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

Continence Care Mini Case Studies

Cleveland Clinic

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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: New onset fecal incontinence secondary to chronic constipation with likely fecal impaction and subsequent overflow leakage. **(1 point)**
Identify any further actions that need completed at this visit. • **A digital rectal exam from a provider or imaging to assess for level of stool burden and fecal impaction**   o **If impaction is present administer enema or have a provider manually disimpact patient** • **Further assess diet, fluid intake, and medications used.** • **Have patient begin tracking her bowel movements including frequency, consistency, size, leakage, and dietary intake in a daily journal** • **Provide patient with constipation prevention education** **(2 points)**
The long term-recommendations for this patient are … • Establish a structed toileting schedule such as attempting to have a bowel movement roughly 30 minutes after meals • Increase dietary fiber intake or add a fiber supplement • Intake 1.5-2L of fluids daily unless medically contraindicated • Reduce chronic laxative use and replace with osmotic laxatives such as polyethylene glycol only as needed. **(2 points)**
Rationale for your actions: • A digital rectal exam or imaging are necessary to determine if there is fecal impaction and stool presence.   o Identifying fecal impaction and stool burden allows for prompt treatment while also confirming the suspected diagnosis of fecal impaction with subsequent overflow • Patient makes brief mention of her diet, but things like level of fluid intake and certain medications could also be contributing to this patients symptoms • A daily journal can help identify patterns and triggers of leakage • Education is always a key component, and allows patients to have the resources and

knowledge they need to be successful on their own

- A structed toileting schedule, especially after meals, can help prevent leaking episodes by attempting to make bowel movements more predictable
- Patient reports little to no intake of dietary fiber which can reduce constipation. If patient is unwilling to take in fiber through her diet (as she claims it upsets her stomach) a fiber supplement can be added.
- Adequate levels of hydration can also decrease constipation and allows fiber to work more efficiently
- We want the patient to only utilize a laxative when she feels she is constipated, not chronically as the way to induce a bowel movement.

(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: Stress urinary incontinence
(1 point)

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

- Collect a focused continence history assessment including:
  - Onset and duration of symptoms
  - Frequency of voiding and incontinent episodes
  - Nocturia
  - Fluid intake
  - Medications
  - OB/GYN history
  - Bowel function
- Perform a physical examination of external genitalia, pelvic floor muscle strength, cough stress test, and observe for organ prolapse
- Have patient attempt to void and collect a sample for urinalysis. Then perform a post-void residual urine volume test
- Have patient begin a journal recording voiding habits, fluid intake, and activities associated with leakage.

(2 points)

Describe your treatment plan.

- Refer patient to pelvic floor physical therapy and initiate pelvic floor exercises.
- Scheduled toileting every 2 hours while awake.
- Lifestyle modifications such as smoking cessation, weight loss if applicable, and reduction of bladder irritants
- Referral to urologist if conservative therapy fails

(2 points)
Rationale: • A detailed history and physical assessment can help distinguish between the types incontinence as well as help to identify potential causes and triggers of the incontinence episodes that might be modifiable • A post void residual will allow for evaluation of incomplete bladder emptying the patient is feeling. It will help determine if the patient is just having the sensation of still having urine to void or if there is residual urine being left behind   o If we are having the patient void anyway, it is always a good idea to take a sample to be analyzed to rule out other causes • A journal will help keep track of bladder habits and allow for better tracking of potential causes and triggers of episodes • Pelvic floor therapy helps to strengthen the muscles often responsible for stress incontinence and is a great non-invasive non-pharmacologic way to treat the issue of stress incontinence. • Timed voiding can help prevent overfilling of the bladder and may help with bladder emptying if patient is retaining urine after voiding • Certain modifiable lifestyle factors could be contributing to the incontinence and should be addressed if applicable • If the patient fails to respond to conservative options like pelvic floor physical therapy, more specialized evaluation and potential surgical management may be required. **(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 with nocturia **(1 point)**
Describe your recommendations and include any consults needed. • Timed voiding every 2 hours while awake and voiding before bed at night • Reduce fluid intake 2 hours before bed, especially caffeine or alcohol • Use a bedside commode or urinal during nighttime hours if distance to the bathroom is a problem • Recommend consults to physical therapy, occupational therapy now, and urology if problems persist **(2 points)**
Rationale: • Timed voiding every two hours helps to keep the volume of urine in the bladder lower and therefore decrease number of urgency episodes • Voiding before bed helps to empty the bladder and reduce the chances of waking up feeling like you need to void at night • Reducing fluid intake, especially of diuretics, before bed will help to limit the amount of urine produced at night while sleeping, decreasing urge and nocturia. • Reducing the distance between the patient and the toilet may help to reduce the amount of incontinence episodes as it seems mobility is a large factor • Patient with a recent knee replacement and now a fall is clearly having some mobility issues which are likely contributing to his incontinence episodes. Physical therapy can help work on patients’ strength and mobility, reducing the amount of time it takes him to get to the bathroom. Occupational therapy can work with the patient to see if there are any modifications or adaptive equipment needed at the patient’s home. If patients’ problems are not improving with first-line therapies, then more specialized assessment and testing may be required from a urologist. **(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: Urge incontinence **(1 point)**

Identify further components of your focused assessment and include any diagnostic tests.
• **Perform a detailed bladder history including:**
    o **Onset and duration of symptoms**
    o **Medications**
    o **Bowel habits**
    o **OB/GYN history**
    o **Surgical history**
• **Have the patient attempt to void and if able obtain a sample for urinalysis and culture**
• **Perform a post-void residual (PVR)**
(2 points)

Describe your treatment plan. • Timed voiding every 2 hours while awake and void before bed. • Eliminate the intake of alcohol and caffeine (bladder irritants) and replace with water, non-carbonated clear beverages, or caffeine free teas. • Educate patient on the importance of smoking cessation • Teach patient pelvic floor muscle exercises and refer to a pelvic floor physical therapy program. • If symptoms persist, refer to a urologist or provider to explore pharmacological therapies such as antimuscarinic agents and beta-3 adrenergic agonist • Educate patient that surgery is generally not a first line treatment for her symptoms and is usually reserved for when all other less invasive treatment options have failed. **(2 points)**
Rationale: • **A detailed history helps confirm suspected problem and identify potential modifiable contributing factors.** • **Sending a urine sample for testing can help eliminate other more serious causes of incontinence such as urinary tract infection or hematuria** • **PVR will allow for assessment of incomplete bladder emptying** • **Timed voiding helps to retrain the bladder and prevent it from overfilling. Voiding before bed ensure the bladder is emptied prior to going to sleep** • **Caffeine, alcohol, and nicotine are known bladder irritants and should be reduced or eliminated.** • **Nonpharmacologic options such as pelvic floor physical therapy should always be**

attempted before jumping right into medications

- **If patients symptoms persist, medications are likely the next step after evaluation from a specialized provider**

- **Educating the patient about surgery will hopefully help to reduce some of the anxiety she is feeling**

(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: Catheter bypass (leaking) likely related to incorrect catheter position, or possible catheter obstruction. **(1 point)**

Identify components of your focused assessment and include any diagnostic tests.
• Evaluate the catheter including:
  o Size and type
  o Volume in the balloon
  o Presence of kinks or obstruction in tubing
  o Position of the drainage bag
• Evaluate bladder for distension and measure urine volume using bladder ultrasound
• Obtain a urine sample from the catheter port (not the drainage bag) to assess for catheter associated urinary tract infections
• Evaluate mental status and attempt to identify underlying causes
• Assess if there is still a need for urinary catheter (is this acute or a chronic catheter)
 	
(2 points)

Describe your recommendations and any necessary products. • Assess catheter patency and position. Confirm ballon is inflated using 10cc syringe. Aspirate contents to confirm it is the correct amount documented on catheter initiation. Then attempt to advance catheter further in case it has changed positions before re-inflating the balloon. • Irrigate the catheter if an obstruction is noted or suspected after orders from a provider are obtained • Replace the catheter if a malfunction is noted or blockage cannot be resolved using a standard 14-16Fr catheter and proper sterile urinary catheter insertion technique • Secure catheter using appropriate catheter securement device ensuring catheter has some slack is not taught when patient moves their leg. • Manage fecal incontinence with frequent checks for soilage, performing peri care when soiled, and initiating a moisture barrier ointment (such as zinc oxide paste). Avoid the use of adult diapers or briefs in this patient. **(2 points)**
Rationale: • **Catheter bypass (leaking around catheter) is commonly caused by a catheter obstruction or improper placement/size. Ensuring catheter is functioning properly, is patent and free from obstruction, in the correct position, and properly inflated can help to alleviate the common causes of leaking.**

- **Frequent incontinence episodes and subsequent moisture exposure places this patient at a high risk for moisture associated skin damage. Ensuring patient is clean and free of stool and applying a protective barrier cream helps to protect the skin from moisture damage and stool breakdown.**
- **A confused/disoriented patient is more likely to try to tug or pull at lines and devices such as a catheter. Ensuring the catheter is properly secured and attempting to identify underlying causes of confusion will help to improve patient safety while also reducing the risk of catheter malfunction from patient manipulation**
    - **Assessing whether patient still needs catheter or not will not only increase safety for a confused patient by eliminating a potential hazard, it will also eliminate the potential for a catheter associated urinary tract infection**

(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.
• Explain the purpose and the function of the Gellhorn Pessary to the patient
    o Teach the patient that the pessary provides temporary or long term non-surgical management of pelvic organ prolapse by supporting the vaginal walls and pelvic organs.
    o It may help to improve symptoms like urinary dysfunction and pelvic pressure
• Educate the patient that this type of pessary typically remains in place all the time and is removed periodically by a trained health care professional for cleaning and vaginal assessment as part of scheduled regular follow-up visits.
    o If pessary is accidentally removed, do not reinsert unless specifically instructed by a provider. Contact the clinic or facility where it was placed for a re-evaluation and re-insertion.
• Discuss vaginal tissue health and care with possible need for topical vaginal estrogen cream if symptoms like bleeding, irritation, or pain are persistent.
• Talk about important lifestyle modifications like avoiding heavy lifting, avoiding straining when going to the bathroom, and pelvic floor muscle therapy exercises.
(2 points)

Describe your treatment plan. • Fit the patient with the appropriate size Gellhorn pessary by a trained professional • Schedule patient for one week follow up with routine follow-ups for removal, cleaning, and vaginal examination every 3 months. • Teach patient pelvic floor muscle therapy training exercises and refer to a pelvic floor physical therapy program • Coordinate with surgeon and primary care doctor about a blood pressure management program to reduce hypertension and allow for surgical intervention **(2 points)**
Rationale: • **It is important to educate the patient on this non-surgical treatment option for her organ prolapse so she understands what is being placed into her body. It is important this patient understands this type of pessary does a good job at managing even advanced pelvic organ prolapse.** • **The patient should know that the device is meant to stay in place at all times and will be removed periodically for cleaning and re-assessment as part of routine follow-up appointments.**   o **It is important the patient knows what to do if it does accidentally become removed as well** • **Pelvic floor muscle therapy helps to strengthen the muscles associated with pelvic**

floor support and may help reduce prolapse associated symptoms.

- **More conservative approaches such as a pessary are always nice to try before jumping to surgery. However, patient should still address their hypertension in case the pessary is not effective and managing her symptoms or patient wishes to have surgery as a treatment.**

(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 of CIC is to manually empty the bladder through catheterization at regularly set intervals to achieve full bladder emptiness **(1 point)**

Mr. J will need to learn CIC. Detail your education plan.
• **The education provider to Mr. J will be performed in a verbal education session, followed by having the patient perform a hands-on demonstration**
• **First steps will be to educate Mr. J on the purpose of CIC**
    o **To manually empty the bladder through catheterization at regularly set intervals ensuring the bladder is completely empty. CIC however will allow Mr. J to avoid a permanent indwelling catheter**
• **Next will be the hands-on demonstration where the process of CIC will be demonstrated to the patient and the patient will perform the process on themselves to ensure adequate technique is used. Steps are as follows:**
    o **Gather needed supplies (catheter, lubricant, and collection device if using)**
    o **Wash hands with soap and water.**
    o **Lubricate catheter if necessary**
    o **Clean penis and genital area with soap and water**
    o **Hold penis with one hand and a good grip around penile shaft and raise to a 90 degree angle**
    o **Slowly insert the catheter using other hand into urethra. Advance urine begins to flow and stop**
    o **Allow bladder to drain fully (until urine stops flowing) into collection device or toilet**
    o **Slowly remove catheter until fully removed**
• **Develop a CIC schedule with Mr.J**
    o **Educate Mr. J that CIC is performed on a routine basis of about every 4-6 hours, as well as before going to sleep at night.**
• **Educate on signs and symptoms to look out for when performing CIC. If patient observes these signs or symptoms please head to a health care facility to be assessed by a trained professional**
    o **Cloudy or malodorous urine, burning with catheterization, blood in the urine, fevers or chills, and inability to advance catheter.**
 	
(3 points)

Identify at least two complications that can occur with CIC. o **One of the complications that can occur with any form of urinary catheterization is a urinary tract infection. Inserting a catheter repeatedly means you are**

repeatedly exposing the urethra to potential bacteria and other contaminants.

- **A second complication would be trauma caused to the urethral tract from repeated catheterization. Again, we are repeatedly introducing a material into the urethra that can cause damage if the proper technique and equipment are not used. That is why it is important to ensure patients can perform the proper technique prior to sending them home to perform it themselves.**

(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. Problem identification, data collection, goal of project, evidence-based intervention(s), implementation of project, re-evaluation of data after implementation, and project sustainability **(2 points)**
Describe how <u>you</u> would design a CAUTI QI project. (Make sure to include problem identification and evaluative measures) The first step is to determine whether or not CAUTIs are even a problem at the facility. This would be done by collecting and auditing data of all patients who had an indwelling catheter who developed a catheter associated urinary tract infection. For the sake of the assignment, we will say that the data audit revealed a large number of CAUTIs at the facility. Other data points that would be pertinent to audit would include reason for catheterization, insertion techniques and number of attempts to insert, average patient time with a catheter before removal, and staff compliance with catheter care protocols to try and identify potential gaps in care and factors leading to CAUTIs. Next is to develop the goal of the project, which for example we will say will be to reduce the number of facility wide CAUTIs by 10% over the next 12 months. Now, how is this going to be achieved? Some evidenced based interventions include performing a daily CAUTI risk assessment and implanting a facility wide program or assessment to identify and remove catheters that are no longer necessary, ensure that the supplies for following best practices for sterile insertion technique and managing urinary issues are readily available to staff in each unit, implement documentation protocols to address various steps of catheter life cycle including catheter appropriateness, insertion technique, maintenance care, and prompt removal when no longer indicated. Ensure only trained health care professionals are inserting urinary catheters and that staff's competency is routinely assessed; this goes hand-in-hand with educating the appropriate staff on proper sterile insertion technique, proper catheter maintenance care, and alternatives to indwelling catheters. Implementing nurse-driven catheter removal protocols can also be useful to help with prompt removal when no longer necessary. Evaluative measures for this project would include percentage of CAUTIs over the 12 month period after evidence-based interventions and comparing that to the previous 12 month period to see if the goal of a 10% reduction was met. Additionally, the areas of reason for catheterization, insertion techniques and who inserted the catheter, days catheter was in place, and staff adherence to catheter maintenance and daily catheter documentation could be evaluated as well to see if there is a correlation between any of those areas and CAUTIs. **(3 points)**
Discuss the dissemination of information regarding the project results. **Dissemination of the project results would start with internal communication amongst the team members involved in the improvement project. The data would then be presented to quality improvement committees, nursing leadership, facility managers, and infection prevent committees. If the project is deemed notable by these staff members,**

then the results can be provided to staff throughout the facility with the hope of further education and feedback based on project results. It is likely staff might need routine education or skill evaluations to ensure all staff are completing the latest evidence-based practices at the bedside. The quality improvement team may consider putting together something like a power point or education board that they utilize as part of an annual or semi-annual education event. If enough improvement is observed, the project PowerPoint or board could even be shared at something like a conference to spread the information to other facilities.
(2 points)

/7 points

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