**Suggested Answers to Discussion Topics, Chapter 25, Assisting With Urinary and Bowel Elimination**

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| Suggested Answers for Topics for Discussion | Learning Objectives |
| 1a. Students’ responses should include the following:   * Pauline has chronic constipation. * Their acute problem is most likely a fecal impaction. * One cause is their history of regular laxative use. * Dementia will also play a part due to their inability to remember basic functions.   1b. Students’ responses should include the following:   * A digital examination should be done to determine the presence of impacted feces. You may assist the nurse. Pauline has heart disease, and rectal stimulation could be dangerous for them. * You may assist the nurse during the procedure by supporting Pauline in the proper position, providing reassurance, and monitoring them for signs of distress. The impaction is removed by using a gloved finger to break the feces apart and scoop it out of the rectum. * Oil retention enema may be used to lubricate the stool and intestine to make the stool easier to pass or remove. You may assist the nurse by caring for Pauline until results are obtained. * Very careful monitoring of Pauline’s bowel movements should be part of the care plan. This will be your responsibility as nursing assistant. * The doctor may order a stool softener to be given on a daily basis. The nurse will administer this. You will monitor their bowel movements for consistency and report to the nurse. * They may require a rectal suppository every 3 days to keep them from becoming impacted again. Because of Pauline’s heart disease, the nurse may insert this. Your role is to assist Pauline and report the results to the nurse. | 8, 9, 10, |
| 2a. Students’ responses should include the following:   * To prevent the catheter from being pulled out, secure it loosely near the insertion site with tape or a catheter strap. * Coil the tubing and secure it to the bed with a plastic clip to avoid kinking and tension on the skin under the tape or catheter strap. * Make sure Michelle is not lying on the tubing. * Keep the drainage bag below the level of the bladder at all times. * Attach the drainage bag to the bed frame and not to the bed rail. * Never let the drainage bag or tubing touch the floor. * Empty the drainage bag when full or at the end of your shift, carefully cleansing the drainage spout and avoiding touching it with your hands or against the collection container. * Record the amount of urine drained. * Provide catheter care by cleansing it starting at the insertion site and moving outward from the body about 4 in. * Use a clean portion of the washcloth for each stroke.   2b. Students’ responses should include the following:   * Observe the skin under the tape or catheter strap for irritation or breakdown. * Observe the urine for hematuria and report to the nurse immediately. * Observe the urine for abnormal color. * Observe the urine for clarity. * Check for particles in the urine and in the tubing. * Check for abnormal odor. * Check to make certain Michelle is putting out a normal amount of urine. * Report to the nurse, oliguria and polyuria. * Report if the urine is not flowing freely through the tubing after you’ve checked for kinks. * Ask Michelle for and report any complaints of pain or discomfort due to the catheter. * When doing perineal and catheter care, check for redness, swelling, or discharge from the catheter insertion site. Report to the nurse any of these findings. * Check for urine leakage from around the catheter insertion site as well as tubing connections and drainage spout. * Observe Michelle for signs and symptoms of infection such as elevated temperature, confusion or agitation, and report these to the nurse immediately. | 4, 6 |