R. B. Turnbull Jr. MD WOC Nursing Education Program
Continence Care Mini Case Studies

Cleveland Clinic

Student Name & Date: Alice Pownall-Gray 10 /27/2025
Reviewed by: _____
Score: **39.9** /55
Score 2: X minus 1 resubmission = Y/55

Alice, you did not achieve the required 80%. Please look over each question that does not have the max points and add information to the selected areas.

Please write the new answers in another color font on this paper & submit via Dropbox.

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:
(1 point) 1Functional constipation with fecal impaction

Identify any further actions that need completed at this visit.
Would recommend:

1. **Full Assessment (auscultation and palpation of abdomen) and medical history, including sexual history, obstetric history, asking about her bowel habits including frequency, and consistency of stool. Meals per day frequency. ETOH use and caffeine intake daily.** sounds as if this was done BUT asking more about bowel habits, diet, etc. would be good
2. **An enema to help her have a bowel movement but if unsuccessful, digital stool removal for impaction.** might work but may need to do digital
3. **Ask patient about her nutrition, refer to a nutritionist for consult for incorporating fiber foods that patient can tolerate ok**
4. **Functional assessment ok**
   Review of current Medications ok
5. **Referral for anorectal manometry. Referral to gastroenterologist.** not yet

(2 points) 1.5

The long term-recommendations for this patient are …

1. Increased Fiber, use of daily psyllium fiber such as Metamucil, take 1 packet or 1 tablespoon mixed with 8 oz of cool liquid daily by mouth. how much
2. Increased fluid intake, drink 7-13 cups or 2 liters of fluid daily. how much
3. Regular exercise, such as brisk walking, or swimming for 30 minutes at least 5 days per week. such as, how often, etc. Alice you are giving patients instructions & these are way too vague
4. PRN use of laxatives auch as? When? + do you really want to do this now? Introduction of a bowel regimen to include ...If no stool for 24 hours, begin taking MiraLAX 1 packet of powder,(17 grams) in any 4 to 8 ounces of fluid, daily for up to 7 days.

5. **Protective under garments, and prn skin barrier ointment to protect skin from stool leakage when needed.** may help at moment
6. **Pelvic floor exercises, due to chronic constipation if she has been straining to help keep her pelvic floor strong.** perhaps not yet

A little more here—above you jumped to the sophisticated testing but there are things such as these to be done first

(2 points) 1

Rationale for your actions:

Full assessment and medical history to give an overall baseline as to if the patient has any immediate health issues such as abdominal blockage.

The enema would be used to help removes any impacted stool that is causing leakage around the impacted stool.

Because she has chronic constipation, a functional assessment could provide valuable information on the type and degree of malfunction. This may determine what type of bowel regimen she ultimately be prescribed.

With increased fiber through daily psyllium product, increased fluid intake and exercise, the patient should have better stool motility through bowels.

I would recommend due to the chronic constipation that the patient has therapy for pelvic floor strengthening (if she has been straining and due to her age, keeping her pelvic floor strong can be proactive). but she did have normal response & sphincter strength**, and if her manometry to check the pelvic strength shows weakness/or disfunction. Pelvic floor muscle exercises may be beneficial for stool leakage. (Callan & Francis 2022)** some of these are not incorrect answers BUT you need to do the other things first & give her a chance to change her patterns, diet, fluid intake, & exercise. Perhaps these other tests will not be necessary…

(2 points) 1.5

5**/7 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.

Suspected Problem:
(1 point) 1 Stress Incontinence

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

1. **Full Assessment (Pelvic exam) and medical history including social and nutritional consult**, sexual history, menopause status, obstetric history, **bowel habits including frequency, and consistency of stool.**
2. **Use of “OLDCART” Systemic Interview**
3. **Review of Current Medications**
4. **Post void residual volume assessment**
5. **Urodynamic testing** if indicated after PVR results not yet – get results from PVR first and your other treatments

(2 points) 1.8

Describe your treatment plan.

1. **If pt is overweight would recommend weight loss**, limit caffeine intake and ETOH use, regular exercise of 30 minutes daily think bigger about lifestyle changes – what else can you suggest?
2. **Regular exercise and pelvic floor muscle exercises** ok
3. **Teach the “Knack” stress maneuver** ok
4. ~~**Toileting habits**, pt may need to urinate on a regular schedule~~ what does this mean?
5. Wear incontinence panty liner.

(2 points) 1.7

Rationale: Losing weight if a patient is overweight t can decrease pressure on bladder. Teaching the patient pelvic floor muscle exercises can help the muscles prevent leakage. The “Knack” stress maneuver also helps prevent leaks by having the patient squeeze the pelvic muscles prior to cough or squeeze (Thompson 2022).

(2 points) 2

6.5/7 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:
(1 point) 1 urge w Functional component Urinary Incontinence

Describe your recommendations and include any consults needed.
Toileting schedule yes
Use of Commode
Occupational therapy and physical therapy or maybe PT
Use of ~~absorbative undergarment~~, commode,bed pads, use of a urinal, or option of using a temporary Texas catheter. ok What else could you do beside a brief?
Supervision ? Having a caregiver to supervise ambulation to prevent falls and assist with toileting hygiene.
Night lights yes

(2 points) 1.5

Rationale: Gate disturbances and weakness can be put a patient at risk for functional urinary incontinence (Palmer, 2022). This patient had a recent knee surgery and a fall. The patient may have been trying to get to the toilet~~te~~ quickly and lost balance. Having a commode near his bed would eliminate the distance to the bathroom and provide physical support. Also wearing undergarments and padding his bed, just in case would reduce anxiety over rushing to bathroom as it would help prevent leaks. Having a home care agency perform an OT evaluation and perform a safety evaluation to make a safe transfer plan and home DME equipment will be very helpful. Supervision with a caregiver during transfers to toilette and assist with hygiene temporarily,

(2 points)2

4.5/5 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:
(1 point)0Urinary tract infection not my first thought (Overactive bladder)

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

1. Full medical assessment and history, including sexual history, menopause status, obstetric history, we are looking for specifics here as we could do this for any person we see
2. Medication review yes
3. Diagnostic Blood labs including glucose ok
4. UA/Culture ok
5. Labs to test menopause status

(2 points) .8

Describe your treatment plan.

1. Antibiotics (remove this as primary suspicion has changed to overactive bladder)
2. **Phenazopyridine** (remove this if overactive bladder is now primary suspicion)
3. **Increase fluids** ok
4. **Hygiene education, wipe from front to back**-good for everyone to know

You are missing obvious things here to discuss w pt.

5. Reduce caffeine intake
6. Reduce ETOH intake, refer to therapy for ETOH reduction as well as smoking cessation education and support.
7. If pt is postmenopausal, use of topical vaginal estrogen may be used to help with any vaginal atrophy which can help reduce symptoms of overactive bladder
8. Start oral medication for overactive bladder with lower side effects Myrbetriq 25 mg daily po.
9. Pelvic exercises as prophylactic
10. Toileting schedule every 2-4 hours, gradually extending the time by 10-15 min.
11. Wear absorbent UI pad if needed.

(2 points) .2

Rationale:
If the U/A and culture are positive, then continue with antibiotics and phenazopyridine. Increasing fluids will help hydrate and flush out the bladder and education on wiping from front to back may help prevent future uti.

If this patient has overactive bladder, caffeine, EtOH and smoking can irritate bladder lining. Reducing these triggers may help reduce the symptoms.

(2 points) .2

1.2/7 points you do not have the correct suspected problem so your plans is off

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:
(1 point) 1 Urinary tract infection maybe with clogged foley catheter yes

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

1. Medical history and noting from caregivers his normal mentation
2. Remove foley replace and obtain sterile urine specimen
3. Assess UA/Culture ok
4. Assess stool for C-diff, also check if he may be stool impacted which may cause the stooling and this can also cause the catheter to leak.
5. Checking for sediment and dislodged catheter or if it fits properly as well. ok & check for what else that can cause Foley obstruction?
6. Asses perineal skin for breakdown ok

(2 points) 1.8

Describe your recommendations and any necessary products.

1. Antibiotics perhaps
2. Use a **Texas catheter** or male external catheter such as a Purewick for male) YES forget the indwelling cath if he continues to pull foley
3. Skin barrier ointment YES!
4. Absorbative undergarments not my first choice the condom cath is better or one of the newer male external caths

As the WOC nurse for patients like this, think about their big picture

6. Keep log of pt BM, institute a bowel regimen if he is constipated or hx of impaction. This may include increased fiber and laxatives.
7. Log I&O, keep pt hydrated

(2 points)1,8

Rationale:

The rationale for this was that the patient has stool leakage, and this may be a factor in him having a UTI especially if it was getting onto the catheter and contaminating the foley. yes true, but why switch to an external cath? He may be constipated or have an impaction which may cause the stooling, and this can also cause the catheter to leak. Switching to an external male catheter or Texas catheter can lower his risk of catheter associated UTI. Making sure the patient has adequate hydration is important to help keep catheter patent and flowing flushing out debris, as well as alleviate constipation or impaction issues. Long term care staff may keep a log of his I &O, this may be very helpful to manage this since he has memory loss.

(2 points) 1.8 what about fluids?

6.4/7 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.

1. **Regular exercise and pelvic floor muscle exercises**

Use of Gellhorn Pessary. **The patient would be taught to wash her hands then grasp the rim of the pessary just under the pubic bone at the front of your vagina. Locate the notch or opening and hook your finger under or over the rim. Next the patient would tilt the pessary, to about a 30-degree angle, and gently pull down and out of the vagina. Folding the pessary somewhat, it will ease the removal. To insert the pessary the patient should wash her hands then grasp the pessary midway between the ring and the ring with the peg and fold the pessary in half. The curved part should be facing the ceiling, like a taco. Put a small amount of water-soluble lubricant, such as KY Jelly, on the insertion edge. Next, she should the fold the pessary in one hand and spread the lips of your vagina with the other hand. Gently push the pessary as far back into the vagina as it will go. You can do this squatting, standing with one foot propped on the tub or toilet, or sitting with your feet propped up.** Instruct patient to report any fouls smells, discharge, pain, bleeding, bowel changes such as constipation, ulceration, also signs or symptoms of allergies or swelling in the vaginal area.-

Adverse effects; When to call the MD? + she may very well not insert it as this can be tricky so may need to have it done on a time schedule.

1. **B/P control including medications and diet**
2. **Management of pelvic prolapse**

(2 points) 1.5 see below for additional items to discuss

Describe your treatment plan.

Gellhorn Pessary use and education on insertion and removal, trouble shooting, things to report to provider.
Pelvic floor therapy
Reassess B/P
Re-refer to surgeon after B/P controlled

(2 points)1.7 After the pessary is inserted there are a few things to check out w positioning

Rationale:

Due to blood pressure issue, patient will need to have control over this before she can be ~~re~~referred back to surgeon. The patient will need educated regarding pessary use. This would include removal and insertion. **Educating the patient about the benefits of a pessary are beneficial. Pessaries are minimally invasive and can provide very quick relief of symptoms, low risk and financially affordable. They can be a good choice for women who choose a nonsurgical** intervention (Al-Shaikh et al 2018). This is the education plan

(2 points) 1.8

5/6 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 of CIC is to completely empty the bladder and prevent damage to bladder and kidneys as well a prevention of UTI.

(1 point) 1

Mr. J will need to learn CIC. Detail your education plan.
Gather his Supplies: Sterile catheters, antiseptic solution, gloves, disposable towels, a container for urine
Wash his hands thoroughly: Use soap and water for at least 20 seconds.
Prepare a comfortable area: Educate the patient to lie down comfortably or sit on the toilet.
Insert the catheter: Show the patient how to gently insert the catheter into the urethra, following the natural curve of the penis.
Drain the urine: Allow the urine to flow into the container.
Remove the catheter: Gently withdraw the catheter and discard it if it is disposable.
Clean up: Wipe the area with antiseptic solution, dispose of used supplies, and wash hands again.
Report any pain or signs symptoms of infection to provider.
Discuss where to order his supplies for self-catheterization.
Create a self-catheterization schedule with patient, discuss need to catheterize every 4-6 hours upon waking and before bed. Keep log of outputs and bring to follow up appointments.
Good cath plan but what other items do you need to discuss w this patient who is doing ISC?

(3 points) 2

Identify at least two complications that can occur with CIC. Complications that can occur include infection and urethral trauma. Handwashing as well as gentle maneuvers that that encourage complete evacuation of the urine from the bladder. The most frequent complication is UTI. The reason for this is when urethral damage occurs, the mucosal barrier to infection is compromised as bladder wall is compromised, also stretched from retained urine, the capillaries can become occluded, making the bladder more vulnerable to infection (Kennelly et al 2022).
2

5/6 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.

1. Establish goals
2. Collaborate with interdisciplinary team
3. Identify the problem
4. Identify measures
5. Collect data
6. Evaluate processes and root causes
7. Develop solution and test the changes

(2 points) 2

Describe how <u>you</u> would design a CAUTI QI project. (Make sure to include problem identification and evaluative measures)

I would design my CAUTI to reduce home care CAUTI rates and the evaluative measures would include outcome measure that indicates how the system is working. The goal of the outcome measure was to decrease rates of CAUTI in the homecare setting.

The project would go through an approval process.

Patients identified with catheters would be tracked for a period of time, and data collected using a qualitative method. Collecting rates of urinary tract infections over a 6-month period. From this data changes in several areas to prevent UTI could be instituted including staff education, patient and caregiver education, and types of catheters being used.

After the education was in place and or change in types of catheters used(if determined a change was needed), another set of data would be collected to see if the rates of UTI decreased.

Alice, this section is looking for the implementation of the steps above-how you would do that

(3 points) .5

Discuss the dissemination of information regarding the project results. I would approach my home care agency and discuss this information through huddles, memos, education of staff, update policies and possibly present this information in a WOC conference. Using collective efforts of the interdisciplinary team responsible for providing patient care, along with the improved implementation of reliable CAUTI prevention strategies and the education and buy in of staff, patients, and families, can impact positive clinical outcomes and reduce the risk of urinary tract infection (Plando et al 2024).

(2 points) 2

4.5/7 points

***Reference**s: 3 points* References pertinent but not formatted **1.8**

Callan,spaceL. L., Francis,spaceK.(2022). Fecal IIncontinence: Pathology, AAssessment, and MManagement. In J. Carmel, J. Colwell, & M. T. Goldberg (Eds.), *Wound, Ostomy, and Continence Nurses Society core curriculum: Ostomy management* (2nd ed., pp. 489pages of the chapter belong here). Wolters Kluwer.

Palmer, M.(2022). UI and Lower Urinary Tract Symptoms in the Older Adult. In J. Carmel, J. Colwell, & M. T. Goldberg (Eds.), *Wound, Ostomy, and Continence Nurses Society core curriculum: Ostomy management* (2nd ed., pp. 489). Wolters Kluwer.

Thompson, D. (2022)Management Fundamentals For Incontinence. In J. Carmel, J. Colwell, & M. T. Goldberg (Eds.), *Wound, Ostomy, and Continence Nurses Society core curriculum: Ostomy management* (2nd ed., pp. 489). Wolters Kluwer.

Kennelly, M., Thiruchelvam, N., Averbeck, M., Konstatinidis, C., Chartier-Kastler, E., & Trøjgaard, P. et al. (2019). Adult Neurogenic Lower Urinary Tract Dysfunction and Intermittent Catheterisation in a Community Setting: Risk Factors Model for Urinary Tract Infections. *Advances In Urology*, 2019 (2757862), pp 1-13. DOI: 10.1155/2019/2757862

Al-Shaikh,G., Syed,S., Osman,S., Bogis,A.,Al-Badr, A.(2018).Pessary use in Stress Urinary Incontinence: A Review of Advantages, Complications, Patient Satisfaction, and Quality of Life. International Journal of Women's Health. 17(4) pp. 195-201. DOI 10.2147/IJWH.S152616

Plando,R., Obaid, L., Baker,A., Khan,O.,Solatorio, M., DeLeon, B., Tabasin,V.,Obsioma. (2024).Prevention and Control of Catheter-Associated Urinary Tract Infection. (CAUTI): A Patient Safety and Quality Improvement Project. Cureus 16(10): e72105. DOI 107759/

1. Caps & spacing between initials is an issue throughout. 2.
2. I have no idea why this is pink highlighted.
3. DOI is not a URL
4. Word docs actually have double spaced, hanging indent list.—see example below If you highlight the references below & go to the Home tab & select the arrow in lower right hand corner of paragraph the settings used for the below info will be visible.

Bryant, R. A., & Nix, D. P. (2024). Principles of wound healing and topical management. In R. A. Bryant & D. P. Nix (Eds.), *Acute & chronic wounds: Intra-professionals from novice to expert* (6th ed., pp. 441-457). Elsevier.

Emmons, K. R., & Dale, B. A. (2022). Palliative wound care. In L. L. McNichol, C. R. Ratliff, & S. S. Yates (Eds.), *Wound, Ostomy, and Continence Nurses Society core curriculum: Wound management* (2nd ed., pp.776-792). Wolters Kluwer.

References

Al-Shaikh, G., Syed, S., Osman, S., Bogis, A., & Al-Badr, A. (2018). Pessary use in stress urinary incontinence: a review of advantages, complications, patient satisfaction, and quality of life. *International Journal of Women's Health*, *Volume 10*(17(4)), 195–201. https://doi.org/10.2147/ijwh.s152616

Callan, L. L. (2022). Fecal Incontinence: Pathology, Assessment, and Management. In J. Carmel, J. Colwell, & M. T. Goldberg (Eds.), *Wound, Ostomy, and Continence Nurses Society core curriculum: Ostomy management, 2nd edition* (p. 506). Wolters Kluwer.

Kennelly, M., Thiruchelvam, N., Averbeck, M., Konstatinidis, C., Chartier-Kastler, E., & Trojgaard et al, P. (2019). Adult Neurogenic Lower Urinary Tract Dysfunction and Intermittent Catheterization in a Community Setting: Risk Factors Model for Urinary Tract Infections. *Advances in Urology*, *2757862*, 1–13. https://doi.org/10.1155/2019/2757862

Palmer, M. (2022). UI and Lower Urinary Tract Symptoms in the Older Adult. In J. Carmel, J. Colwell, & M. T. Goldberg (Eds.), *Wound, Ostomy, and Continence Nurses Society core curriculum: Ostomy management, 2nd edition* (p. 489). Wolters Kluwer.

Plando, R., Obaid, L., Baker, A., Khan, O., Solatorio, M., DeLeon, B., & Tabasin, V. (2024). Prevention and Control of Catheter-Associated Urinary Tract Infection

(CAUTI): A Patient Safety and Quality Improvement Project. *Cureus*, *16(10):e72105*. https://doi.org/107759/

Thompson, D. (2022). Management Fundamentals For Incontinence. In J. Carmel, J. Colwell, & M. T. Goldberg (Eds.), *Wound, Ostomy, and Continence Nurses Society core curriculum: Ostomy management, 2nd edition* (p. 489). Wolters Kluwer.