R.B. Turnbull, Jr. MD School of WOC Nursing Education

Continence Care Mini Case Studies

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Reviewed by: Patricia A. Slachta

Score: 44.2/48 well done Bria!

This assignment focuses on holistic assessment of the individual with continence issues, the application of specialist knowledge, and the synthesis of holistic continence plans.

For each of the below continence focused scenarios, use the information provided to identify a plan.

- Be specific: Thoroughly answer each scenario applying what you know. _
- When providing rationale: Make sure to explore *why* an action or actions are chosen. Citations may be used as necessary but are not required.

Example

A 67-year-old obese female patient is referred to the outpatient clinic with worsening fecal incontinence. The patient reports she has a low fiber, high carbohydrate diet. She reports isolating in fear of an incontinent episode.
Identify any further actions that need completed at this visit and include specific tests. Referral to a nutrition specialist… Functional assessment… Referral for anorectal manometry… Explore diet, liquids Quantification of inc and characteristics **(2 points)**
The long term-recommendations for this patient are … Incontinence diary…. weight management… Dietary improvement- small obtainable goals…. Consider wearing incontinence products when away from home. (include specific products) **(2 points)**
Rationale: A functional assessment identifies… Anorectal manometry is used to assess sphincter function and used when… Reference as needed **(2 points)**

/6 points

Scenario 1

A 76-year-old woman presents to the outpatient setting with a complaint of new onset FI. She has 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.
Identify any further actions that need completed at this visit. **-Additional history of form/consistency when she does have bowel movements, exploring family history for colorectal cancer, weight changes, and history of any colonoscopies, as well as patient's medical/surgical/medication history. Did any changes take place with medicine/medical diagnoses/surgery around the time the constipation began?** **-Abdominal examination with potential pelvic exam to check for prolapse and distention or masses as well as check for bowel sounds** based on her history what other hands on exam should you do? **-What is the patient currently using as a laxative?** **-Obtain order for abdominal X-ray** **(2 points) 1**
The long term-recommendations for this patient are … **Food/fluid diary** **Bowel diary** **Referral to dietician for formulation of a dietary plan** **Start a fiber supplement or plan for 21 g/day of fiber in diet with a list of high-fiber foods** **(2 points) ok 2**
Rationale: **Patient should be evaluated for any signs/symptoms of colorectal cancer and family history of colorectal cancer. If these are noted, the patient should be referred for colonoscopy and follow-up.** **Constipation can be caused by neurogenic bowel dysfunction (spina bifida, spinal cord injury, back injury and back surgery) as well as central nervous system disease (MS, Parkinson's, Alzheimer's dementia) and metabolic disorders (hypothyroidism, diabetic neuropathy), as well as medications.** **Women over age 50 are recommended to consume 20 g/day of fiber to assist in softening the stool by retaining moisture and decrease transit time. The patient could also benefit from a meeting with a nutritionist/dietician to develop a meal plan as she is unable to tolerate certain foods due to stomach upset.** **Some laxatives, osmotic laxatives, can be used repeatedly, however, stimulant laxatives are only to be used for short periods of time.** **A food and bowel diary can offer insight into when the patient notices the constipation/FI most and what her intake has been recently, as well as consistency of the stool. Monitoring fluids offers insight to whether the patient is ingesting an adequate amount of fluids daily and this can worsen constipation.** **Fecal impaction is possible and will need addressed with a prescription for an enema or potential surgical intervention pending size/severity of impaction.** **(2 points) 2**

5/6 points

Scenario 2

A 50 y/o female presents to the outpatient clinic for “management of incontinence”. She describes periods of incontinence with sneezing. She indicates she does not feel like she empties her bladder completely.

Identify components of your focused assessment and include any diagnostic tests.

What do the episodes of incontinence involve (when, how frequently, how much urine, when did they start)
BMI
Patient’s normal daily fluid and foot intake
Abdominal and pelvic exam. Any prolapse?
Any causes of increased abdominal pressure (smoking, coughing, obesity, job requirements, sports)
Any history of pregnancy? If so, how many?
Any history of surgeries or fractures in the abdomen or pelvis?
What is the patient’s hormone status?
Diagnostic tests: urinalysis, urine culture, labs (BUN, Cr, electrolytes, GFR, CBC, prealbumin), post-void residual testing, renal ultrasound, cough test, cystometrogram

(2 points) 2

Describe your treatment plan.

Voiding diary
Referral to pelvic floor physical therapy
Referral to urologist if needing surgical options for prolapse, or additional need for pharmacologic management
? fluids & caffeine?

(2 points) 1.5

Rationale:

Pelvic floor physical therapy is a first-line treatment for stress incontinence. However, it sounds like the patient may have retention with incontinence as well. Getting a thorough history of factors affecting the bladder including pregnancy, surgery, exam of the pelvis and abdomen, food/fluid intake, etc can offer insight into what is happening. Diagnostic tests such as lab work, urinalysis and urine culture will check for bladder irritation that may affect retention, as well as other testing such as the cough test to offer more insight into stress incontinence and post-void residual testing and renal ultrasound to offer more information about potential retention. A cystometrogram will test detrusor contraction.

(2 points) 2

5.5/6 points

Scenario 3

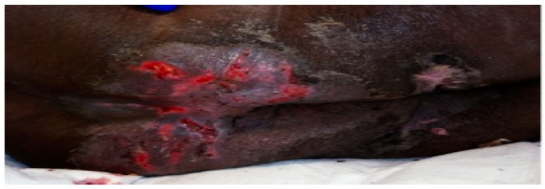

Photo courtesy of Sandy Hughes, MSN, RN, CWOCN

The continence nurse is consulted to evaluate a nursing home resident for fecal incontinence. On physical assessment areas of skin breakdown on bilateral buttocks noted. On chart review the individual's dietary intake is mostly fruit, activity is limited, and patient is mostly bedridden. Recent stool sample is positive for C-diff. Incontinence has been managed using an adult brief when in chair and area open to air when in bed on a cloth incontinence pad.

Identify your treatment plan, including any products.

Limit chair sitting to meals only, otherwise turning and repositioning every 2 hours and checking hourly for periods of incontinence with prompt hygiene care.

Evaluate for appropriateness of an internal bowel management system, such as the Dignicare system.

Consult with nutritionist/dietician to formulate a dietary plan, avoiding fruit juices, caffeine and milk, and limiting sugars and fatty foods. Follow the BRAT diet.

Consider use of a bulk-forming fiber supplement such as Citrucel or Metamucil before each meal.

Clean the skin of buttocks and perianal area with a soft cloth and pH-balanced no-rinse cleanser. Dust pectin powder such as McKesson Skin Barrier Powder over the lesions and dust away excess. Apply crusting with a polymer-cyanoacrylate skin protectant such as Cavilon Advanced Skin Protectant wand. Allow to dry completely and reapply twice per week.

If neither external fecal collection pouch or internal bowel management systems are able to be utilized, continue skin protectant measures/treatment and have patient wear a brief that contains superabsorbent polymers, such as NorthShore MegaMax Airlock diaper style. Instead of wear, consider using a pad that absorbs & wicks vs. the cloth pad since pt not ambulating

Consult physical therapy to develop an appropriate exercise/activity plan.

Verify C-diff is being treated based on culture results.

(2 points) 1.9

Discuss an educational program to be developed for staff.

The staff could benefit from a program on incontinence-associated dermatitis and prevention**.** It would be interesting to review what the facility's incontinence protocols consist of and if they need to be updated, then develop an educational program from that, including potentially a short PowerPoint-like presentation of incontinence/IAD/pressure risk and then a hands-on portion involving different incontinence products (ointments, creams, briefs, external collection pouches, crusting techniques, cleansing options, etc). If I were leading this program, I would split it into 2 sections spaced about 4 weeks apart so that the staff's skills and growth could be evaluated after the initial session. Looking for specific points for education of the staff

(2 points) 1

Rationale:

As the patient has broken perianal and buttock skin, an external fecal collection pouch is not able to be used. We pouch around stomas w skin breakdown all of the time Internal bowel management systems are mostly used in acute care settings, but could be considered for this patient if they are experiencing large amounts of liquid stool, meet criteria for the device with no contraindications, and the device is able to be used per SNF protocols and stocking.

The patient is mostly eating fruit, and foods with high sugar content as well as fruit juices increase the motility of the GI system. Fatty or greasy foods also cause similar issues, and the BRAT diet is recommended for diarrhea. Bulk-forming fiber supplements are recommended to bulk up the stool. Citrucel (1 tsp) or Metamucil (3.4g) can be dissolved in water and given to the patient at mealtime – either before or after – to assist with slowing motility of the GI tract.

pH-balanced no-rinse cleansers are gentle on the skin. Pectin powder will absorb drainage and a liquid skin protectant will enable a barrier to be made between the skin and the stool that does not need cleaned and reapplied as frequently as moisture barrier paste or ointment and prevents excessive friction on skin that is already damaged. Patients with moist skin and, specifically, IAD, are at increasing risk of pressure injury development and precautions should be taken to offload and reduce pressure.

Leaving the patient's skin open to air is no longer recommended since most absorbent products contain superabsorbent polymers to wick moisture from the skin and leaving the skin open to air can allow urine/stool to worsen incontinence associated dermatitis. Skin should be cleansed promptly as the fecal material contains irritants and enzymes which compromise the skin barrier, breaks down the skin and can make the skin more susceptible to infection.

Physical activity can assist in regulating the bowels and, although the patient is mostly bedbound, developing an activity plan of things the patient can do would be beneficial.

Infectious diarrhea is usually treated with antibiotics which should be chosen based on sensitivity of culture results.

(2 points) 2

4.9/6 points

Scenario 4

A 68-year-old male patient is in the hospital for a fall. The continence nurse is consulted per the patient request. The patient reports that he has “difficulty reaching the toilet in time at night” after his discharge from a knee replacement surgery 2 months ago. He is frustrated that he has no help at home. The patient is independent with his ADLs and reports his bathroom is on the second floor of his home.

What type of incontinence is this patient most likely experiencing?

Overactive Bladder/Urge incontinence

(2 points) 2

Describe your treatment plan and include any consults needed.

-Patient can wear incontinence products such as an adult brief/Depends at nighttime to aid in control of incontinence symptoms.
-Consider use of a bedside commode for short-term use and consult with case management to assist in obtaining one for home use through insurance
-Referral to physical therapy and/or joining a physical exercise program at a local gym or taking a 30 minute walk in the evening
-Bladder training brochures and teaching
-Referral to urologist for pharmacologic options should conservative measures be unsuccessful

(2 points) 2

Rationale:
Patients can be taught bladder training programs to help overcome or suppress the feelings of urgency. For those with mobility issues, toileting programs/functional training can assist in improving incontinence. However, toileting programs require a caregiver being involved and the patient lives alone with no additional help and the patient will not qualify for a SNF rehab program if he is independent of ADLs. Therefore, the patient may benefit more from physical therapy for exercise programs or taking a 30-minute walk each evening, as this has shown effectiveness in reducing the need to urinate at night. In the meantime, the patient may benefit from the use of incontinence products at nighttime to protect his skin, or using a bedside commode to avoid walking up a flight of stairs to get to the bathroom.

(2 points) 2

6/6 points

Scenario 5

A 53-year-old female patient presents to the outpatient clinic with complaints of increased urinary urgency. Patient is anxious and requesting “surgery” to fix her continence issues. She is a 2ppd smoker and reports daily oral fluid intake is two “Venti” cups of coffee, 1-2 8oz glasses of water, and 3 shots of tequila. Physical assessment finds abdomen soft, non-tender, non-distended with no palpable masses and no obvious hernias. External genitalia normal. The anus and perineum are normal. No visible prolapse. Reported daytime urinary frequency is every 30 minutes with nocturia 4-5 times a night with no enuresis.

Identify further components of your focused assessment and include any diagnostic tests.

BMI
Personal medical history
Current medication list – prescribed and OTC
Diet
Obstetric, genitourinary, bowel and sexual history as well as family history to check for any cancers
Mobility/functional assessment along with cognitive assessment
What is the patient using to control incontinence symptoms?
Pad test
Urinalysis

(2 points) 2

Describe your treatment plan.

Bladder diary
Encourage smoking cessation
Weight reduction if appropriate – small, feasible goals
Encourage caffeine and alcohol reduction
Referral to a mental health counselor should patient voice concerns for increased stressors affecting life and using smoking and alcohol habits to cope.
Refer to therapy for urgency suppression/bladder training
Should these fail, patient could be referred to a urologist for pharmacological interventions

(2 points) 2

Rationale:

The pad test will provide data of how much urine occurs each time the patient voids. Urinalysis will check for UTI as infection could exacerbate urgency. Of biggest concern is the extent of the patient’s caffeine intake and smoking as both of these are bladder irritants which increase urgency. A functional assessment will assess patient’s ability to make it to the bathroom during periods of urgency, and a thorough medical history will provide insight into other medical/surgical/family history that could be pertinent to the current situation. Bladder training can assist in overriding or delaying urgency. Weight reduction to treat obesity has been shown to reduce urgency. Urodynamic testing is normally used only in complex patient’s histories, for those who have neurological disease, or for those who have failed initial treatment, not as a first-line consideration.

(2 points) 2

6/6 points

Scenario 6

A non-ambulatory 90 y/o male presents to the emergency department from a long-term care facility for change in LOC. Continence nurse consulted for management of “a leaking catheter.” The patient is disoriented and wearing a brief soiled in liquid stool in bed. He is also pulling at an indwelling urinary catheter, which has urine leaking from insertion site. The patient is a poor historian and has no other present caregivers. His skin is intact. Patient has no non-verbal signs of pain.

Identify components of your focused assessment and include any diagnostic tests.

Orders from provider for urine culture to assess for UTI, lab work including CBC and CMP, and stool sample to test for C. difficile

Call the SNF and ask if any other patients have reported similar symptoms of loose stool and what the patient’s diet has consisted of the last week as well as the patient’s normal stooling pattern.

Bladder scan to check amount of urine in the bladder

Inspect the catheter

- Find out why it was placed and how long patient has been incontinent, if possible.
- When was it placed? Is it due for a change? What is the catheter size?
- Flush the catheter to see if there is an obstruction
- Check the amount of sterile water used to inflate it
- Stabilize the catheter tubing
- Check the catheter tubing- is it secured to a non-movable part of the bed and off the floor?
- **Cleanse the patient’s perineal skin with gentle cleansing agents like Readibath wipes or a no-rinse Remedy cleansing lotion** this is your treatment plan

Inspect appropriateness for an external collection device for liquid stool

(2 points) 2

Describe your treatment plan and any necessary products.

Replace the catheter, if needed, with a 12-16F catheter secured with 10mL of sterile water and secured to the patient’s leg. However, if the patient is pulling at tubing, he may need mitts or assessment if intermittant catheterization would be a more appropriate intervention.

Consult urology – depending on patient’s history, patient could benefit from a suprapubic catheter. Perhaps a condom would work ? but you need to remove this indwelling cath first

Apply an external collection device for stool containment such as the fecal collection from Hollister after removing the soiled brief and cleansing the patient’s skin in the same manner as

(2 points) 1

Rationale:

Leakage of a catheter can be caused by infection, hence the lab work and cultures. It can also be caused by obstruction, too large of a balloon or an unstabilized catheter as well as kinking of the tubing or other blockage. For this reason, I would focus on the various parts of the catheter mentioned above, as well as take measures to prevent worsening infection and protection of the patient’s skin with gentle cleansing agents as mentioned above to remove excess urine and stool. An external collection device for stool is the first-line treatment for large amounts of liquid stool and precautions should be patient to protect the patient’s intact skin, as well as assess for causes of the liquid stool.

(2 points) 2

5/6 points

Scenario 7

A 47-year-old female patient is seen in the outpatient clinic. The patient has pelvic organ prolapse and moderate hypertension. She has high anxiety and is not a current candidate for surgery due to BP issues. Her surgeon referred her for further education regarding a Gellhorn pessary until her BP is controlled, with regular follow-ups in the clinic. Previous urodynamic testing showed normal bladder capacity and compliance. Cystoscopy showed no lesions and CT urogram showed no suspicious renal or urothelial lesions.

Discuss your education plan.

Before starting any fittings, I would spend time with the patient discussing the goals of using a Gellhorn pessary, procedure for fitting it and fears/anxieties that the patient has. As this will require items that could cause discomfort and the need to internally assess the patient's vagina, the patient may have high anxiety about the visit, and measures should be taken to make the patient feel comfortable and safe.

I would have an example of the Gellhorn pessary available for patient to see and touch while educating in addition to various printed materials to go over prior to fitting that touch on placing and removing the pessary, cleaning it, and abnormal findings/common problems to be aware of. I would also make sure to discuss sexual activity and if the patient is menopausal or not, as well as review the patient's medical history to determine the grade of the prolapse and surgical history.

(2 points) 2

Describe your treatment plan.

In my case, I am not an APRN and would not be able to fit the patient for a pessary. However, I could act as a chaperone during the visit and would be involved in the educational process and handle phone calls from the patient for concerns.

If I was an APRN I would fit the pessary then have the patient stand, walk, sit, and bear down to make sure the pessary fits well but does not cause discomfort or fall out. I would have the patient teach-back the information and do a return demonstration. Should the patient be menopausal or have vaginal tissue atrophy, I would treat with intravaginal estrogen for one month prior to fitting, then continue the estrogen during use of the pessary. I would have the patient follow up in 1-2 weeks following fitting to have a check-in and see if refitting is required and if symptoms have improved.

(2 points) 2

Rationale:

It can take multiple attempts to identify a correctly fitting pessary, but studies show more than 90% of women can successfully use and be fitted for one. Reasons for this not working involve shortened vaginal length, incontinence with pessary use and history of many pelvic surgeries. Gellhorn pessaries are recommended for patients who do not participate in sexual activity and have a grade 3 or 4 prolapse which ring pessaries would be more appropriate for patients who have prolapse of grade 1 or 2.

Topical estrogen can help to prevent and treat erosions of the vaginal tissue.

(2 points) 2

6/6 points

Scenario 8

The continence nurse is tasked with identifying trends and implementing interventions related to continence issues in an inpatient organization and is asked to develop a CAUTI QI project.

Identify the components of a quality improvement project.

Identify a problem
Create a goal
Develop a plan
Evaluate the results

(2 points) 2

Describe how you would design a CAUTI QI project.

I would assess data from both the organization overall, and each individual unit regarding CAUTI prevalence. & compare to national benchmarks I would then discuss with both staff and leadership to identify a main problem and create SMART and realistic goals for the project. This would also present valuable insight into the overall buy-in from the staff and organization, and previous level of knowledge. When developing the plan, I would need to be aware that there may be multiple factors at play and a singular project may not solve all problems at once. I would check with the research committee/internal review board to see if there were any requirements I would need to complete before pursuing this project. I would then break the project down into a series of short, consistent educational sessions over a period with bedside staff involving teach-back and handouts, or a combination of in-person educational sessions following a short, online educational session and quiz, depending on the situation. I would follow the CAUTI statistics for each unit compared to the statistics prior to education. At the same time, I would evaluate procedures and policies impacting catheterizations and perineal hygiene, to see if improvements need to be made.

(2 points) **1.8**

Discuss the dissemination of information regarding the project results.

Following finalization of the review period after the interventions, I would compile the information into a document for review, and work to schedule time with each unit to go over their data results at their staff meetings as well as meeting with leadership to review the results.

(2 points) 2

5.8/6 points