal cleanser, trim any hair, do not shave because this can cause ingrown hairs. When dry cover the area with skin prep wipes, this will protect the skin when taking off the condom catheter as well as allow the condom catheter to adhere well. When skin prep is dry, apply condom catheter the same way a condom is applied, holding the shaft of the penis and rolling on the condom. Ensure that the condom is not too tight and that the correct size is used, then attach the drainage bag. The condom catheter should be changed every day with perineal care. I would evaluate the group of CNAs understanding by having a return demonstration either on Manikin or while on orientation have their preceptor verify a return demonstration.

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?

a. I would first encourage this patient to increase her water and fluid intake as well as her fiber intake. If she does not want to derive fiber from her diet by adding in fruits and vegetables, then looking for cereals with fiber, protein bars with added fiber, pasta with added fiber would be good addition. Lubricating the digestive tract with an increase in water, as her intake is not mentioned will help her bowel movement be softer. The impaction she is experiencing may need to be broken up by digital evacuation, the use of mineral oil enema can also break up and soften the stool, to ensure that the stool impaction has been completely removed a cleanse of the colon would help, for this a bisacodyl suppository is recommended. The straining can come from constipation or lack of lubrication, fiber can naturally give the patient softer stools and easier bowel movements. If she can find a way to enjoy fruits and vegetables without them hurting her stomach, this would change her bowel movements greatly, maybe introducing a new fruit or vegetable every 5 days to her diet would allow her tolerance to this new form of fiber to increase. Appropriate laxative use should be educated to the patient, her overuse can be contributing to her problems with constipation. Stimulant laxatives should only be used on an as needed basis, and an osmotic laxative should be suggested by the practitioner for daily use. If she is not going to make lifestyle changes, a stool softener could also help her.

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

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

i. To improve CAUTI incidences, start by changing the culture surrounding foley catheters. Collecting data on how many CAUTI occurred over the course of a month, how long were those catheters in place for? Were there other factors that effecting the patient's risk for infection? Are the staff properly educated on 1. How to place a foley catheter using aseptic technique? And 2. How to maintain a clean catheter, and prevent infection with proper perineal care using front to back wiping and CHG wipes? Having this data will help guide the quality improvement project. Next would be maintaining the education standards of the hospital, by having staff complete bi yearly education courses or in services. Targeting the units and or type of patients who get the most CAUTIs to begin the quality improvement project will help to decrease numbers faster as well.

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

i. A nurse driven project to discontinue Foley catheters when there is no indication for chronic retention or comfort care/hospice. Questioning the orders in place for Foley catheter and holding providers responsible for monitoring the necessity of a Foley catheter, encouraging trial of void periods for patients with chronic UTIs. I would take the data gathered on the patients or populations/units with the highest number of CAUTIs and work there first. Changing the culture via education and complacency of having Foley catheters. Education on how to place as well as how to clean the patient with a foley catheter. Monitoring changes to patient's condition with a Foley catheter, their temperature, WBC count and color/odor and consistency of their urine output.

1. Increasing knowledge to the staff will help to reduce outliers and increase the escalation process when a change occurs in the patient with a Foley. New staff, and new graduate nurses should be oriented with the infection control standards. Then all staff should have a quiz or knowledge proof scheduled every 6 months to reiterate the training.

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. The purpose of a voiding trial is to see if the patient can urinate on their own, without a Foley catheter in place. The voiding trial in the urologist's office takes place as such: The urinary drainage bag is removed, fluid is then instilled into the bladder via the catheter, a measured amount. Then once the urge to void is felt by the patient, the balloon is deflated, and the catheter removed. The patient is then asked to void into a measurable container, to compare to the amount of fluid instilled into the bladder to start with. The goal is for the bladder to empty what was instilled into it, or completely. If retention is still noted, a bladder scan can confirm what is left in the bladder and if necessary the catheter may need to be reinserted.

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.
    a. The goal of intermittent self-catheterization is train the bladder to fill and empty completely as a way to not rely on foley catheters. This method of catheterization also leaves the patient with less risk to infection than indwelling catheterization. This patient can also have greater freedom for expression of sexuality, and fewer barrier to intimacy.

b. Describe education points to include for an individual performing self-catheterization.
    a. First I would describe why we may need to resort to intermittent self catheterization- if urine is retained in any part of the urinary system, kidney, bladder, ureter or urethra an infection can occur. Catheterization should take place every 4-6 hours or if the bladder feels full. Signs of bladder distention include: pain, uncomfortable feeling in lower abdomen, feeling restless, sweating, chills, headaches, flushed or pale skin, cold extremities. You need soap and water, a catheter, washcloths and water based lubricant, and a container to collect the urine into.
    b. Steps for catheterization:
        i. Lubricate tip of catheter, about 6 inches.
        ii. Lie back, and wash penis with warm wet soapy washcloth using a circular motion, from tip to base including under foreskin.
        iii. Place the collection container in front of the penis with the drainage end of the catheter inside the container to prevent a spill.
        iv. Hold the penis with your nondominant hand and insert the catheter at least 6 inches or until urine starts to drain. Feeling a sensation of resistance is normal when the catheter is passing into the bladder, use gentle pressure and relax your pelvis muscles.
        v. When urine stops flowing, remove the catheter, flush the urine and wash hands.
        vi. If re-using the catheter, wash with soap and water , allow to air dry on a clean towel and store in a dry plastic bag.

c. Identify at least three complications that can occur with intermittent self- catheterization.
    a. Three complications are: urethral scarring and strictures, urinary tract infection and bladder perforation or spasms. UTIs can be prevented with frequent self catheterization, on a schedule rather than waiting over 8 hours at a time.

d. Describe the action of Finasteride (Proscar) and any other teaching points, such as side effects.
    a. Finasteride works by blocking the body's ability to convert testosterone into dihydrotestosterone, resulting in an increase in testosterone. Dihydrotestosterone causes the prostate to grow. Some side effects are the inability to have or maintain an erection, decreased sexual desire, problems ejaculating, pain in the testicles and depression. If

there are any allergy type side effects, rash, itching, hives, burning, swelling or the lips throat or face, difficulty swallowing or breathing, seek emergency assistance immediately.

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?
    a. In the pre-op teaching of a suprapubic catheter insertion I would include how the procedure is done: Cleaning of the skin of the lower abdomen where the incision is made. They may apply a local anesthetic to numb the area, some cases general anesthesia is used. A small cut is made into the skin and place the suprapubic catheter, once in the bladder pee will drain from the catheter into a collection bag. To keep the catheter in place it is stitched into the skin. The balloon of the catheter will be inflated so it stays in place. The procedure takes about 20 minutes. A bandage will be placed to anchor the tube and prevent any infection.

b. Discuss care of the suprapubic tube post-operatively including cleansing, dressing, securing of the catheter, changing of catheter, etc.
    a. It is important to always wash your hands when caring for the catheter, just as you would when going to the bathroom. It important to remove the bandage after 24 hours to inspect for any swelling, discoloration or pus as well as assess if you are having any pain. If there is, call the doctor. When caring the tubing, empty the bag into the toilet by unclamping the stopper on the tubing. Remove the bag by clamping the tubing and disconnecting the drainage bag. Clean the end of the catheter with soap and water or an antiseptic wipe, clean the tip of the new drainage bag and connect it to the catheter. Always make sure that the tubing is not clamped or kinked. Wash your hands when finished too. Always make sure that the tube is anchored to the thigh or hanging to gravity when lying flat. Always cleanse the area and gently pat dry before placing the new dressing. The dressing for the tube site can be a 4x4 gauze with a paper tape border to anchor the tube and prevent infection to the site.

    b. To change the tube, your provider may change the tubing the first time it is necessary. First, wash hands and put on two pairs of gloves, cleanse the area with normal saline or soap and water. Lubricate the new catheter on the side that inserts into the belly, clean around the site using a sterile solution. Deflate the old catheter's balloon with a syringe, remove slowly. Then remove the top layer of gloves and insert the new catheter as far in as the other one was placed (this can be noted by marking the old catheter before removal and marking the new one before starting). Wait until urine is flowing and inflate the balloon, attatch the drainage bag and place a new dressing to anchor the tube.