

10 19 2024 Continence Care Mini Case Studies

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Reviewed by: _____

Score: 48

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.

- Explain the structure/connection between constipation and liquid stool leakage.
- Determine exactly what OTC laxatives she is using and frequency of use. (Osmotic vs Stimulant)
- Review the correct position for emptying the bowel
- Explain and discuss anal manometry with patient, consent and schedule per clinic protocol.
- Referral to dietician to address diet modification, such as adding fiber while limiting aggravating stomach issues.
- Determine daily fluid intake. Educate related to a minimum of 8, 8 ounce glasses of water or other non-sugary, non-caffeinated, nonalcoholic beverages.
- Determine patient’s current exercise habits. Discuss and set healthy goal for weekly exercise.
- Review instructions for completing Stool Diary. Instruct to complete X 2 weeks. (attached example)
- Record daily fluid intake and exercise in comment section of stool diary.
- Explain the Bristol Stool Consistency Scale and provide visual/written material for accurate record in stool diary.

(2 points)

The long term-recommendations for this patient are ...

- Return in two weeks to review 2 week completed stool diary and anorectal manometry results.
- Increase fluid intake (8, 8 ounce glasses of water or other non-sugary, non-caffeinated, nonalcoholic beverages).
- Increase or begin regular moderate exercise (walking) 3 times per week.
- Use correct positioning for opening bowels. (Consider purchasing a Squatty Stool)
- Slowly increase daily fiber intake.
- Record laxative usage and type on stool diary.

(2 points)

Rationale:

- Current behavior (Fluid, exercise, fiber, position when toileting, consistency and frequency of stools) must be determined to modify behavior.
- Anorectal Manometry measures pressures in the anus and rectum and assesses their function.
- Lifestyle modification of fluid, fiber, and exercise are the initial management for constipation.
- Osmotic agents work by distending the bowel and are safe on a routine basis. Stimulant agents activate nerve cells and should be used on a limited basis.
- Only a high fiber diet or fiber supplement is recommended for long term laxative use.
- Goal for fiber intake is 14 grams /1000 kcal/day
- squatting moves your colon into the ideal position to go without straining. (Knees above hips)

(2 points)

/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.

- Obtain detailed childbirth history, smoking, alcohol intake, medical and surgical history, current medications, diabetic status/recent HA1C. Any history of traumatic injury.

-Determine patient’s familiarity with Pelvic Floor Muscle Exercises. Educate as needed.

-Determine if she is familiar with or has had urodynamic testing. Explain this testing might be an option if PFME are not sufficient to address stress incontinence.

Urodynamic tests include:

Cystometry: measures the pressure inside the bladder as it’s being filled

Electromyography: measures activity of the pelvic floor muscles

Pressure flow study: measures pressure inside the bladder and the flow of urine while urinating

Uroflowmetry: measures the flow of urine

Postvoid residual measurement: measures how much urine remains in the bladder after urinating

Video urodynamic tests: Combine cystometry, uroflowmetry, and X-ray cystography

-Discuss Bladder Diary and patient’s willingness to complete x 2 weeks and return to clinic to review.

(2 points)

Describe your treatment plan.

-Return to clinic in 2 weeks with completed Bladder Diary (example attached below).

-Bring all current medications with you to your next visit.

-Referral to Physical Therapy for Pelvic Floor Muscle Exercises.

-Obtain any previous urodynamic results or refer per facility protocol for urodynamic testing.

-Provide basic PFME instructions along with advanced instructions and KNACK instructions (attached).

BASIC EXERCISE

1. Empty bladder prior to PFME

2. Supine position with knees bent, head on a pillow.

3. Muscle Isolation: Squeeze like you are trying to prevent the passage of gas (abdomen, thighs, buttocks remain relaxed)

4. Tighten pelvic floor muscles for 5 seconds, then relax pelvic floor muscles for 5 seconds, do 5 reps.

5. Aim for 10 seconds at a time, relaxing for 10 seconds between contractions.

6. Work up to 3 sessions of 10 full Kegels per day

ADVANCED: FULL PELVIC FLOOR WORKOUT (FAST-TWITCH & SLOW-TWITCH MUSCLE FIBERS)

Short Muscle Contractions (Fast Twitch Muscle Exercise) – Works fast-twitch muscle fibers that respond quickly to compress the urethra and shut off the flow of urine to prevent leakage.

Tighten muscles quickly and hold for 1-2 seconds, and then release. Continue to breathe normally.

Long Hold Muscle Contractions - works supportive strength and endurance of the slow-twitch muscle fibers and is referred to as a long hold contraction.

Contract the same muscles used with the quick contractions but now gradually tightened, lift up, and hold. It may be difficult to hold the contraction for more than 1 or 2 seconds. Ultimately, the goal is to hold the

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.

- Administer C-diff treatment as ordered.
- Minimize skin contact with urine and feces, assess for incontinent episodes Q 2 H.
- If able, instruct patient to call with each incontinent episode.
- Cleanse skin with a pH balanced cleanser (DermaRite PeriFresh Rinse-Free Perineal Cleanser) after each incontinent episode and use soft materials (washcloth or towel) for cleansing and drying.
- Apply 3M Cavilon Durable Barrier Cream to affected area after each incontinent episode.
- Use Body Worn Absorbent Products that are breathable and moisture wicking such as MOLLIS Adult Diapers when up in chair.
- Referral for physical therapy assessment to increase mobility/range of motion.
- Referral to Dietician for increased need of protein to heal wounds.

(2 points)

Discuss an educational program to be developed for staff.

Instruct all direct care and housekeeping staff on C-diff.

-Disposable protecting clothing reduces the risk of C diff spread between providers, patients, staff members, and can eliminate the risk of facility-wide colonization.

-Disposable PPE prevents the spread of the spores to laundering personnel, laundering equipment, or others if the clothing is worn outside of the workplace.

-Patients are most contagious when C diff symptoms such as diarrhea are present before treatment as begun. Skin-to-skin and skin-to-clothing contact is likely to spread C diff infections at this stage.

-All team members working with patients are advised to wear disposable personal protective clothing when providing caregiver or cleaning services.

The following steps will reduce the risk of infection:

- Wash hands with antibacterial soap or gel sanitize.

-Put on disposable clothing (gown, eye covers, mask, gloves) before entering the patient's room.

-After providing care or cleaning the room of a C diff patient, remove and dispose of the protective equipment in this order: Gloves - Eye coverings – Gown - Mask

-Then, thoroughly wash and sanitize hands before coming into contact with another patient, loved one, or team member.

REMEMBER: Consistently utilize protective clothing AND effectively dispose of it.

(2 points)

Rationale:

-Treating the underlying cause is a priority.

-Decreasing/preventing the irritant from contacting the skin facilitates healing.

-An Alkaline microclimate will compromise skin barrier integrity.

-Skin protectants provide a physical barrier to urine and feces.

-Disposable protective clothing remains a front line of defense against C diff spreads.

(2 points)

/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. The patient is independent with his ADLs.

What type of incontinence is this patient most likely experiencing? Functional Incontinence

(2 points)

Describe your treatment plan and include any consults needed.

- Physical therapy referral to assess lower extremity strength, gait, and mobility.
- Determine patient’s average daily fluid intake. (specifically include caffeinated, alcoholic, carbonated).
- Determine usual timing of fluid intake.
- Consider home health assessment (occupational therapy) of living environment after discharge. (Distance from bedroom or sleeping area to bathroom, rug placement, obstacles, etc.).
- Assess pain level. Assess pain medication regimen at home.
- Assess manual dexterity, visual acuity, motivation, and cognitive status.

(2 points)

Rationale:

- Following knee replacement mobility and gait may remain impaired two months post op.
- Fluid intake, type and timing, influence continence. For example, caffeine or alcohol late at night may contribute to patients difficulty reaching the toilet in time.
- The living environment may impede the route between sleeping area and bathroom.
- Both pain and pain medication can interfere with mobility.
- Manual dexterity, visual acuity, motivation, and cognitive status can interfere with mobility, speed of ability to reach the toilet and ability to undo clothing for toileting. These could contribute to functional incontinence.

(2 points)

/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.

-Explain surgery is not the first intervention.

-Obtain detailed childbirth history, medical and surgical history, current medications, diabetic status/recent HA1C and history of any traumatic injury.

-Determine patient’s familiarity with Pelvic Floor Muscle Exercises. Educate as needed and refer to physical therapy for pelvic floor exercises.

-Determine if she is familiar with or has had urodynamic testing. Explain this testing might be an option if PFME are not sufficient to address her incontinence.

Urodynamic tests include:

Cystometry: measures the pressure inside the bladder as it’s being filled

Electromyography: measures activity of the pelvic floor muscles

Pressure flow study: measures pressure inside the bladder and the flow of urine while urinating

Uroflowmetry: measures the flow of urine

Postvoid residual measurement: measures how much urine remains in the bladder after urinating

Video urodynamic tests: Combine cystometry, uroflowmetry, and X-ray cystography.

-Explain and discuss Bladder Diary and patient’s willingness to complete x 2 weeks, return to clinic to review, and discuss progress with PFME.

- Explain importance of bringing all current medications to the next clinic appointment.

(2 points)

Describe your treatment plan.

-Educate regarding necessity of smoking cessation.

-Obtain HA1C.

-Increase fluid intake of non-caffeinated, nonalcoholic beverages. (8, 8 oz glasses per day)

-Complete a Bladder Diary x 2 weeks. Return to clinic after the two weeks, bring all current medications.

-Obtain any previous urodynamic results or refer per facility protocol for urodynamic testing. If no previous testing, order and schedule per protocol.

-Provide basic PFME instructions along with advanced instructions and KNACK instructions (below).

BASIC EXERCISE

1. Empty bladder prior to PFME

2. Supine position with knees bent, head on a pillow.

3. Muscle Isolation: Squeeze like you are trying to prevent the passage of gas (abdomen, thighs, buttocks remain relaxed)

4. Tighten pelvic floor muscles for 5 seconds, then relax pelvic floor muscles for 5 seconds, do 5 reps.

5. Aim for 10 seconds at a time, relaxing for 10 seconds between contractions.

6. Work up to 3 sessions of 10 full Kegels per day

ADVANCED: FULL PELVIC FLOOR WORKOUT (FAST-TWITCH & SLOW-TWITCH MUSCLE FIBERS)

- Short Muscle Contractions (Fast Twitch Muscle Exercise) – Works fast-twitch muscle fibers that respond quickly to compress the urethra and shut off the flow of urine to prevent leakage.
- Tighten muscles quickly and hold for 1-2 seconds, and then release. Continue to breathe normally.
- Long Hold Muscle Contractions - works supportive strength and endurance of the slow-twitch muscle fibers and is referred to as a long hold contraction.
- Contract the same muscles used with the quick contractions but now gradually tightened, lift up, and hold.
- It may be difficult to hold the contraction for more than 1 or 2 seconds. Ultimately, the goal is to hold the contraction for 10 seconds then rest for 10 seconds between each long contraction.
- Be careful not to flex the muscles in your abdomen, thighs, or buttocks. Also, avoid holding your breath. It may be helpful to count the seconds of the hold out loud to maintain normal breathing.
- REPEAT YOUR EXERCISES 3 TIMES A DAY. GOAL: 3 sets of 10 repetitions per day

KNACK MANEUVER: Quickly contract pelvic floor muscles before coughing, sneezing, laughing, bending over, lifting, or any other activity that causes leaking.

(2 points)

Rationale:

- Smoking increases risk for incontinence. Smokers develop a chronic cough. Coughing puts pressure on the pelvic muscles, causing them to weaken and increasing the chance of incontinence.
- Physical therapy will instruct in biofeedback and exercises to teach relaxation and strengthening of the pelvic floor muscles.
- Certain medications can increase incontinence issues.
- Pregnancy and childbirth (especially difficult deliveries) can cause pelvic floor dysfunction.
- Trauma can contribute to pelvic floor dysfunction.
- Urinary incontinence may be a sign of diabetes. If blood sugar levels are poorly controlled, diabetes can damage nerves that control the bladder.
- Bladder Diary will provide information about output, intake, leakage, frequency. It may help identify underlying causes of incontinence.

(2 points)

/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.

- Remove indwelling urinary catheter.
- Replace with The PureWick™ Male External Catheter.
- Culture and Sensitivity urine test.
- Stool culture.
- Assess for dehydration.

(2 points)

Describe your treatment plan and any necessary products.

- Maintain The PureWick™ Male External Catheter
- Treat the urinary tract as indicated.
- Treat dehydration as indicated.
- Monitor disorientation (most likely related to UTI) and maintain patient safety.
- Maintain bed and chair alarm when patient is alone. Bed rails up when patient is in bed.
- Treat any stool culture results as indicated.
- Minimize skin contact with urine and feces, assess for incontinent episodes Q 2 H.
- Cleanse skin with a pH balanced cleanser (DermaRite PeriFresh Rinse-Free Perineal Cleanser) after each incontinent episode and use soft materials (washcloth or towel) for cleansing and drying.
- Apply 3M Cavilon Durable Barrier Cream to affected area after each incontinent episode.
- Use Body Worn Absorbent Products that are breathable and moisture wicking such as MOLLIS Adult Diapers when up in chair.
- When in bed, leave skin open to air. Maintain clean, dry absorbent pad beneath peri-area.

(2 points)

Rationale:

- Indwelling catheters are the most common cause of urinary tract infections.
- Culture and Sensitivity identifies and quantifies the microorganisms in a urine sample and determines sensitivity to various antibiotics.
- The PureWick sits outside the body and is held in place with an adhesive designed with a full seal around the anatomy to minimize leakage.
- When the user urinates, the PureWick™ Urine Collection system uses suction to pull urine through tubing to the connected collection canister.
- Stool culture detects bacterial pathogens in the stool, such as Salmonella, Shigella, Campylobacter, and enterohemorrhagic E coli.
- Treating the underlying cause of diarrhea is a priority.
- Decreasing/preventing the irritant from contacting the skin facilitates healing.
- An Alkaline microclimate will compromise skin barrier integrity.
- Skin protectants provide a physical barrier to urine and feces.

(2 points)

/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.

- Explain a pessary is a removable device that is inserted into the vagina to support the pelvic organs. Pelvic floor muscles provide the structural support necessary to hold the uterus, bladder, urethra and rectum in place. Show the patient what it looks like.

-Explain when pelvic floor muscles are weak, the uterus, bladder, urethra and rectum can slip out of place and cause uncomfortable symptoms. This is called pelvic organ prolapse.

-Reassure the patient there are many reasons the pelvic muscles become weak including pregnancy, childbirth, repetitive heavy lifting, aging, and trauma.

-Explain a Gellhorn pessary is used to treat advanced pelvic organ prolapse. It is disk-shaped with a knob in the center. It is also called a space-filling pessary because it provides support and fills the space in the upper part of the vagina to create a barrier to prevent the pelvic organs from slipping into the vaginal canal.

-A pessary is an alternative treatment often used if medical problems (high blood pressure) make surgery too risky. A pessary can reduce or resolve symptoms of pelvic organ prolapse and stress incontinence without surgery and are inexpensive and safe.

- When the pessary is placed it will be lubricated to decrease discomfort. Lidocaine can be used to numb the vaginal opening before insertion.

-To test the pessary stand, sit, squat or perform other maneuvers to determine if the pessary stays in place and remains comfortable. The provider may ask you to cough to check for leakage.

-They will ask you to empty your bladder before you leave to make sure you can pee with the pessary in.

REMEMBER: It may take two or three fitting attempts to get the pessary fit right. A pessary that's too small may fall out when you use the bathroom. A pessary that's too big can feel uncomfortable. The goal is to find a pessary large enough to stay in place but comfortable enough that you don't feel it.

(2 points)

Describe your treatment plan.

-Referral for pelvic exam to examine the vagina and pelvic organs with measurements of the vaginal opening, the length of the vaginal canal, and placement of Gellhorn pessary.

-Provide written material for teaching as follows;

- To care for a pessary remove and clean it weekly or even nightly.
- Wash your hands with soap and water and gently pull out the pessary.
- Wash it with mild soap and water.
- Rinse and dry it completely before reinserting.

- Follow-up every six to 12 months with the provider. During the visit, the provider will examine the vagina to ensure the pessary hasn't damaged the vaginal walls and that it still works correctly.
- If you can't remove the pessary on your own, you will need to see the provider every three to six months for cleaning and checkups. Hard-to-remove pessaries can be left in for a few months.
- If you can remove the pessary yourself, you may want to clean it nightly or weekly. You can also clean it before bed, sleep without it and reinsert it the next morning.
- You can wear smaller ring pessaries during intercourse, or remove the pessary before sex.

-Schedule follow up appointments every 6 to 12 weeks.

-Instruct patient regarding the following examples of when to call the clinic.

- Pain or discomfort. Patient may need a different size.
- Pink or bloody discharge. The pessary is rubbing against the vaginal wall. Patient may need a different size or may need to remove the pessary while the skin heals.
- Provider may prescribe low-dose vaginal estrogen. This helps improve the vaginal skin health, which gets thinner with age.
- Unusual vaginal discharge and odor. White-colored vaginal discharge is normal with a pessary. An unpleasant vaginal odor signals an infection. Patient may need antibiotics to clear it.

(2 points)

Rationale:

- Pessary is a removable device that is inserted into the vagina to support the pelvic organs.
- Pelvic floor muscles provide the structural support necessary to hold the uterus, bladder, urethra and rectum in place.
- Gellhorn pessary is used to treat advanced pelvic organ prolapse. It provides support and fills the space in the upper part of the vagina to create a barrier to prevent the pelvic organs from slipping into the vaginal canal.
- A pessary too small may fall out when the patient uses the bathroom. A pessary too big can feel uncomfortable. The goal is to find a pessary large enough to stay in place but comfortable so the patient doesn't feel it.
- Follow-up every six to 12 months to ensure the pessary hasn't damaged the vaginal walls and that it still works correctly. Every 3 to 6 months if the patient is not able to remove the pessary on their own (for cleaning and reassessment).
- Pessary is safe but pain, discomfort, infection, bloody or pink discharge are signs to call the clinic (rationale listed above in plan).
- Low-dose vaginal estrogen improves vaginal skin health, which gets thinner with age.

(2 points)

Reference: <https://my.clevelandclinic.org/health/treatments/16036-pessaries>

/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.

P.D.S.A. – Plan –Do - Study – Act

(2 points)

Describe how you would design a CAUTI QI project.

Plan:

What is the aim/goal/objective of the project. What steps are needed. What resources are necessary (both people and materials)? How will the implementation of interventions be measured?

Do:

Put the plan in action. What was observed? What challenges/surprises arose?

Study:

Analyze the results.

How do the measured results compare with predictions?

Are any of the results a surprise?

What are potential solutions?

What are the next steps needed to take to improve knowledge and practice?

Act:

Once a cycle is completed, look at the data and see what changes need to be made?

Based on the findings, how is change implemented on a larger scale?

What did you conclude from this cycle?

Is another cycle needed? What is the focus of the next cycle?

(2 points)

Discuss the dissemination of information regarding the project results.

Before the project begins, implement the CUSP model. (Comprehensive Unit-Based Safety Program) This model aligns culture with change and empowers staff at all levels to be involved in the process. This facilitates communication/dissemination of information in real time, at the front line of patient care.

Dissemination of results without staff engagement can be meaningless. CUSP is a proven method to improve staff engagement and effect lasting change.

Communication problems are cited as the root cause of most errors in studies by the Joint Commission and others.

The “Implement Teamwork and Communication” module covers these four learning objectives:

1. Recognize the importance of effective communication,
2. Identify barriers to communication,
3. Describe the connection between communication and medical error, and
4. Identify and apply effective communication strategies from CUSP.

The CUSP model supports the eight steps of John Kotter’s change model

Step 1: Create a sense of urgency,

Step 2: Create a guiding coalition,

Step 3: Develop a shared vision, and
Step 4: Communicate that vision.
Step 5: Empower others to act,
Step 6: Generate short-term wins,
Step 7: Consolidate gains and produce more change,
Step 8: Anchor new approaches in culture.

The steps of implementing CUSP include:

- Learn About CUSP,
- Assemble the Team,
- Engage the Senior Executive,
- Understand the Science of Safety,
- Identify Defects Through Sensemaking ,
- Implement Teamwork and Communication, and
- Apply CUSP

“Sustainable improvement can occur when frontline staff members take ownership of the improvement process. Frontline staff can use the (CUSP) modules to educate one another, patients, and physicians. They can further use communication tools to engage with physicians, patients, and staff in other disciplines or departments.”

Retrieved from <https://www.ahrq.gov/hai/cusp/modules/learn/index.html>

(2 points)

/6 points