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

Continence Care Mini Case Studies

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Score: 44/48

As a continence nurse, your focus should be on assessment and treatment within your scope of practice. Testing and referrals supplement your scope.

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.

Refer for defecography

Collect food and stool diaries from patient. Identify if there are specific foods that patient is unable to tolerate due to stomach upset.

Collect list of medications from client

Inquire about patients level of activity, exercise, hobbies, etc.

Possible need for disimpaction

(2 points) **Awarded: 2**

The long term-recommendations for this patient are …

Increase intake of fluids to at least 6 to 8 glasses of water a day

Increase fiber intake to 30-40 grams of fiber a day from food. Inform patient that bloating and flatulence at beginning of diet change is normal and will reduce over time. Patient should introduce foods slowly.
Offer medications to reduce bloating, such as simethicone.

If patient continues to not experience rectal fullness, implement a stimulation defecation program by use of suppositories and enemas rather than laxatives

(2 points) **Awarded: 2**

Rationale:

Passive incontinence is defined as an unrecognized leakage of stool due to neurological or sensorimotor issue. Chronic overdistention of rectum due to chronic constipation can cause sensory issues, decreases sensation of rectal fullness.

Lack of fiber in diet and poor hydration status will increase transit time and increase risk of constipation. Constipation is aggravating the incontinent episodes for this patient.

Defecography will help to tell if there are defects in the musculature of the anal canal as well as its length.

Medications such as anticholinergics, opioids, and anticholinergics can worsen constipation. Reviewing med list with patient will help to identify possible insulting agents and prompt discussion about

Regular exercise will help to promote GI motility.

Stimulation defecation programs can be helpful to those who cannot feel rectal fullness, and minimize use of laxatives. Increase sense of control over defecation for patient. Client is struggling with her lack of control at this time.

(2 points) **Awarded: 2**

Awarded: 6/6 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.
Refer for defecography
Refer for endoanal ultrasound
Refer for anorectal manometry

Collect history regarding frequency of episodes and when they began. Inquire about history of patients normal stool pattern before incontinence began.
Collect list of medications client takes, as well as medical and surgical history.

Assess anus for tone, size of aperture, and shape. Perform digital rectal exam. Also assess for presence of anal wink.

Collect post-void residual to measure urine left in bladder after urination.

Order MRI
Scenario indicates stress inc Referring is important, but does not describe your assessment.

Realistically if leaking with sneezing would that more likely stool or urine? If not known, then assess for each would be a component of the assessment.

(2 points) Awarded: 2

Describe your treatment plan.
Refer to pelvic floor physical therapy with biofeedback
Refer to neurology

Apply fecal incontinence pads between natal cleft, covering anus daily and change PRN following leaks

Voiding diary, teaching PFME, Avoid caffeine, increase fluids

(2 points) Awarded: 1

Rationale:
Patient is incontinent of feces when she sneezes, which indicates weakness in the anal sphincter, abnormal growth, or issue with innervation.

Defecography will help identify possible defects in the anal sphincter. Anorectal manometry will assess patients rectal strength and control of muscles in canal. Endoanal ultrasounds will help to identify and possible structural abnormalities in patients floor that could be disrupting sphincter function. Since patient is also experiencing difficulty with emptying bladder, there is

a chance that a mass could be present somewhere in the pelvis or that retention is due to systemic nerve issue.
Alternatively

Some medications are known to reduce muscle tone of the sphincter, like antispasmodics, which she could be taking for another illness/condition. It is important to assess for the state of her health overall to see if any underlying issues could be contributing to her incontinence.

Weak muscle tone or visible abnormalities of anus can contribute to incontinence, especially if they lead to anus not being able to close completely at rest.

PFPT with biofeedback can help strengthen mind-body connection and improve control over voluntary sphincter. If no masses present, it is likely that both urinary and fecal incontinence are related to an issue with sensorimotor system/innervation.

MRI will demonstrate if there is prolapse of the bladder which could also be creating pressure on the rectum. Bladder prolapse can cause retention of urine.

Awarded: 1.5
What about attention to treatment; inc pads, etc

(2 points)
Awarded: 4.5/6 points

Scenario 3

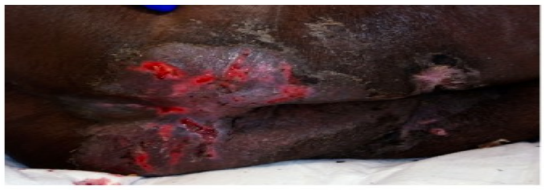

Photo courtesy of Sandy Hughes, MSN, RN, CWOCN

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.

Apply internal fecal management system (Convatec Flexiseal) if available, while patient continues to have active diarrhea. Change system every 1-2 days and remove when stools become thicker in consistency, type 5 on Bristol stool scale or less. If internal system is not available, external pouching device can be placed if it does not adhere to open skin.

Remove cloth incontinence pads from room and replace with Medline Ultrasorb incontinence sheets on bed and in chair.

Clean perianal area and sacrum with no-rinse pH balanced bath wipes, Medline Readybath Luxe wipes, BID and PRN after episodes of incontinence or if leakage around management system.
Apply Coloplast Baza moisture barrier ointment to perianal area and sacrum BID and PRN after episodes of incontinence or if leakage around management system.

Medicate patient with psyllium husk supplements to promote safe bulking of stool.

Notify attending/provider of positive C. diff result and medicate client with antibiotics as soon as they are ordered and available.

(2 points) Awarded: 2

Discuss an educational program to be developed for staff.

The staff in this facility would benefit from education regarding risk of skin damage when patient is incontinent, and that that risk if heightened the more liquid the stool is.
Education regarding available products, including bed pads and barrier ointment will be helpful as well to understand how they are designed to protect skin from excess moisture.

Staff would also benefit from education regarding importance of frequent turning and skin checks to ensure that client is not sitting or laying in stool for extended periods of time.

Handwashing, PPE for c-diff, FMA management
(2 points) Awarded: 1.75

Rationale:
C-diff can cause transient incontinence, and the focus for treating that is to treat the cause. Diarrhea is common in c-diff. Imodium is not indicated in cases of C-diff. Psyllium husk is safe to use in cases of C-diff.
Client is not ambulatory, and internal bowel collection devices are indicated for acute diarrhea in bedridden patients. This will be a safer alternative to having the clients skin in contact with liquid stool.
Wounds do not appear to be perianal, so an external pouching system may be an adequate second choice.

Clients wounds indicate MASD combined with chemical irritation due to enzymes present in liquid stool. Skin needs to be protected from further insult and offloaded in order to allow healing.

(2 points) Awarded: 2

Awarded: 5.75/6 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?

Incontinence secondary to mobility issues and environmental factors with possible additional urge incontinence.

(2 points) **Awarded: 2**

Describe your treatment plan and include any consults needed.

Client would benefit from a functional assessment to assess mobility and what motions or activities are most difficult for him.
Client would also benefit from an environmental assessment of his home.
Also your treatment, then, would be: perform a functional assessment, environmental assess, etc
Prompted toileting in evening 1 hour before typical incontinence episode times.

Avoiding before bed, urinal at bedside, limiting fluids 3 hours before bed, avoiding bladder irritants, etc

Consult to PT.

(2 points) **Awarded: 1.5**

Rationale:

An environmental assessment of patients home will help to highlight what structural changes can be made to facilitate easier access to bathroom. Patient may not be able to afford to have a new bathroom built on the first floor, but placement of handrails, removal of items blocking footpaths, and improved lighting can all help to increase access.
Additionally, patient may me interested in a commode at the bedside if structural changes are not enough for him due to his current mobility concerns.
Physical therapy may be able to help improve patients mobility and recovery from surgery as well as recovering from his recent fall.

Creating a toileting schedule for 30-60 minutes prior to usual times of episodes may also help patient avoid further episodes, as episodes appear to happen only at night.

(2 points) **Awarded: 2**

Awarded: 5.5 /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.

Refer to urodynamic testing
Food and bladder diary collection
Assess for stool impaction

Pregnancy hx, history including previous interventions, urinalysis
BMI, obstetric, genitourinary, bowel & sexual history
Mobility, functional, & cognitive assessment

(2 points) **Awarded: 1**

Describe your treatment plan.
Enroll patient in smoking cessation program.
Provide client with urge control strategies such as Knack and distraction techniques. Enroll patient in bladder training program.
Refer to nutritionist to review foods and drinks that are known bladder irritants and how to enjoy them in moderation if not eliminate them

If symptoms persist after consistent diet change, refer to urology to discuss medication, botox, or neuromodulation treatments and refer to pelvic floor physical therapy.

(2 points) **Awarded: 2**

Rationale:
While presentation indicates OAB, urodynamic testing will help rule out any structural causes of frequency.
Client appears to be drinking many things that trigger OAB, but can further assess what else could be aggravating her system as well.
Chronic constipation and impaction and aggravate OAB symptoms due to pelvic floor pressure.

Bladder training programs help to reduce feelings of urge and can increase time between bathroom visits. Goal is to void 6-8 times a day.

Smoking is a known bladder irritant.

While urge inhibition strategies will not eliminate symptoms completely, it can help client

improve her sense of control over the situation and reduce anxiety.

(2 points) **Awarded: 2**

Awarded: 5/6 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.
Urine culture and sensitivity with urinalysis via straight cath for clean collection
Remove catheter? Cognition assessment
Stool culture, rule out C. diff or other illness causing diarrhea.

Assess for CVA tenderness

(2 points) **Awarded: 2**

Describe your treatment plan and any necessary products.
Replace indwelling urinary catheter with condom catheter or urine pouch.
Implement frequent toileting program, with q1hour prompting for both urine and stool.
Perform q1hour skin checks as well.
Check for PVR q4hours and straight-cath patient if over 100mL of urine retained in bladder.

Apply external fecal pouch to perianal area and change daily and PRN after bowel movements
(2 points) **Awarded: 2**

Rationale:
Altered LOC is a hallmark sign of UTIs in the elderly population.

Patient prone to injury while altered LOC, removing catheter altogether will eliminate the risk of him pulling it out. External condom catheters are a safer alternative to indwelling systems. Current assessment of client does not indicate that other urinary collection systems have been attempted by facility.

Client is not ambulatory and has liquid stool so he is a good candidate for an external pouching system. Risk of complications is high if internal management system is put into place at this time due to clients disorientation.
(2 points) **Awarded: 2**

Awarded: 6/6 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.

Provide client with education regarding non-surgical methods to reduce severity of symptoms from pelvic organ prolapse, including avoidance of lifting heavy items, weight loss, and constipation prevention (NHS, 2021).

Provide client with education regarding potential benefits of pelvic floor exercises.

Education regarding the pessary with include the following:

- Purpose: to provide support and fill in space in pelvis via the vagina to reduce severity of prolapse (Cleveland Clinic, 2023).
- Insertion and fitting: A pelvic exam that includes measuring proper fit of device will be done in the office (Cleveland Clinic, 2023). The provider will assess to make sure you do not feel device when placed, and that it does not fall out with movement (Cleveland Clinic, 2023). You may be asked to sit, bend, and squat to ensure a good fit before leaving the clinic (Cleveland Clinic, 2023).
- Maintenance: If the pessary is designed to be removable, you will be able to remove and re-insert it yourself, and can clean with a mild soap and let dry before re-insertion (Cleveland Clinic, 2023). Your provider will inform you if your device can be removed, what materials it's made of, and how often you should attend follow-ups.

When to call or seek medical intervention

(2 points) **Awarded: 2**

Describe your treatment plan.

Refer to nutritionist if client is overweight as well as to discuss dietary changes to reduce risk of constipation.

Refer to pelvic floor physical therapy with biofeedback.

Return to clinic 6months after pessary insertion for follow-up or sooner if client expresses concerns.

Some of education info would be here as treatment: sit, stand, etc

(2 points) **Awarded: 1.75**

Rationale:

Pelvic organ prolapse can be treated non-surgically or without a pessary. Client would likely benefit from not-surgical options while she is also working on lowering her BP through medication and diet.

Weight loss and avoiding lifting heavy items can help to reduce overall pressure in abdomen and pelvis.

(2 points) **Awarded: 2**

Awarded: 5.75/6 points

Reference:

Cleveland Clinic. (26 December 2023). Pessary. Cleveland Clinic. https://my.clevelandclinic.org/health/treatments/16036-pessaries

NHS. (24 March 2021). Overview: pelvic organ prolapse. NHS. https://www.nhs.uk/conditions/pelvic-organ-prolapse/#:~:text=Pelvic%20organ%20prolapse%20is%20when,can%20cause%20pain%20and%20discomfort.

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.

Quality improvement projects aim to improve standards of care by implementing evidence-based practice into facility policies and procedures (Center for Medicare & Medicaid Services, 2023). Changes are implemented in cycles, with phases that are meant to identify the problem or target population, implement changes in practice, and analyze the efficacy of the changes that were made. This process is often known as Plan-Do-Study-Act (Minnesota Department of Health, 2022).

Planning involves creation of a QI team, identifying goals, understand what the current processes are in relation to this goal, and identify possible causes to the issue at hand, and creating solutions to address the issue (Minnesota Department of Health, 2022).

The "Do" phase is the step where the solutions that were created are then implemented. The team will decide how long the implementation phase will go for.

Once implementation is complete, the QI team will then study results of the implementation plan, to see if there were any changes in the trends being measured.

Lastly, the results will determine what further steps will be made, if further changes need to be made to the new implementation plan, or if a new plan needs to be created altogether.

This process repeats at predetermined intervals to ensure that goals are continually monitored.

What about education on the new strategies and implementation of the project as well as dissemination of the information?

(2 points) **Awarded: 1.75**

Describe how you would design a CAUTI QI project.

Plan: I would recruit a multidisciplinary team that would include floor nurses, providers, infectious disease specialists, urologists, and data analysts from the organization to participate in this initiative. Initial meetings would help to establish what all team members perspectives are on CAUTI rates in the facility, and if current data collection strategies are effective and accurate. Staff would identify what supports they have, and what they feel is lacking in regards to support and policies/procedures. These meetings would also ensure that one single definition is being used to determine CAUTI, so that future measurements are consistent.
Can you truly "ensure"?
Do: For an implementation project, I would like to establish a weekly interdisciplinary rounding of all inpatient floors to discuss all clients with indwelling catheters. This team would ensure that all clients being catheterized were done in accordance to accepted indications by the CDC, which does not include urinary incontinence without other complicating factors such as perineal wounds or palliative care (Newman, 2022). This rounding team would also assess if orders are in place for catheterization, as well as discuss potential removal of catheters for patients that have had them in place for longer tan 14 days. These teams would do their rounding at the bedside to additionally assess proper placement of

drainage bags, bag labelling, frequent emptying and other proper bedside practices (Newman, 2022). ***Good!***

Study: Success of this program would be measured by comparing rates of CAUTIs in the facility before and after its implementation. I would also measure frequency of appropriate intervention once a CAUTI is diagnosed, including removal of the catheter if possible, or at the least, having the catheter changed prior to initiation of antibiotic treatment to reduce presence of biofilm (Newman, 2022). The goal would be to have statistically significant reduction in CAUTI prevalence and 100% adherence to treatment protocol when a CAUTI is identified.

Act: The results of the data comparison would then determine next steps. If changes make satisfactory improvements, the next step would be to work on ensuring the longevity of the rounding program. If rates are not significantly declined, the next step would be for the QI team to brainstorm other possible causes for the high rates and produce new interventions to measure in the next cycle.

(2 points) **Awarded: 2**

Discuss the dissemination of information regarding the project results.

To ensure that all patient-facing care team members were aware of the results of the project and how they as individuals can help to prevent CAUTIs, I would ensure that all staff attended a mandatory online training that provides education regarding how CAUTIs develop, and what interventions are in place to prevent them. Attendance could be incentivized by sponsoring CEU hours to complete the training. Ease of access to the training could be increased by putting the information in a podcast format, so that employees are free to listen to it during their commute or while sitting in the unit without having to struggle to find a computer screen to access a video. Many hospitals are tight for computer space and giving staff flexibility to listen to results with some flexibility will help it feel like less of a chore for many.

Additionally, I would create laminated graphics that would be posted in every patient room outlining the purpose of CAUTI rounds, how collection systems should be maintained, and encouraging patients to ask providers about why a catheter has been placed.

What about dissemination to others, not just the bedside care providers; the appropriate management, committees, physician groups etc.

(2 points) **Awarded: 1.75**

Awarded: 5.5/6 points

References

Center for Medicare & Medicaid Services. (6 September 2023). *Quality Measurement and Quality Improvement*. CMS. https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/MMS/Quality-Measure-and-Quality-Improvement-

Minnesota Department of Health. (3 October 2022). *PDSA: plan-do-study-act*. MDH. https://www.health.state.mn.us/communities/practice/resources/phqitoolbox/

pdsa.html#:~:text=More%20information-,What%20is%20PDSA%3F,works%20and%20what%20doesn't.

Newman, Diane K. (2022). Indwelling and Intermittent Urinary Catheterization. In J. M. Ermer-Seltun & S. Engberg (Eds.), *Wound, Ostomy, and Continence Nurses Society core curriculum: Continence management* (2nd ed., pp. 328-354). Wolters Kluwer.