R. B. Turnbull Jr. MD WOC Nursing Education Program

Continence Care Mini Case Studies

Student Name & Date: Carla Edeh_____

Reviewed by: _____

Score: /55

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.

- Individualize your recommendations specific to the case study. *Apply* what you know as the continence expert. _
- When providing rationale make sure to explore *why* an action or actions are chosen. Citations may be used as necessary but are not required.
- To support your actions, include at least three relevant references in addition to the course textbooks. (Use 7th edition APA formatting)

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.
Suspected Problem: **(1 point)**
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 incontinence 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 for your actions: *A functional assessment identifies…* *Anorectal manometry is used to assess sphincter function and used when…* *Reference as needed* **(2 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.
Suspected Problem: Fecal incontinence due to chronic constipation with impaired rectal sensation due to stool retention **(1 point)**
Identify any further actions that need completed at this visit. Perform a rectal exam to check for current fecal impaction and pain. Notify provider if there is impaction and suggest an abdominal xray. Review patient's medication list to identify any opioids that may contribute to the constipation. Assess patient's mobility and daily fluid intake. **(2 points)**
The long term-recommendations for this patient are … Start a bowl routine protocol if patient is impacted like daily Miralax. Have a hydration goal of 1.5-2 L of water daily unless it is contraindicated by patient's health history like renal failure or heart failure. Encourage daily activity to stimulate gut motility Recommend provider to place an order for urogynocologist for pelvic floor training **(2 points)**
Rationale for your actions: Fecal incontinence is a common sign of chronic constipation. Abd xray is an evidenced based support for confirming fecal impaction. Miralax is recommended due to it's ability to prevent re impaction Pelvic floor strengthing supports continence recovery. **(2 points)**

/7 points

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.

Suspected Problem:
Stress urinary incontinence and or mixed incontinence
(1 point)

Identify components of your focused assessment and include any diagnostic tests.
Assess when this started and what activity she’s doing when it happens.
Assess the amount of urine she leaks with each episode and if it requires her to use pads.
Assess the time of day she usually has this issue.
Assess if she’s had any pelvic surgeries and what type.
Assess her birthing history did she have vaginal births or c sections or both.
Assess her medical history and her medication. Does she have diabetes
Consider a referral to the urogynocologist.
Ask provider to Check UA to see if she has a urinary tract infection.

(2 points)

Describe your treatment plan.
Referral to the urogynocologist.
Suggest to not drink caffeine, sodas, and alcohol
If she is obese, refer to weight management.
Advised to void every 2-3 hours

(2 points)

Rationale:
Caffeine, sodas and alcohol are irritants acting as a diuretic which increases urine production
Urogynocologist specialize in all different types of pelvic floor disorders and can treat far beyond what a woc nurse can implement.
Weight management is important because when you have increased abdominal fat it can increase pressure on the bladder and the pelvic floor muscles which can increase leakage
Asking the provider to order a urinalysis is important because untreated UTI can cause incontinence

(2 points)

/7 points

Scenario 3

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.

Suspected Problem:

Urge incontinence due to limited mobility
(1 point)

Describe your recommendations and include any consults needed.
Place a bedside commode and place a urinal in reach
Check patient every 2 hours to see if he needs assistance to go to the bathroom.
Activate motion sensors
Recommend PT and OT

(2 points)

Rationale:
Functional incontinence occurs when the patient is physically unable to reach the toilet despite normal bladder function. His recent knee replacement and nighttime mobility difficulty place him at high risk.
Providing accessible toileting options, such as a bedside commode or urinal, reduces the time and distance needed to void, directly preventing accidents and reducing fall risk.
Timed voiding and pre-bedtime voiding decrease bladder volume overnight, reducing urgency episodes.
PT and OT are essential because improving mobility, balance, and environmental safety directly reduces both incontinence episodes and fall probability.

(2 points)

/5 points

Scenario 4

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.

Suspected Problem:
Overactive bladder and urge urinary incontinence
(1 point)

Identify further components of your focused assessment and include any diagnostic tests.
Review pateint's medication to see if she takes any diuretics.
Note that smoking is a bladder stimulant.
Assess if she has had any vaginal deliveries

(2 points)

Describe your treatment plan.
Obtain a urinalysis to see if she might have a urinary tract infection
Get a post void residual using a bladder scanner.

Recommend a referral to a urogynocologist. Teach patient the potential side effects of caffeine, alcohol, and smoking and the benefits when you don't take them **(2 points)**
Rationale: A urinalysis, bladder diary, pelvic exam, and PVR are standard WOCN/AUA components of evaluation. Caffeine, alcohol, and nicotine directly stimulate detrusor overactivity, worsening urgency and frequency. Reducing these irritants significantly improves symptoms. Bladder retraining is the gold standard for first-line OAB treatment, helping recalibrate bladder signaling pathways and lengthen voiding intervals. **(2 points)**

/7 points

Scenario 5

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 anxious and 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.

Suspected Problem:
Leakage due to an obstruction or leakage due to inappropriate air in the balloon and/or patient at risk for MASD
(1 point)

Identify components of your focused assessment and include any diagnostic tests.
Evaluate catheter stabilization, securement device, tension, and position.
Assess whether catheter is actually draining (kink, dependent loops, bag position, sediment).
Inspect urinary meatus for trauma, swelling, or balloon displacement.
Assess for bladder fullness by bladder palpation or bladder scan to rule out retention/obstruction.
Confirm catheter size, type, and balloon volume.
Evaluate perineal skin, perirectal skin, and inner thighs for early MASD.
Assess stool consistency and frequency; determine if diarrhea is new or chronic
Review recent vitals, hydration status, and presence of delirium triggers.
Evaluate mental status changes and agitation (pulling at catheter often signals discomfort or obstruction).
Bladder scan (PVR) — identify retention or obstruction.
Urinalysis with culture — rule out CAUTI given change in LOC.

(2 points)

Describe your recommendations and any necessary products.
Remove and replace the indwelling urinary catheter using sterile technique
- Rationale: leakage and patient pulling suggest misplacement or obstruction.

Use appropriate catheter size (usually 14–16 Fr; avoid upsizing to stop leakage).
Use securement device (StatLock or catheter stabilization device) to prevent traction.
Ensure closed drainage system, no dependent loops, and bag below bladder level.
Remove soiled brief and cleanse skin with pH-balanced no-rinse cleanser.
Apply moisture barrier ointment (zinc oxide or dimethicone) to protect against MASD.
If liquid stool is ongoing and skin risk is high, consider a fecal management system (e.g., Flexi-Seal) *if clinically appropriate and no contraindications*.
Implement q2h incontinence checks and repositioning.

(2 points)

Rationale:

Leakage around a catheter is not normal and often indicates obstruction, balloon misplacement, sediment, or bladder spasms. The safest intervention is catheter removal and replacement, not upsizing.

The patient is pulling at the catheter, which strongly suggests discomfort caused by traction or incorrect balloon position in the urethra—this is a medical urgency, as traction can cause urethral trauma.

The combination of delirium + catheter + stool-soaked brief places the patient at very high risk for CAUTI, sepsis, and MASD; immediate correction is required.

Bladder scan and urinalysis are essential to rule out retention or CAUTI, both common causes of sudden LOC changes in older adults.

Proper securement of the catheter prevents further traction injury and repeated displacement.

Management of liquid stool and moisture prevents MASD, reduces infection risk, and protects fragile elderly skin.

A fecal management system is appropriate when stool is liquid and frequent, reducing moisture exposure and preventing contamination of the catheter area.

(2 points)

/7 points

Scenario 6

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.
My focus is explaining how the Gellhorn will provide support the prolapse, by reducing pressure/bulge and can improve bladder emptying. I would recommend routine follow up visits to have the Gellhorn removed, cleaned, and put back to help prevent odor and discharge. I would discuss signs of vaginal irritation and recommend patient avoid heavy lifting and straining and constipation.

(2 points)

Describe your treatment plan.
f/u in 1-2 weeks to assess for comfort, position and tissue health, then every 2-3 months.
Recommend referral to behavior health for anxiety.
Explain each step when placing the Gellhorn

(2 points)

Rationale:
Pessary is a firt line, evidenced based non surgical management option for pelvic organ prolapse.
Gellhorn offers firm support for more advanced prolapse.
Regular f/u is necessary because the Gellhorn is not easily removed.
Managing anxiety via behavior health increases adherence

(2 points)

/6 points

Scenario 7

Mr. J. 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. visits the urologist for a 2 month follow-up for removal of his indwelling catheter and a voiding trial. The PVR is 425ml, and the urologist orders clean intermittent catheterization (CIC) rather than indwelling catheter use.

State the goal of CIC:
The goal is to completely empty the bladder to prevent urinary retention, reduce the risk of infection, and maintain continence.

(1 point)

Mr. J will need to learn CIC. Detail your education plan.

Discuss that CIC is recommended because Mr. J's post-void residual (PVR) of 425 mL indicates incomplete emptying.

Reinforce that intermittent emptying reduces risks associated with chronic retention, including UTIs, bladder overdistention, and upper urinary tract damage.

Emphasize advantages over an indwelling catheter: fewer infections, improved comfort, better independence, and reduced urethral trauma.

Review catheter types (straight vs. coude tip), lubrication (water-soluble), and storage of supplies.

Instruct on hand hygiene, clean technique, privacy, and positioning (standing, sitting on toilet, or semi-reclined).

Provide visual teaching (model or diagram) followed by demonstration.

Review steps:

1. Wash hands.
2. Cleanse meatal area with soap and water or wipes.
3. Lubricate catheter.
4. Insert catheter at the correct angle (slightly upward and toward the umbilicus; coude tip pointed upward if used).
5. Allow urine to drain fully.
6. Slowly withdraw catheter once flow stops.
7. Dispose of catheter or clean per manufacturer's instructions (if reusable).

Educate about the usual schedule (e.g., every 4–6 hours) or as prescribed by the urologist.

Discuss adequate hydration and monitoring urine output and color.

Teach symptoms requiring medical attention: fever, chills, worsening flank pain, inability to pass catheter, hematuria, foul urine odor, urethral bleeding, or reduced output.

Reinforce importance of reporting any catheterization difficulties, especially with a prostate obstruction history.

Provide return demonstration to verify competence.

Use a step-by-step written guide.

(3 points)

Identify at least two complications that can occur with CIC.

Urinary tract infection (UTI) due to incomplete emptying, contamination during insertion, or infrequent catheterization.
Urethral trauma or bleeding, especially in males with BPH or urethral narrowing

(2 points)

/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 the issue and clearly write it identify why change is needed. The goal should be measurable and timed. Compile evidenced based literature to support intervention. Identify what contributed to the problem. Determine how you will measure the outcome of the intervention. Determine how data will be collected and assess effectiveness of the intervention. Communicate the outcome with the organization

(2 points)

Describe how <u>you</u> would design a CAUTI QI project. (Make sure to include problem identification and evaluative measures)
To reduce CAUTI rates by 25% in 6 months by implementing a catheter necessity checklist, daily removal prompts, and a standardized catheter care bundle."
.Intervention Plan (Based on Evidence-Based Bundles)
Interventions may include:

- Implementing a nurse-driven Foley removal protocol.
- Standardized catheter insertion checklist to ensure aseptic technique.
- Daily catheter necessity rounds ("Is the Foley still needed?").
- Ensuring proper securement devices, unobstructed drainage, closed system integrity.
- Instituting a CAUTI prevention champion on each unit.
- Education: annual competencies and just-in-time training for staff.

Evaluative Measures
Outcome Measures:

- CAUTI rate per 1,000 catheter days.
- Device utilization ratio.

Process Measures:

- Compliance with insertion checklist.
- Daily documentation of catheter necessity.
- % of catheters removed within 24 hours of meeting stop criteria.

Balancing Measures:

- Rates of urinary retention following Foley removal.
- Patient or staff satisfaction with new workflows.

Data Collection & Analysis

- Track monthly CAUTI rates, catheter days, and compliance audits.
- Compare data to baseline and benchmark against national standards (NHSN).
- Adjust interventions based on findings using the PDSA cycle.

(3 points)

Discuss the dissemination of information regarding the project results.

Share results with nursing leadership, infection prevention, QI committees, and unit-based councils.
Provide unit-level dashboards highlighting trends and successes.
Post monthly CAUTI data on unit boards.
Provide real-time feedback to bedside staff regarding compliance with bundles.
Include outcomes in quarterly quality reports and annual nursing evaluations.
Present at interdisciplinary rounds and staff meetings.
Submit findings to hospital-wide clinical practice councils.
Share at professional conferences or quality forums if appropriate.

(2 points)

/7 points

References: 3 points

Alqarni, M. S. (2021). Catheter-associated urinary tract infection (CAUTI) in ICU patients. *Middle East Journal of Nursing, 15*(1), xx–xx.

Anthony, B. F., Davies, J., Pisavadia, K., Roberts, S., Spencer, L. H., Gillen, E., Hounsome, J., Noyes, J., Hughes, D., Fitzsimmons, D., Tudor Edwards, R., Edwards, A., Cooper, A., & Lewis, R. (2024). The clinical and cost-effectiveness of interventions for preventing continence issues resulting from birth trauma: A rapid review. *medRxiv.* https://doi.org/10.1101/2024.09.09.24313310

Baker, S., Shiner, D., Stupak, J., Cohen, V., & Stoner, A. (2022). Reduction of catheter-associated urinary tract infections: A multidisciplinary approach to driving change. *Critical Care Nursing Quarterly, 45*(4), 290–299. https://doi.org/10.1097/CNQ.0000000000000429

Budib Lourenço, D., Octaviano Duarte-Santos, H., Dib Partezani, A., Borborema Teles, S., Bianco, B., Seabra Rios, L. A., Caserta Lemos, G., & Carneiro, A. (2023). *Urodynamic profile of voiding in patients with pelvic organ prolapse after surgery: A systematic review with meta-analysis.*

Colón-Emeric, C. S., McDermott, C. L., Lee, D. S., et al. (2024). Risk assessment and prevention of falls in older community-dwelling adults: A review. *JAMA*, *331*(16), 1397–1406. https://doi.org/10.1001/jama.2024.1416

Dwyer, L., & Kearney, R. (2020). Conservative management of pelvic organ prolapse. *Obstetrics, Gynaecology & Reproductive Medicine.* https://doi.org/10.1016/j.ogrm.2020.12.003

Ermer-Seltun, J. A., & Engberg, S. (2021). *Wound, Ostomy and Continence Nurses Society core curriculum: Continence management.* Wound, Ostomy and Continence Nurses Society.

Espiño-Albela, A., Castaño-García, C., Díaz-Mohedo, E., & Ibáñez-Vera, A. J. (2022). Effects of pelvic-floor muscle training in patients with pelvic organ prolapse approached with surgery vs. conservative treatment: A systematic review. *Journal of Personalized Medicine, 12*(5), 806. https://doi.org/10.3390/jpm12050806

Kobashi, K. C., Vasavada, S., Bloschichak, A., Hermanson, L., Kaczmarek, J., Kim, S. K., Kirkby, E., & Malik, R. (2023). Updates to surgical treatment of female stress urinary incontinence (SUI): AUA/SUFU guideline (2023). *Journal of Urology.*

Lightner, D. J., Gomelsky, A., Souter, L., & Vasavada, S. P. (2019). Diagnosis and treatment of overactive bladder (non-neurogenic) in adults: AUA/SUFU guideline amendment 2019. *Journal of Urology, 202*, 558–563. https://doi.org/10.1097/JU.0000000000000309

Mari, A., Mahamid, M., Amara, H., Abu Baker, F., & Yaccob, A. (2020). Chronic constipation in the elderly patient: Updates in evaluation and management. *Korean Journal of Family Medicine, 41*(3), 139–145. https://doi.org/10.4082/kjfm.18.0182

Neurogenic bladder – concepts and treatment recommendations. (2022). *International Brazilian Journal of Urology, 48*(2), 1–12. https://doi.org/10.1590/S1677-5538.IBJU.2021.0098

Quallich, S., Lajiness, M., Engberg, S., & Gray, M. (2023). Patient education in intermittent catheterization: A consensus conference. *Journal of Wound, Ostomy and Continence Nursing, 50*(5), 393–399. https://doi.org/10.1097/WON.0000000000001013

Riley, M. M.-S., Tung, W.-C., & Tofanelli, C. (2025). Nurse-led implementation of evidence-based bundles to reduce CAUTIs in an academic acute care hospital: A four-year longitudinal quasi-experimental study. *Applied Nursing Research, 85*, 152004.

Storme, O., Tirán Saucedo, J., & Naber, K. G. (2019). Risk factors and predisposing conditions for urinary tract infection. *Therapeutic Advances in Urology, 11*, 1–28. https://doi.org/10.1177/1756287218814382

Todhunter-Brown, A., Hazelton, C., Campbell, P., Elders, A., Hagen, S., & McClurg, D. (2022). Conservative interventions for treating urinary incontinence in women: An overview of Cochrane systematic reviews. *Cochrane Database of Systematic Reviews.* https://doi.org/10.1002/14651858.CD012337.pub2

Włodarczyk, J., Waśniewska, A., Fichna, J., Dziki, A., Dziki, Ł., & Włodarczyk, M. (2021). Current overview on clinical management of chronic constipation. *Journal of Clinical Medicine, 10*(8), Article 1738. https://doi.org/10.3390/jcm10081738

Wound, Ostomy and Continence Nurses Society. (2021). *Clinical practice guideline for the management of urinary incontinence.* WOCN Society.