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

Continence Care Mini Case Studies

Cleveland Clinic

Student Name & Date: Amanda Peters, RN February 4, 2026

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: Impaction with stool leakage around the impaction/constipation (1 point)
Identify any further actions that need completed at this visit. **-A digital examination should be done for an attempt of digital breakup if rectal stool mass is felt (Callan & Francis, 2022)** **-If digital breakup of impaction cannot be done, then an order for milk and molasses enema 1:1 ratio of 60 to 90 ml can be warmed to mix and then cooled to administer rectally adjacent to the fecal mass (Callan & Francis, 2022)** **-After 30 minutes of instillation, another digital breakup of impaction can be attempted and repeated until the mass is broken up or removed (Callan & Francis, 2022)** **-An order for an enema can be obtained to further cleanse the proximal bowel after digital breakup of impaction (Callan & Francis, 2022)** **-If impaction is higher up in colon, the patient can be treated with a tap water enema for the patient to have a bowel movement (Callan & Francis, 2022)** **(2 points)**
The long term-recommendations for this patient are … -Increase fluid intake to 2L a day if no comorbidities inhibit this amount of intake of fluid per day (Callan & Francis, 2022) -The patient primarily eats starches, dairy products, and meats. The patient needs to increase soluble fiber intake to draw water into stool bulk and to have lubrication in the bowel (Callan & Francis, 2022) -Obtain order from physician or refer to GI specialist for further bowel regimen or laxatives, keeping in mind the patient's comorbidities (Callan & Francis, 2022) -Increase mobility as tolerated (Callan & Francis, 2022) -Avoid skipping meals and eat 3 balanced meals a day (Callan & Francis, 2022) -Encourage to try to defecate after eating (Callan & Francis, 2022) **(2 points)**
Rationale for your actions: The patient appears to have an impaction caused by chronic constipation. The stool is beginning to leak around the fecal mass due to an obstructing effect that relaxes the internal sphincter, ultimately allowing the patient to have liquid stool leak around the fecal mass

(Callan & Francis, 2022). The patient may have a further up impaction rather than a rectal impaction, and a differential way to figure out what could be going on would be with a digital examination. Both possible types of impactions have a treatment plan indicated above that could be initially treated in the office. However, the patient should look into long term recommendations for prevention of constipation, such as increasing mobility, increasing soluble fiber (oats, pectin, apples, fruits, psyllium), and increasing fluid intake. The patient's body may need to adjust to the fiber at first, hence why she may be experiencing some GI upset when she is rarely eating fruits and vegetables (Callan & Francis, 2022). **(2 points)**

/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: Pelvic organ prolapse with stress urinary incontinence (1 point)
Identify components of your focused assessment and include any diagnostic tests. -Obtain how much the symptoms bother the patient; patient's weight, medical history, surgical history, obstetric history and types of deliveries, family history, bowel function, how often the patient is experiencing urinary leakage, fluid intake and type, products the patient is using to contain urinary leakage, and amount of urinary leakage when it occurs (Ermer-Seltun & Engberg, 2022). -A pelvic examination will need to be performed (possibly by the LIP) after the patient has emptied her bladder. The patient will need to lay supine with the head of the bed at 45 degrees. Have the patient perform the Valsalva maneuver by bearing down to assess for bulging (Ermer-Seltun & Engberg, 2022). Inspection of the vaginal mucosa should be done to assess for atrophy, that may present with thin, pale, and shiny with decrease of vaginal folds (Engberg, 2022) -A cough stress test can be performed while the patient is lying and standing, and have the patient cough while observing the urethral meatus for involuntary urine loss. If incontinence is observed, the patient has a positive cough stress test (Engberg, 2022). -Perform a neurological examination which includes the following: perineal sensation, anal wink, and anal sphincter tone (Engberg, 2022) -A post void residual can be performed after the patient empties her bladder to assess for urinary retention (Engberg, 2022). -A urinalysis should be performed with the clean catch and dipstick method (Engberg, 2022). **(2 points)**
Describe your treatment plan. -The patient should be educated to perform a 3-day bladder diary with voiding time and volume, episodes of urinary leakage and amount, activities performed when leakage is experienced, presence of urgency, and types of products used for urinary leakage (Engberg, 2022) -The patient can follow up with clinic and bring her BWAP's in a plastic bag from a full 24-hour period. The patient should be educated to also bring 1 unused BWAP to calculate the difference in weight (Engberg, 2022). -Educate patient on weight loss if patient is overweight or obese (Engberg, 2022) -Caffeine reduction education if the patient is drinking high amounts (Engberg, 2022) -Educate the patient to drink 1500ml of fluid a day to prevent dehydration (Engberg, 2022) -Educate the patient on pelvic floor muscle training (Engberg, 2022) -Referral to urogynecologist or continence APRN if prolapse is observed for fitting of pessary and/or use of a vaginal cone, or possibly further advanced therapy if needed (Engberg, 2022) **(2 points)**

Rationale:
Inadequate urethral support from weak pelvic floor muscles and prolapses have been linked to stress urinary incontinence (Engberg, 2022). Pregnancy has been linked to multiple changes that can change the continence support system within the female anatomy, including a descending bladder neck, decreased urethral resistance, and a reduction in pelvic floor contractility (Engberg, 2022). Vaginal deliveries place the patient at a higher risk for stress incontinence symptoms. Other risk factors that could exacerbate SUI symptoms with a possible pelvic organ prolapse include obesity, hysterectomies, high caffeine intake, smoking, and genetics (Engberg, 2022). A bladder diary and pad weight testing will tell the clinician more information on how much urine is lost and activities that are performed when SUI is occurring. High fluid intake over 2L a day, or insufficient fluid intake can also worsen symptoms. Depending on state and WOC nurse guidelines, the patient will need to be referred to a urogynecologist for further investigation of the prolapse, pessary fitting, weighted cone usage to strengthen pelvic floor muscles, and possible medication or surgical evaluation (Engberg, 2022).

(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: functional incontinence (urinary?)
(1 point)

Describe your recommendations and include any consults needed.
-PT/OT consult for recommendations for mobility and assistive devices such as a walker, cane, bed side commode at home, and need for rehabilitation and gait training (Thompson, 2022)
-Provide patient urinal at bedside (Thompson, 2022)
-Place bedside commode next to patient’s bed (Thompson, 2022)
-Nursing care team to offer to take patient to the bathroom every 2 hours during the day, and every 3 hours or with vital signs at night
-Non-slick socks or nonskid shoes when getting out of bed (Thompson, 2022)
-Place bed to where feet are flat on the floor when patient is sitting on the side of the bed (Thompson, 2022)
-Case management consult in case of need for supplies, DME, or rehab facility
-Avoid linen or pillows that may restrict or delay the patient’s ability to get out of bed (Thompson, 2022)
-Clear assess to bathroom with no obstacles with night light in place that visualizes the bathroom (Thompson, 2022)
-Apply protective incontinent under pads on the patient’s bed, assess and change every shift or PRN if soiled
(2 points)

Rationale:
The patient is experiencing functional urinary incontinence due to decreased mobility after a knee replacement surgery. The patient has also had falls since the surgery. The patient should have a physical therapy and occupational therapy consult to assess the need for rehabilitation, mobility, possible assistive devices, and gait drainage (Thompson, 2022). The patient should have access to a urinal at bedside in case the patient is not able to get up in time to reach the bedside commode. The patient should always have assistance when going to the bathroom as he is a fall risk currently. Offering to take the patient to the bathroom every 2 hours during the day and every 3 hours or with vitals at night may alleviate the awakening of an urgent need to void. He needs clear access to the bathroom, with nonskid socks or shoes and a night light in place so the patient is able to see better. Protective under pads on the bed will wick away moisture from the skin if incontinence does occur, and will also protect the bed linens. The patient will need linens and pillows that are not difficult to mauver when the patient is getting out of the bed. The patient’s feet should be flat on the floor when getting out of bed so he is able to get up with stability (Thompson, 2022). The case manager can assist with ordering of potential DME supplies and rehabilitation facilities if needed.

(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: Urinary urgency from high caffeine intake, alcohol, and smoking use **(1 point)**
Identify further components of your focused assessment and include any diagnostic tests. The patient’s general health and medical history should be assessed. A history of how much urine is excreted with each urination should be assessed (Wooldridge, 2022). Frequency is already noted. Stool habits and issues, sexual history, family history, surgical history, obstetric history, and quality of life should be obtained as well (Wooldridge, 2022). Assessment of other symptoms indicating a UTI will warrant a clean catch UA. Urodynamic testing is reserved for complicated cases after conservative management has failed. Coping strategies and other methods they have used to try to alleviate symptoms should be assessed (Wooldridge, 2022). The patient’s weight will need to be determined. **(2 points)**
Describe your treatment plan. **-Refer as needed for treatment of coexisting medical conditions** -Bladder diary for 1 week with foods and drink taken in, number of trips to the bathroom and time with urge or no urge, activities performed at time of urge, and amount of urine excreted (Nelles, 2022) -Weight loss if overweight or obese -Smoking cessation or counseling -Caffeine reduction counseling -Alcohol reduction counseling -Increase fluid intake if no comorbidities not allowing it to 2L a day -Refer for constipation management if the patient is having this symptom -Teaching of urgency suppression to delay voiding by rapid pelvic floor contraction with the onset of urgency, sitting on a hard surface, and using distraction techniques to defer urination -Teach patient to perform 3-5 Kegel exercises for 5-10 seconds at a time, with 5-10 seconds of rest and distract herself when learning urge suppression (Wooldridge, 2022) **(2 points)**
Rationale: The patients story tells us that she has 3-4 possible causes to her urinary urgency, including alcohol, decrease water intake, smoking, and high amounts of caffeine (Wooldridge, 2022). Concentrated urine can be very irritating to the bladder. Caffeine is a stimulant and a diuretic, which can further be concentrating her urine (Wooldridge, 2022). Smoking increases the patient’s risk for bladder cancer (Wooldridge, 2022). Alcohol use can impair the neurological signals that are in charge of bladder function, and also is a diuretic (The Urology Foundation,

2024). The patient will need to be educated to decrease caffeine intake and alcohol intake. She will also need educated on smoking cessation to reduce bladder cancer risk. If the patient is overweight or obese, weight loss reduction will need to be explained to the patient, as weight loss has been shown to help urinary urgency (Wooldridge, 2022). Bladder training requires adherence, however, performing 3-5 Kegel exercises with distraction and relaxation has been shown to decrease urgency (Wooldridge, 2022). Constipation will need to be assessed as well, as straining has been correlated with urologic symptoms (Wooldridge, 2022).
(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: Possible UTI with urinary catheter usage and mispositioning or blockage of the urinary catheter causing leakage from the insertion site **(1 point)**
Identify components of your focused assessment and include any diagnostic tests. The WOC nurse will need to find the history as to why the patient had the catheter and for how long the patient has had the catheter. If possible, the last catheter exchange should be noted if it is applicable. The WOC nurse should also see if the patient has had a previous UTI with the catheter. The patient’s vital signs should be noted to determine if patient has more extensive signs of a UTI with pyelonephritis such as tachycardia, fever, of flank pain (Nelles & Ermer-Seltun, 2022). The patient can be tested for CVA tenderness. A PVR can be assessed with a bladder scanner to determine if the patient is retaining urine with the catheter in place, which indicates a blockage and could be causing urinary leakage around the catheter (Nelles, 2022). The catheter should be checked for kinks and loops that could be causing an obstruction of the urinary flow through the catheter. Palpation can also be done of the lower abdomen to see if the bladder is palpable, indicating urinary retention from a blocked catheter (Nelles, 2022). The catheter should be checked to see if it is properly secured as well, as mispositioning may have occurred due to the patient pulling on the catheter. Color, consistency, presence of sediment and odor of the urine should be noted. Either way, if indication of the catheter is needed, then the catheter will need to be replaced, possibly with a smaller catheter if too large of catheter is suspected. The patient could be having bladder spasms from a possible UTI or bladder overactivity which can cause leakage around the catheter (Newman, 2022). The catheter size needs to be inspected as it may be too large and causing leakage around the catheter, which wound indicate a need for a smaller catheter (Newman, 2022). The patient is experiencing symptoms of a UTI with a change in LOC. A urinalysis and urine culture from the specimen catheter port should be obtained from a newly inserted catheter if the catheter has been in place for more than 14 days, as biofilm may already be formed (Newman, 2022). The patient is wearing a brief in bed. This should be promptly removed as it can trap heat and stool/urine against the skin. The patient can have protective under-pads placed underneath him, and if liquid stool continues, cleansing with pH balanced or barrier wipes should be done as needed. A skin protectant such as Cavilon liquid skin protectant and Remedy zinc-oxide paste should be used to protect the skin from external moisture/stool/leaking urine. An external fecal pouch can also be attempted to catch liquid stool. **(2 points)**
Describe your recommendations and any necessary products. -Remove previous catheter

-Insert new catheter with physician order and aseptic technique of smaller size if blockage is suspected and catheter is still indicated (Newman, 2022) -Secure new catheter with securement device -Keep catheter tubing free of kinks and loops (Newman, 2022) -Keep drainage bag below bladder and off of floor (Newman, 2022) -Remove catheter and apply external urinary device if indwelling catheter is no longer indicated -Obtain physician orders for UA/UC after new catheter insertion or with straight intermittent catheterization with sterile technique (Newman, 2022) -Remove brief while patient is in bed -Assess patient's protective under-pads with turning schedule for soiling -Change protective under-pads on patient's bed every 12 hours or more frequently if soiled -Assist patient with incontinence care as needed of stool and urine -Cleanse patient during incontinence care with Sage Essential pH balanced wipes gently and allow to dry -Apply Cavilon liquid skin protectant to skin exposed to incontinence (stool and urine) and allow to dry -Apply Remedy zinc-oxide barrier paste to skin exposed to incontinence to protect the skin from external moisture -If liquid stool continues, consider use of external fecal pouch applied to patient's perianal skin to catch stool -A physician's order for a C-diff PCR or stool culture may be indicated if patient is having copious amounts of liquid stool **(2 points)**
Rationale: Differential for the leaking catheter could be mispositioning from the patient pulling on the catheter, blockage, bladder spasms, or too large of size catheter (Newman, 2022). Each of these will need to be ruled out. The time the patient has had the catheter will need to be investigated along with last catheter exchange. If the catheter is needed, the catheter will need to be removed and a new, possibly smaller if blockage is suspected will need to be reinserted (Newman, 2022). Then, a UA/UC will need to be performed, as a change in LOC may indicate symptomatic UTI symptoms (Newman, 2022). The catheter needs to be properly secured so the catheter does not become malpositioned. The catheter bag should be placed below the bladder and off of the floor to prevent backflow and minimize introduction of bacteria into the drainage bag (Newman, 2022). If the catheter is no longer needed, an external urinary device such as a male Primofit device can be placed to catch urine. The patient's brief needs to be removed because he is currently bed bound, and the skin needs to be protected with a liquid skin protectant and zinc-oxide paste to prevent IAD from urine and liquid stool mixing together. If the patient continues to have liquid stool, it will need to be further investigated, and an external fecal pouch can be applied to the perianal skin to catch the stool. Protective wicking under pads can be placed on the patient's bed and changed as needed for incontinence. Prompt incontinence care will need to be performed to prevent IAD. **(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. -Pessaries are a silicone device that are placed in the vagina to support prolapses of the pelvic organs (Ermer-Seltun & Engberg, 2022). Gellhorn pessaries are a type of pessary for women with stage 3 and stage 4 pelvic organ prolapses that are inserted into the vagina and are space occupying and supportive of the prolapsed structures (Ermer-Seltun & Engberg, 2022). Gellhorn pessaries are first inserted and fitted by an APRN or physician, however, follow ups will need to be performed on a routine basis to determine if the pessary is a good first and close monitoring for s/s of possible complications. Multiple fittings may be required to find the pessary size that works for the patient. The Gellhorn pessary may be difficult to remove, so usually the patient will have to come to the office for removal and cleaning. Recommended follow ups occur first at 2 weeks. If the pessary is a right fit, then subsequent follow ups will occur every 3 months. Not following up is not an option, but a requirement for pessary maintenance. These types of devices need to be removed with sexual intercourse, and other pessary types will need to be considered if the patient cannot be taught how to remove the pessary at home for daily cleansing and removal/reinsertion (Ermer-Seltun & Engberg, 2022). Women with vaginal lesions, vaginal dryness, active pelvic infections, exposed vaginal mesh, allergy to silicone, or nonadherence to follow ups are contraindications to pessary use (Ermer-Seltun & Engberg, 2022). These conditions will be ruled out by the provider prior to pessary insertion. The provider will have you empty your bladder and have you lay down in a Semi-Fowlers position. Then, the provider will perform a pelvic examination to assess for contraindications for use, along with estimating the size of the pessary needed. Then, the pessary will be inserted with water-soluble lubricant. After pessary insertion, the provider will have you sit, stand, squat, and jump in place to see if pessary is a good fit and does not fall out or cause discomfort. The provider will then have you go to the bathroom and simulate urination and defecation with a Valsalva maneuver to see if pessary comes out. If you are wanting to learn how to perform self-care, this will be taught to you, including how to remove, cleanse the pessary daily, and placement of the pessary. A follow up will be scheduled in 2 weeks to reevaluate the pessary, along will assess for any complications with pessary use (Ermer-Seltun & Engberg, 2022). **(2 points)**
Describe your treatment plan. -Provide education as above on pessary use -Assist the APRN or physician during pelvic examination and pessary insertion -Schedule follow up in 2 weeks after pessary has been inserted -Provide verbal and written education on removal, cleansing, and reinsertion of pessary if patient is performing self-care -Provide emotional/psychological support

-Educate patient that follow ups will be every 3-6 months depending on self-care versus physician guided pessary insertion and removal (Ermer-Seltun & Engberg, 2022) -Educate patient to continue to follow up with PCP and surgeon **(2 points)**
Rationale: The type and staging need to be confirmed of the prolapse prior to use of the Gellhorn pessary. The patient is young and may still be sexually active, so other forms of pessaries may need to be considered if this is a concern of the patient if the patient is unable to perform self-care with pessary use. Since the patient is not a surgical candidate at this time, a pessary would be beneficial for the patient for conservative management until surgery can be performed (Ermer-Seltun & Engberg, 2022). A Gellhorn pessary will assist and manage with the symptoms she is having with the pelvic organ prolapse. The patient will need to continue to follow her physician and surgeon instructions of BP management. Emotional and psychological support will be needed for the patient, as she has high anxiety. The patient will need thorough education to follow up regarding pessary use, as not following up is a contraindication of use (Ermer-Seltun & Engberg, 2022). **(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: To allow the bladder to fill and be emptied completely, which acts like a normal bladder (Newman, 2022). It will maintain the patient's renal function by keeping low pressures in the bladder, improves blood flow to the bladder, reduces bladder degeneration, reduces the risk of UTI compared to indwelling catheters, and allows for sexual activity if desired (Newman, 2022). It is a preferred method of emptying the bladder in patients with chronic urinary retention in contrast to an indwelling catheter (Newman, 2022). The patient will need to perform clean intermittent catheterization when his bladder feels full, a strong felt need to void without the ability of doing so, or every 4-6 hours (Newman, 2022). **(1 point)**
Mr. J will need to learn CIC. Detail your education plan. -Educate patient of steps and 1 additional family member or caregiver if possible (Gray, 2022) 1. Perform hand hygiene. 2. Gather all supplies, including 14 Fr or 16 Fr Coude catheter (Gray, 2022), clean soapy wet washcloth, wet clean washcloth with dry side, water soluble lubricant, collection container for urine to drain into, and paper towel 3. Sit on toilet or on the side of the bed for positioning 4. Put a large amount of water-soluble lubricant onto the tip of the catheter about 3 inches long 5. Place draining end of catheter into collection container 6. With nondominant hand, hold penis behind penile head and tilt upward 7. Cleanse the head of the penis with soap and water washcloth, pulling back foreskin if not circumcised to wash 8. Rinse the head of the penis with wet washcloth and pat dry 9. Using dominant hand, obtain lubricated catheter and guide slowly into the urethra while breathing slowly and relaxing as much as possible 10. When urine starts flowing, begin emptying into collection container 11. When urine stops flowing, slowly begin to remove catheter as more urine may come out as the rest of the urethral space is emptied 12. Wipe penis and foreskin with toilet paper or dry washcloth 13. Measure how much urine obtained, and write down along with the time on a documentation sheet (Canadian Urological Association, 2023) **(3 points)**
Identify at least two complications that can occur with CIC. Trauma to the urethra or bleeding may occur in instances where the catheter was forcefully inserted, or the catheter was not lubricated prior to insertion (Gray, 2022). The patient will

need educated on the Coude catheter which can help bypass possible structures while catheterizing, along with demonstration of lubricating a catheter. The patient also needs educated on types of catheters, such as red rubber catheters, relubricated hydrophilic catheters, and clear catheters (Gray, 2022).
A urinary tract infection may occur if UTI prevention steps are not performed. The patient should be educated that Medicare can cover up to 200 single catheters per month, and a new one should be used every catheterization if possible (Gray, 2022). Strict hand hygiene should be performed prior to catheter insertion, along with catharizing in an upright position if possible and slowly removing the catheter to facilitate urinary drainage (Gray, 2022).

(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. The first component of a quality improvement project includes a problem statement with a plan (National Council for Mental Wellbeing, 2025). The problem needs to be identified to formulate why it matters, who is included in the problem, who does the problem affect, and when the problem seems to occur. A goal also needs to be identified. The project should be guided and aimed to fulfill this goal, such as the goal of decreasing catheter-associated urinary tract infections. Measurements need to be defined to determine how data is going to be collected, who is going to collect the data, and what data needs to be collected. There will need to be someone who reviews and evaluates the data and interprets it as well. Next, based on conclusions, changes can be placed into a policy format, and the policy can be introduced to the proper entity with the ability to make policy changes. Outcomes of the project can be used to support a policy change request. Testing out and implementing the changes prior to a full policy change can be trialed. The policy change should be feasible and performable in order to promote compliance to the changes based on the quality improvement project data (National Council for Mental Wellbeing, 2025). **(2 points)**
Describe how <u>you</u> would design a CAUTI QI project. (Make sure to include problem identification and evaluative measures) I would identify the problem such as increased catheter-associated urinary tract infections, (CAUTI), such as on a progressive care unit, during hospital admission stay. Data would have to be collected as how many patients are having catheters inserted, how long catheters are staying in these patients, and how many patients are developing UTI's with catheters within a specific time frame to support a need for change within the policy. Previous policies will also need to be reviewed, such as catheter removal protocols if any, catheter care protocols, and insertion indications. The goal would be to decrease CAUTI's during hospital admission stays within catheterized patients. Temporary changes will be made on this unit including the following: catheter use restricted to only postoperative urinary retention with a nurse-guided removal policy, acute urinary retention, strict I&O (although may not apply on this unit), prolonged immobilization with an unstable spine or unstable pelvic fractures, urinary incontinence only in setting to assist in healing of an open sacral or perineal wound, CBI, administration of medications that need to go directly into the bladder, and palliative care for comfort during transition of end of life (Newman, 2022). Physicians will put in a nursing removal protocol order for urinary catheter. Then, the charting system can be changed to alert the nurse to evaluate need for catheter every shift and require the nurse to select an indication. If an indication cannot be determined, the nurse will follow the urinary catheter nursing removal protocol order and remove the catheter in a timely manner. If a catheter is deemed to remain in place, then other interventions need to be provided, such as prevention of dependent loops and kink in drainage tubing, keeping the drainage back below the bladder and off the floor, catheter changes every 30 days, maintaining closed system of the catheter and drainage bag, perineal and catheter care with BD Surestep wipes every 12 hours, proper emptying of catheter drainage bag, and perhaps a CHG bath daily if the patient is not allergic. Data can be collected over a 3-month period with these changes and measured/evaluated. If the new data

shows that there has been a decrease in catheter associated urinary tract infections in comparison to data prior to the quality project, a policy change can be written and implemented for the rest of the hospital to begin following. **(3 points)**
Discuss the dissemination of information regarding the project results. The project results will need to be reviewed with those in charge of policy changes and infection control, which may include administration, the quality improvement team, infection control team, the policy team, CNO, and unit managers. It would be preferred to meet in person with these people to present the data. This way, the project results can be reviewed and deemed effective, and a new policy can be written with assistance of the policy team under hospital guidelines. The unit managers would receive information about the policy possibly via email or manager meetings. The unit managers can discuss with their unit's learning specialist to create an education module to have their staff learn the policy. Emails can also be despised out to show project results or the policy change. **(2 points)**

/7 points

References: 3 points

Callan, L. L., & Francis, K. (2022). Fecal incontinence: Pathology, assessment, and management. In L. L. McNichol, C. R. Ratliff, & S. S. Yates (Eds.), *Wound, Ostomy, and Continence Nurses Society core curriculum: Wound management* (2nd ed., pp. 484-519). Wolters Kluwer.

Canadian Urological Association. (2023). Clean intermittent self-catheterization for men (CIC). https://www.cua.org/system/files/PIB/PIB%201_en_web2023.pdf

Engberg, S. (2022). Stress urinary incontinence in women. In L. L. McNichol, C. R. Ratliff, & S. S. Yates (Eds.), *Wound, Ostomy, and Continence Nurses Society core curriculum: Wound management* (2nd ed., pp. 213-236). Wolters Kluwer.

Ermer-Seltun, J. M., & Engberg, S. (2022). Pelvic organ prolapse and vesicovaginal fistula. In L. L. McNichol, C. R. Ratliff, & S. S. Yates (Eds.), *Wound, Ostomy, and Continence Nurses Society core curriculum: Wound management* (2nd ed., pp. 237-253). Wolters Kluwer.

National Council for Mental Wellbeing. (2025). *Quality improvement toolkit.* https://www.thenationalcouncil.org/wp-content/uploads/2025/02/Quality-Improvement-Toolkit-1.pdf

Nelles, K. (2022). Primary assessment of patients with urinary incontinence and voiding dysfunction. In L. L. McNichol, C. R. Ratliff, & S. S. Yates (Eds.), *Wound, Ostomy, and Continence Nurses Society core curriculum: Wound management* (2nd ed., pp. 45-67). Wolters Kluwer.

Nelles, K., & Ermer-Seltun, J. M. (2022). Urinary tract infection (UTI) prevention and management in adults. In L. L. McNichol, C. R. Ratliff, & S. S. Yates (Eds.), *Wound,* *Ostomy, and Continence Nurses Society core curriculum: Wound management* (2nd ed., pp. 382-404). Wolters Kluwer.

Newman, D. K. (2022). Indwelling and intermittent urinary catheterization. In L. L. McNichol, C. R. Ratliff, & S. S. Yates (Eds.), *Wound, Ostomy, and Continence Nurses Society core curriculum: Wound management* (2nd ed., pp. 405-432). Wolters Kluwer.

Thompson, D. L. (2022). Management fundamentals for incontinence. In L. L. McNichol, C. R. Ratliff, & S. S. Yates (Eds.), *Wound, Ostomy, and Continence Nurses Society core curriculum: Wound management* (2nd ed., pp. 83-110). Wolters Kluwer.

The Urology Foundation. (2024). *Overactive bladder (OAB).* https://www.theurologyfoundation.org/urology-health/bladder-conditions/overactive-bladder-oab/

Wooldridge, L. S. (2022). Overactive bladder/urgency UI: Pathology, presentation, diagnosis, and management. In L. L. McNichol, C. R. Ratliff, & S. S. Yates (Eds.), *Wound, Ostomy, and Continence Nurses Society core curriculum: Wound management* (2nd ed., pp. 111-134). Wolters Kluwer.