DAY 2 — ELIMINATION STUDY GUIDE

Basic Care & Comfort • NGN NCLEX 2026 Master Review

BOWEL RETRAINING | OSTOMY | ENEMA | CATHETER / CAUTI | INCONTINENCE | C. DIFF

CRITICAL / EMERGENCY | PATHOPHYSIOLOGY | SAFE / EXPECTED | COMPLICATIONS | NCLEX TRAPS | PROCEDURES | PT EDUCATION

FOUNDATIONS — BOWEL & BLADDER BASICS

Elimination is governed by autonomic reflexes, voluntary sphincters, fluid/fiber intake, and mobility. Disruption from immobility, opioids, neuro disease, surgery, or aging changes the entire BCC plan. NCLEX prioritizes **preventing complications** (impaction, CAUTI, ostomy ischemia) and **restoring continence**.

> **Normal patterns:** Stool: every 1–3 days; soft, formed; brown. Urine: 30 mL/hr minimum, clear yellow-amber, <500 mL post-void residual is concerning, >100 mL retention.

BOWEL RETRAINING

GOALS

- Establish a regular elimination schedule (typically after breakfast — gastrocolic reflex)
- Reverse chronic constipation, manage neurogenic bowel

PLAN

1. Schedule toileting **30 min after a meal** (gastrocolic reflex peaks)
2. Provide privacy; upright position; lean forward (Valsalva-friendly)

3. Fluid intake 2–3 L/day unless restricted (HF, CKD)
4. Fiber 25–35 g/day (whole grains, fruits, vegetables, legumes)
5. Daily activity/walking to stimulate peristalsis
6. Stool softeners → laxatives → enemas in stepwise order if needed

Trap: Long-term laxative dependency atones the bowel. Educate non-pharm first.

BLADDER RETRAINING & KEGELS

BLADDER RETRAINING

- Scheduled voiding q2–4h while awake; stretches voiding interval gradually
- Limit caffeine, alcohol, artificial sweeteners (bladder irritants)
- Decrease fluids 2 h before bedtime (reduce nocturia) but not total intake

KEGELS (PELVIC FLOOR)

- Identify correct muscles: **stop the stream of urine** mid-flow (1× to identify, then NOT during regular voiding)
- Tighten 5–10 sec → release 5–10 sec, 10–15 reps × 3 sets/day
- Effects in 6–12 weeks; benefits stress incontinence most

INCONTINENCE — 5 TYPES MATRIX

TYPE	TRIGGER	CAUSE	INTERVENTION
Stress	Cough, sneeze, laugh, lift	Weak pelvic floor (postpartum, menopause)	Kegels, weight loss, pessary
Urge	Sudden, can't reach toilet	Detrusor overactivity	Bladder training, anticholinergics (oxybutynin)
Overflow	Constant dribble, no urge	BPH, neurogenic bladder, diabetic neuropathy	Treat obstruction, intermittent cath

Functional	Can't reach toilet in time	Mobility/cognition issue (dementia, stroke)	Scheduled toileting, environmental modification
Reflex (neurogenic)	No warning, automatic	SCI above S2, stroke	Intermittent cath, autonomic dysreflexia precautions

ENEMA — PROCEDURE & PEDIATRIC RULES

ADULT POSITIONING & TECHNIQUE

- **Sims left-lateral** position (anatomy of sigmoid colon)
- Solution height: **12–18 in (30–45 cm)** above rectum (high enema 18 in; low 12 in)
- Insert tube 3–4 in (adult); lubricate generously
- Run slowly over 5–10 min; stop if cramping → resume after pause
- Hold solution 5–15 min (cleansing) before evacuation

VOLUMES BY AGE

AGE GROUP	VOLUME	SOLUTION
Adult	500–1000 mL	Tap water, NS, soap suds (limited)
Adolescent	500–750 mL	NS preferred
School age	300–500 mL	NS only
Toddler	250–350 mL	NS only
Infant	120–250 mL	NS only

NCLEX trap: Tap water/soap-suds enemas in children → fatal hyponatremia and water intoxication. **Pediatric enema = NS ONLY.**

OSTOMY CARE — STOMA & OUTPUT BY SITE

STOMA ASSESSMENT

HEALTHY STOMA

- Pink/beefy red, moist, shiny
- Slight edema first 4–6 weeks
- Painless to touch (no nerves)
- Mild bleeding with cleansing OK

NOTIFY PROVIDER STAT

- Dusky/purple/black = ischemia
- Pale = anemia/poor perfusion
- Retracted below skin
- Profuse bleeding
- No output 24–48 h post-op

OUTPUT BY OSTOMY SITE

SITE	OUTPUT CHARACTER	RISKS
Ileostomy	Liquid, frequent (500–1500 mL/day); high enzymes	Dehydration, electrolyte loss, skin breakdown
Ascending colostomy	Semi-liquid	Skin breakdown
Transverse colostomy	Soft, semi-formed	Moderate
Descending/Sigmoid colostomy	Formed stool, predictable	Best site for irrigation

POUCH & SKIN CARE

- Empty pouch when 1/3–1/2 full (heavier = pulls off seal)
- Change wafer q3–7 days routine; **change immediately** if leak
- Clean peristomal skin with water (no alcohol, no ointments under wafer)
- Stoma should be 1/8 in clearance from wafer opening (too large = skin breakdown; too small = stoma trauma)
- Burp pouch to release gas; do not poke holes

DIET (ESPECIALLY ILEOSTOMY)

- Low-fiber initially; advance gradually
- Avoid: nuts, seeds, popcorn, mushrooms, corn, celery, raw cabbage, dried fruit (obstruction risk)
- Chew thoroughly; small frequent meals
- Fluids 2–3 L/day; replace electrolytes (sports drinks ok)
- Odor-reducing foods: yogurt, parsley, buttermilk; gas: avoid carbonated drinks, beans, broccoli

CATHETERIZATION & CAUTI PREVENTION

MNEMONIC — INDICATIONS FOR INDWELLING CATH

U R I N E

Urinary obstruction · **R**etention/Required strict I&O critically ill · **I**mmobile/end-of-life comfort · **N**eurogenic bladder · **E**xtended surgery (perioperative)

INSERTION KEY POINTS

- Sterile technique throughout
- Female: insert until urine flows + 1 in further; Male: insert to bifurcation/Y of catheter
- Inflate balloon ONLY after urine return confirmed
- Secure to thigh (female) or abdomen (male) to prevent traction on bladder neck

CAUTI PREVENTION BUNDLE

1. **Avoid unnecessary use** — strict indications only; remove ASAP
2. Hand hygiene before/after any cath contact
3. Maintain closed drainage system; bag below bladder, off floor
4. Daily perineal/cath care with soap and water (NOT antimicrobials/powders)
5. No routine bladder irrigations
6. Empty bag q8h or when 2/3 full; spigot must not touch container
7. Daily review for removal — every day with cath in = ↑ risk 3–7%

Trap: Disconnecting tubing to obtain a sample. Use the needleless port at the catheter; never break the closed system.

INTERMITTENT SELF-CATHETERIZATION

- **Clean technique** at home (sterile in hospital)

- Wash hands, wash perineum, lubricate cath, insert until urine flows
- Catheterize q4–6h on schedule; do not skip
- Catch any retained urine in measuring container; record I&O
- Wash silicone cath after use; replace per manufacturer
- Notify provider for cloudy/foul urine, fever, hematuria, flank pain

FECAL IMPACTION & DISIMPACTION

RECOGNIZE

- No stool ≥ 3–5 days, abdominal distension, pain
- **Paradoxical liquid stool around impaction** (looks like diarrhea — do NOT give antidiarrheal)
- Confirm with digital exam; abdominal X-ray if unsure

DISIMPACTION PRECAUTIONS

- Apnea, bradycardia, syncope = **vagal response** from rectal stimulation
- STOP procedure immediately, monitor HR, prepare for atropine if severe
- Cardiac clients (recent MI, arrhythmia): use stool softeners/oil-retention enemas first; manual disimpaction LAST resort

C. DIFFICILE — ISOLATION & TEACHING

- **Contact precautions** with private room
- Soap and water hand washing (alcohol-based sanitizer does NOT kill spores)
- Bleach-based disinfectants for surfaces (sodium hypochlorite)
- Gown + gloves for all room entries; remove before leaving
- Dedicated equipment in room
- Discontinue causative antibiotic if possible; treat with oral vancomycin or fidaxomicin
- Probiotics may be considered (varies by facility)
- Watch for toxic megacolon: severe distension, fever, ↑WBC, ↓BP → STAT

IF / THEN — CLINICAL DECISION RULES

IF dusky or purple stoma	→	notify surgeon STAT — ischemia/necrosis
IF liquid stool with palpable mass	→	suspect fecal impaction — do NOT give antidiarrheal
IF bradycardia/syncope during disimpaction	→	STOP procedure — vagal response
IF ileostomy + recurrent dehydration s/sx	→	add electrolyte drinks; teach signs early
IF C. difficile suspected	→	contact precautions + soap-and-water hand hygiene + bleach for cleaning
IF cath in > 24 h with no clear indication	→	advocate for removal — daily review
IF child needs an enema	→	NS only; NEVER tap water/soap suds

NCLEX TRAPS

Antidiarrheal for liquid stool
Could be impaction overflow — always assess first.

Tap water enema for child
Hyponatremia/water intox. NS only.

Alcohol-based sanitizer for C. diff
Doesn't kill spores. Soap and water.

Stoma "purple" labeled normal
Ischemia. Pink/red is normal.

Routine bladder irrigation
Increases CAUTI. Only if ordered for specific reason.

Cath bag above bladder
Reflux → CAUTI. Always below.

Teaching Kegels via stop-stream every void
Causes UTI/incomplete emptying. Identify once, then Kegel away from bathroom.

Vagal symptoms during disimpaction
Stop. Don't push through.

NCLEX PATTERNS

PATTERN: STOMA COLOR = ACTION

- Pink/red → continue care
- Pale → assess perfusion
- Dusky/purple/black → notify STAT

PATTERN: OUTPUT VOLUME BY SITE

- Ileostomy = highest output, dehydration risk
- Sigmoid = formed, lowest risk

PATTERN: PEDIATRIC SAFETY

- Pediatric enema = NS only
- Volume by age

PATTERN: CLOSED SYSTEM

- Don't disconnect cath tubing
- Bag below bladder
- Daily removal review

NGN BOW-TIE — SAMPLE SYNTHESIS

Case: 64 y/o post-op day 1 sigmoid colostomy. Stoma assessment: dusky, no output × 6 h. T 100.4 °F, HR 102, BP 108/68. Abdomen distended, tender.

TOP 2 ACTIONS	CONDITION	TOP 2 MONITOR
• Notify surgeon STAT — possible stoma necrosis • NPO; prepare for return to OR; IV fluids; serial assessments	SUSPECTED STOMA ISCHEMIA / NECROSIS	• Stoma color trend; output • VS, lactate, abdomen, fever

PATIENT & FAMILY EDUCATION CHECKLIST

- ✓ Drink 2–3 L water/day unless restricted
- ✓ Eat 25–35 g fiber/day; advance gradually with new ostomy
- ✓ Empty pouch when 1/3–1/2 full; change every 3–7 days
- ✓ Inspect stoma daily — pink/red moist is healthy; report dusky, retracted, bleeding
- ✓ Keep peristomal skin clean and dry (water only under wafer)

- ✓ Schedule bowel movements after meals (gastrocolic reflex)
- ✓ Kegels: 10–15 reps × 3 sets/day for 6–12 weeks
- ✓ Self-cath on schedule (q4–6h); don't skip
- ✓ Report fever, cloudy urine, flank pain, or no stool ≥3 days
- ✓ Hand hygiene with soap and water (especially with C. diff or ostomy)

DAY 2 OF 7 — BCC STUDY GUIDE SERIES

Pair this guide with the Day 2 Question Bank (20 NGN items).

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