• Development of a questionnaire to assess habits, knowledge and beliefs about fluid intake and output
  R Das & KA Grimmer-Somers

• A collaborative alliance supports quality in a continence nursing service
  J Hylton, B Mackay, H Brown & G Turner

• Juniper berries, prayer and pelvic floor exercises: managing male incontinence across the ages
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Do you need topic ideas? A variety of topics are possible and include, but are not limited to: outcome studies, aged care, paediatrics, pregnancy and childbirth, novel drug therapies, reviews of devices either surgical or non-surgical, assessment articles, literature reviews of continence-related topics, home and community care issues and successes, men’s health, nursing management, physiotherapy management, support by other allied health disciplines (including occupational therapy and social workers), the psychological impact of living with incontinence, ethical issues, cultural issues and collaborative approaches to care.

Articles may be papers for peer review, clinical updates, case studies or evaluation of programmes.

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To rely on clinical experience alone in assessing efficacy of treatments is unreliable. Patients often get better or worse no matter what we do! Professional health care is often goal-oriented and typically clinicians use measures of bladder function – the amount of urine voided, the frequency of micturition and the post-void residual volume of urine – to gauge the effect of treatments. Although appropriate changes to these parameters indicate improved bladder performance and are sound, knowledge-based measures, they do not adequately define treatment outcome. We understand physiological clinical outcomes do not always equate with what is important to a patient. Treatment outcomes must also include the things that matter to the child or family. Although we are rightly interested in the child's maximum voided volume, the child and their family are probably more bothered about incontinence. Patient-reported treatment outcomes provide direct insight into the impact of treatment. Important patient-reported outcomes of treatments in the area of paediatric continence care include incontinence episode diaries, quality of life measures, documenting the side effects of medicines, or discomfort associated with bowel problems and episodes of urinary tract infection.

While some argue the assumption that a patient's experience is the major indicator of the quality of care provided by health care professionals, I do not agree; but readily acknowledge that self-assessment of the worth of complying with therapy generates data not available from medical tests. Issues of concern to the child are likely to include their differences from peers, embarrassment, isolation, anxiety about other children finding out about their incontinence, strategies to hide episodes and concerns about missing school to attend appointments. Clinical settings that include this kind of communication from a child or their family allow tailored input to address patient concerns. Communication beyond specific symptoms and addressing function and wellbeing is guaranteed to reduce a family's unmet needs.

What is the best way to measure this level of treatment efficacy in paediatric continence care?

In the oncology literature there are descriptions of placing touch-screen computers in waiting areas so that patients can register their concerns before the consultation begins. Clearly most of us are a long way from using this technology but are well able to provide an opportunity for patients and their families to write down their top two or three concerns that day. Another simple technique may be to ask a child to circle a happy, sad or neutral face; depending on how they feel at that moment. Discussing their choice of ‘emoticon’ is likely to reveal issues of concern to them. We know from literature on adolescent health that young people value being asked their opinion and prefer communication to be directed at them rather than their parents.

Another aspect of evaluating treatment efficacy is to understand and define a minimal treatment difference that indicates effectiveness for a particular patient. It may be as simple as presence or absence of a symptom; for example, if nocturnal enuresis either occurs or does not. Objective clinical signs and symptoms are scored or graded and the relative change can be measured. In paediatric care the Wetting and functional voiding disorder score (WFVDS) or the Dysfunctional voiding symptom score are used. Each instrument quantifies symptom severity and indicates response to treatment. However, each has limitations and both instruments are not sensitive to change, nor can they be used to interpret and identify a minimal but clinically important difference in scores after therapy.

In routine clinical practice the measure most commonly reported is the relative change in symptoms of interest. For an incontinent child this is likely to be the change in number of dry days or nights per week or fortnight, while for an adult it may be the reduction in occasions of changing clothes or protective pads. Validated methods to measure incontinence in children have been well described. If health care professionals can assemble a suite of ‘fit for purpose’ instruments that reflect changes due to incontinence treatment it becomes possible to compile useful, meaningful and interpretable data about clinical care and personal practice. When such measures are routinely documented at the time of care, there is a basis for a database or register specific to your patient load. This prospective data provides the information for clinicians to assess efficacy of overall intervention and specific therapies. The process of

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understanding whether treatment has been effective becomes transparent. The use of prospectively collected, valid data is a valuable tool to begin investigating clinical observations and to justify audit cycles and leads clinicians to better practice and a more scientific, goal-oriented and cooperative management of incontinence in patients and evaluation of treatment efficacy.

Why do intelligent well-meaning professionals use ineffective treatments?

In 2004 the BMJ published a list of eight reasons that ineffective or harmful treatments are still offered. Top of the list is the assertion that ‘clinical experience’ equates with excellence. However, gaps exist between knowledge and practice, especially when new evidence becomes available. Another stumbling block to efficacy are beliefs in the natural history of a disorder. For example, in the case of nocturnal enuresis there is the belief that the annual spontaneous remission rate in young children is a reason for watchful waiting, which is contrary to new knowledge that in the presence of severe symptoms or beyond the age of nine remissions rarely occur. In this case, a belief in the pathophysiological model has likely precluded the clinician from adding new information to their understanding of underlying variables that impact nocturnal enuresis.

Some therapies come with their own set of rituals and clinical mystique. I remember a cohort of older women, each with osteoarthritis in their knees, that I inherited from a community care service in my early career. These women were used to receiving a home visit, each fortnight, from a therapist bearing an antiquated electrotherapeutic device that warmed each knee for 20 minutes. There was clearly a ritualistic element to these occasions of service and, while it was highly unlikely that this treatment provided any long-term gains, the patients expected to feel better with the treatment and no doubt the therapist thought it was better to offer something than nothing. While it is easy to understand, from all perspectives, why this intervention was continued it was likely a long way from excellent and demonstrable patient care. The challenge to all of us working responsibly with children and their families to treat and manage incontinence problems, is to continually ask the confronting questions: “How effective was my input?” and “How do I know?”

References

Peer review

Development of a questionnaire to assess habits, knowledge and beliefs about fluid intake and output

Abstract
The purpose of this study was to develop a valid and reliable questionnaire, which describes drinking and voiding habits, urinary symptoms, and knowledge and beliefs about these. A literature review identified the questionnaire-based voiding diary (QVD) as being an appropriate framework for new questionnaire development. This was modified with questions pertaining to demographics, behaviours, knowledge and beliefs about drinking and voiding habits. The psychometric properties of the questionnaire were established using focus groups, peer review and pilot testing. Validity was reported qualitatively, while reliability was reported as reliability coefficients. In addition to identifying the tool used, the literature review established common statements about the benefits of plentiful fluid consumption and sourced the level of evidence for these. New items assessing knowledge and beliefs regarding these common statements were added to the tool. Focus group feedback and expert opinion confirmed face validity of the new items. Respondents' reliability differed between questionnaire sections with the demographic, habits and symptoms sections demonstrating high reliability (reliability coefficient 0.91–1.0) and the knowledge/beliefs section demonstrating the widest range (reliability coefficient 0.35–1.0). The questionnaire was well-accepted, time-efficient and valid. Responses to items within the questionnaire were consistent on occasions of testing with the exception of knowledge and beliefs which are likely to change as a result of exposure to the questionnaire. This questionnaire provides a mechanism for validly and reliably collecting information on drinking and voiding behaviours, beliefs and knowledge.

Keywords: Data collection, urinary incontinence, young adult, drinking.

Introduction
There is a popular belief that drinking eight glasses of water a day is good for health. Unsubstantiated statements abound about the benefits of plentiful water consumption (for example, "detoxifying" and improving skin/hair appearance). However, in 2002 a review by Valtin indicated that most recommendations for eight glasses of water a day had little scientific backing. Indeed, it is possible that drinking too much fluid could contribute to lower urinary tract symptoms (LUTS) such as urgency, frequency and incontinence and restricting fluid intake can improve symptoms of incontinence. Furthermore, some voiding habits may be indicative of urinary problems; for instance, preventative micturition (voiding "just in case") is associated with incontinence. Despite advice on fluid intake and voiding habits frequently being a management strategy for incontinent individuals, little is known about the general public's knowledge and perspectives regarding drinking and voiding. Prevention or improvement of LUTS could include promotion of healthy drinking and voiding habits, starting with healthy young people.
Currently, there is no suitable questionnaire to collect information concerning drinking and voiding habits, urinary symptoms and knowledge and beliefs about habits and symptoms. Information from such an instrument would assist clinicians or health promotion strategists to develop treatment programmes and community health promotion initiatives targeting poor voiding habits and beliefs surrounding fluid consumption. This paper describes the steps taken to develop and psychometrically test a questionnaire about drinking and voiding habits, beliefs and knowledge.

**Method**

**Ethics:** Research approval was provided by the University of South Australia Human Research Ethics Committee.

**Overview:** The questionnaire was developed over four stages. Stage 1 was a literature review to identify currently available instruments and establish current best evidence regarding drinking and voiding behaviours. Based on these findings, new questionnaire items were designed and best-evidence answers to the questionnaire items were developed. Stage 2 established content validity of new instrument items via expert opinion and focus groups. Stage 3 established and improved construct validity via pilot testing. Stage 4 established test-retest reliability.

**Reference population:** The study samples were recruited from a reference population of educated young people (16–35 years), on the assumption that their beliefs would be informed by both publicly available health promotion messages and formal education.

**Method and results of each stage**

**Stage 1: Review of the literature**

**Method:** A search of Google Scholar, Medline and CINAHL was conducted using search terms: drinking or fluid/water intake/consumption and/or voiding and habits and/or knowledge and/or beliefs and/or recommendation. The review had two purposes. Firstly, studies reporting questionnaires which included items on knowledge, beliefs or habits related to drinking and voiding were identified. Secondly, evidence was established regarding healthy drinking and voiding habits.

**Results:** No questionnaires assessing knowledge and beliefs about healthy fluid intake and output were identified. Regarding drinking and voiding habits, the questionnaire-based voiding diary (QVD), was identified as a valid and reliable measurement tool which could underpin a new instrument. In order to assess behaviours, knowledge and beliefs, further questions were, therefore, required.

Permission to modify the QVD was obtained from the authors. Items assessing volume of fluid intake and habits, urinary frequency and voiding habits were retained. The wording of some sections was modified to suit an Australian audience, specifically converting fluid ounces to millilitres. Added were questions addressing demographics and questions addressing knowledge and beliefs. These were compiled from other questionnaires and reflected current prevalent ‘myths’ and facts about drinking and voiding habits. These ‘myths’ and facts were collated from the input of experts, popular magazines, the internet and our knowledge of the field. Statements were categorised (Table 1) as follows: ‘myths’ if published evidence to the contrary was unstated, ‘facts’ if evidence supported the statement.

**Table 1. Evidence status of statements regarding healthy drinking and voiding habits.**

<table>
<thead>
<tr>
<th>Myth (existing evidence to the contrary)</th>
<th>Unsubstantiated statement (no scientific evidence found)</th>
<th>Scientifically proven</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drinking lots of water prevents constipation.</td>
<td>Alcohol doesn’t count as fluid because it dehydrates you.</td>
<td>Thirst is a good indicator of when you need to drink.</td>
</tr>
<tr>
<td>Don’t wait until you are thirsty to drink – you will already be dehydrated.</td>
<td>Drinking lots of water makes your hair shinier.</td>
<td>Drinking too much can be bad for your health.</td>
</tr>
<tr>
<td>Tea and coffee will dehydrate you so you should have an extra drink of water after having tea or coffee.</td>
<td>Drinking lots of water reduces fatigue.</td>
<td></td>
</tr>
<tr>
<td>Drinking lots of water prevents bladder or urinary tract infections.</td>
<td>Drinking lots of water helps digestion.</td>
<td></td>
</tr>
<tr>
<td>You should drink enough to make your urine straw-coloured.</td>
<td>Drinking lots of water helps prevent acne.</td>
<td></td>
</tr>
<tr>
<td>You should drink enough to make your urine clear.</td>
<td>Drinking lots of water flushes toxins from the system.</td>
<td></td>
</tr>
<tr>
<td>Drinking water is harmless so it doesn’t matter how much you have.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
found; ‘unsubstantiated statements’ if no published supporting evidence was found; and ‘facts’ if supporting published evidence was found.

The validity and reliability of all QVD items had been previously tested. However, given they had been tested on middle-aged, American women, who were incontinent, they required testing on young, healthy Australians. Furthermore, the psychometric properties of the new knowledge and beliefs sections of the questionnaire required testing. The following stages were consequently applied.

**Stage 2: Establish content validity**
This stage involved three steps: (a) clinician expert opinion, (b) focus groups and (c) researcher expert opinion.

**Method (a):** To test content validity, expert opinion was sought from two experienced continence clinicians who regularly advise clients on fluid intake. They provided feedback on the wording, range and response categories for questions.

**Results (a):** The expert clinicians who reviewed the first draft of the questionnaire made the following suggestions:
- Remove QVD’s questions pertaining to large void timing, as not directly related to study aims.
- Alter the question regarding experiencing a need to “rush to the toilet” to experiencing an “urgent and strong desire to pass urine which is difficult to control”.
- Provide extra words to guide subjects deciding how much urine is lost during incontinence episodes (“damp” alongside “drops”, “wet” alongside “small splashes” and “soaked” alongside “more”).
- Restrict the number of open-ended questions assessing knowledge and beliefs by increasing the number of true/false questions, to improve data entry efficiency and decrease respondent burden.

**Method (b):** Two focus groups were conducted to establish the range of questions required to address the topic fully from the perspective of the reference population. One group comprised three male, second-year university students and the other, five female, Year 12 students from a local senior college. These groups were representative of the intended respondents and participants volunteered subsequent to invitations from their teachers. The focus group questions were semi-structured, to identify participants’ knowledge about healthy drinking and voiding habits, incontinence and its management. Focus groups were tape-recorded, with an observer taking additional notes. Themes identified from the focus-group data were cross-checked with existing questionnaire items. Where gaps were identified, items were modified, or new items developed.

**Results (b):** Most subjects stated they could answer most questions, although several females indicated uncertainty when estimating height and weight. However, a major gap in the questionnaire related to knowledge or beliefs. Extra questions on the causes and risk factors of incontinence were thus required as focus group participants demonstrated poor knowledge in this area.

**Method (c):** We reviewed all questionnaire items for ease of data analysis.

**Results (c):** The questions assessing physical activity levels were amended to reduce the number of possible responses, and allow for calculation of the actual number of hours of high-impact activity per week (for example, hours spent in the gym and sporting activities). Most open-ended questions were converted to multiple-choice questions with one correct answer, based on the current evidence for drinking and voiding knowledge/behaviour, established in Stage 1. The Stage 2 changes resulted in a revised questionnaire.

**Stage 3: Establish construct validity: focus groups and pilot test**

**Method:** The revised questionnaire was returned to focus group participants for comment, to establish construct validity of new response categories, wording and instructions. A pilot of the revised questionnaire was then conducted. Twenty-three volunteers aged 16–17 years from the local senior college were recruited by invitation from their teacher. They had not been involved in the earlier focus groups. Subjects completed the questionnaire and participated in an individual structured interview to determine:
- Questionnaire completion time.
- Completeness (was anything important left out?)
- Adequacy of response categories (were respondents tempted to tick in-between two response categories for any question?)
- Whether any question caused embarrassment and if so, how the question could be worded to be less embarrassing?
- Ease of layout and design.
- Adequacy of instructions for question completion.

This informed a third and final draft of the questionnaire.

**Results:** Most respondents found the response categories adequate. A suggestion was that examples be given of the size of common drinks to simplify estimating fluid intake amount. Examples were subsequently provided in a text box below the instructions in the fluid intake section of the questionnaire. Another suggestion was to add an option between “never” and “occasionally” (“rarely”). However, these response categories would be considered similarly for data analysis, thus this suggestion was not acted on. The time taken to answer the questionnaire was between eight and 15 minutes. Those who commented that some questions were embarrassing did not regard them as too embarrassing to answer.

**Stage 4: Establish reliability: test-retest reliability study**

**Method:** Test-retest reliability of the questionnaire was tested by administering the Stage 3 questionnaire draft twice, one
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Responses for paired (repeated) questionnaire items were compared, using measures of test-retest reliability appropriate to the data type (Table 2).

### Table 2. Measures of association according to data type.

<table>
<thead>
<tr>
<th>Data type</th>
<th>Example question</th>
<th>Measure of association</th>
</tr>
</thead>
<tbody>
<tr>
<td>Continuous</td>
<td>Weight and height</td>
<td>Pearson r</td>
</tr>
<tr>
<td>Nominal</td>
<td>True/false/I don't know</td>
<td>Cramers V</td>
</tr>
<tr>
<td>Ordinal</td>
<td>Never – all the time scale</td>
<td>Gamma</td>
</tr>
<tr>
<td>Dichotomous</td>
<td>Yes/No</td>
<td>Biserial (Pearson r)</td>
</tr>
</tbody>
</table>

Results: Test-retest reliability coefficients for each section of the questionnaire are reported in Table 3. The results to the open ended questions were assessed with percent agreement. Most achieved 100% agreement. A total of three out of 28 participants did not answer the question “How much fluid do you think a person should drink in day” consistently on both occasions. One out of five participants did not answer the question “What do you think causes your urine leakage?” on the second occasion.

Questions demonstrating less than substantial test-retest statistics were examined to identify reasons for discrepancy. In the urine output section, there was one question about preventive micturition, which demonstrated moderate reliability (reliability coefficient 0.51) and another about waking to void at night, which was marginally “substantial” (reliability coefficient 0.64). Both questions were answered using a scale from “never” to “all of the time”. Analysis of the paired responses to these two questions identified that when answers did not match perfectly, the respondent had chosen “sometimes” on one occasion, and “occasionally” on the other. Given that these answers would make little difference to data analyses, these response categories were combined, as in “sometimes/occasionally”.

In the knowledge/beliefs section of the questionnaire, 11 of the 37 items demonstrated moderate reliability and one demonstrated only fair reliability. Those items that demonstrated moderate reliability were mostly part of the “true/false/I don’t know” section. Three were ‘myths’ about the benefits of drinking lots of water and six were statements relating to contributing factors and treatment of incontinence. In 75% of responses, reliability was compromised by selecting “true or false” on one occasion and selecting “I don’t know” on the other.

The item that demonstrated only fair reliability (reliability coefficient 0.35) was part of a larger question which asked participants how they knew the amount of fluid recommended to be consumed in a day. The nine response options were analysed separately. Two options scored in the moderate range (family/friends and newspapers/magazines) and one scored fair (doctor or other health professional). The questionnaire resulting from the Stage 4 changes was the final version. (For a copy of the questionnaire contact the author via email.)

Discuss

The questionnaire designed in this study is the first that we know of, which describes a psychometrically sound approach to collecting data on drinking and voiding habits, urinary symptoms, knowledge and beliefs about each of these.

Items from the “true/false/I don’t know” section of the questionnaire, which had moderate rather than higher reliability, tended to be statements (some true, some false) about risk factors for incontinence (overweight, chronic constipation, bladder weakness and abdominal muscle weakness). It is not surprising that young people are unsure about factors contributing to incontinence. Of note, statements about pelvic floor muscle weakness and pregnancy being risk factors were answered reliably (reliability coefficients 0.76 and 0.88) indicating that participants were more confident about these better known risk factors.

Most of the ‘myths’ about why it is important to drink lots of water were reliably answered, indicating that participants’ beliefs were stable. Only three items appeared difficult to answer: “drinking lots of water makes your hair shinier”; “drinking lots of water reduces fatigue”; and “drinking lots of water prevents bladder and urinary tract infections”, indicating that some subjects were uncertain about these statements.

Participants not only held misinformed beliefs about how much they should drink in a day, but also did not consistently
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- Haemodialysis;
- Severe hepatic impairment;
- Patients with severe renal impairment or moderate hepatic impairment who are on treatment with a potent CYP3A4 inhibitor.

Precautions:
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- Gastrointestinal obstructive disorders;
- Risk of decreased gastrointestinal motility;
- Narrow-angle glaucoma; hiatus hernia/gastro-oesophageal reflux and/or concurrent use of medicinal products that can cause or exacerbate oesophagitis;
- Autonomic neuropathy;
- Angioedema with airways obstruction;
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- Hepatic impairment;
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- Pregnancy (Category B3);
- Lactation.

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- CYP3A4 substrates (e.g. verapamil, diltiazem);
- CYP3A4 inducers (e.g. rifampicin, phenytoin, carbamazepine);
- Drugs which prolong QT interval. (See full PI).

Adverse events:
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- Common (>1% and <10%): nausea, dyspepsia, diarrhoea, vomiting, upper abdominal pain, urinary tract infection, upper respiratory tract infection, influenza, pharyngitis, headache, dizziness, arthralgia, back pain, fatigue, oedema lower limb, blurred vision, dry eye, cough, urinary retention, insomnia, depression, hypertension, QT prolongation in cases with known risk factors (See full PI).


References:

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report how they sourced the information. This highlights the importance of further research in this area to promote healthy drinking and voiding habits, underpinned by sound evidence sources.

The combination of the "occasionally" and "sometimes" options improved the reliability of most questions with moderate to near perfect reliability. However, this was not the case for the question about preventative micturition, suggesting that it was difficult to answer. It is possible that subjects were unconscious of a habit of voiding "just in case" prior to their first completion of the questionnaire and in the subsequent week either modified their behaviour or noted it more accurately.

The main limitation of this study is that only four subjects suffered from incontinence and answered the related questions. It is, therefore, not certain whether these questions were answered reliably. They were, however, reported to be answered reliably when tested by the authors of the QVD7 and there is no perfect reliability. However, this was not the case for the main limitation of this study is that only four subjects suffered from incontinence and answered the related questions. It is, therefore, not certain whether these questions answered reliably. They were, however, reported to be answered reliably when tested by the authors of the QVD7 and there is no perfect reliability. However, this was not the case for the question about preventative micturition, suggesting that it was difficult to answer. It is possible that subjects were unconscious of a habit of voiding "just in case" prior to their first completion of the questionnaire and in the subsequent week either modified their behaviour or noted it more accurately.

The main limitation of this study is that only four subjects suffered from incontinence and answered the related questions. It is, therefore, not certain whether these questions were answered reliably. They were, however, reported to be answered reliably when tested by the authors of the QVD7 and there is no reason to believe that younger people, as in this study, would answer them less reliably, unless they were more embarrassed about the topic.

Young, educated individuals were the reference population as the questionnaire designed was intended for use in this demographic. Caution is required if administering the questionnaire in different reference populations.

**Conclusion**

This new questionnaire has sound psychometric properties. It comprehensively and efficiently assesses knowledge and beliefs about healthy drinking/voiding and incontinence while concurrently assessing drinking and voiding habits and the presence of urinary symptoms. Use of this questionnaire in young people will identify possible drinking and voiding-related risk factors for lower urinary tract symptoms, thereby informing preventative measures and promotion of healthy habits.

---

**Table 3. Measures of association for each section of the questionnaire.**

<table>
<thead>
<tr>
<th>Questionnaire section</th>
<th>Reliability coefficient</th>
<th>Level of association</th>
</tr>
</thead>
<tbody>
<tr>
<td>Demographics</td>
<td>9 items scored 0.91–1.0</td>
<td>Almost perfect</td>
</tr>
<tr>
<td>Fluid intake</td>
<td>Total fluid calculated: item scored 0.78</td>
<td>Substantial</td>
</tr>
<tr>
<td>Fluid intake behaviour</td>
<td>6 items scored 0.72–0.97</td>
<td>Substantial – almost perfect</td>
</tr>
<tr>
<td>Urinary output</td>
<td>4 items scored 0.51–1.0</td>
<td>Moderate – almost perfect</td>
</tr>
<tr>
<td>Urinary symptoms</td>
<td>4 items scored 0.92–1.0</td>
<td>Almost perfect</td>
</tr>
<tr>
<td>Knowledge/beliefs</td>
<td>37 items total</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• 9 items scored 0.82–1.0</td>
<td>Almost perfect</td>
</tr>
<tr>
<td></td>
<td>• 15 items scored 0.61–0.79</td>
<td>Substantial</td>
</tr>
<tr>
<td></td>
<td>• 11 items scored 0.43–0.58</td>
<td>Moderate</td>
</tr>
<tr>
<td></td>
<td>• 1 item scored 0.35</td>
<td>Fair</td>
</tr>
</tbody>
</table>

---

**References**

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TENA Duo Protection Layer™ is a purpose-built faecal management solution that is used in partnership with a base pad from the TENA range. The bowl-shaped design of the TENA Duo Protection Layer™ captures faeces to save the base pad from contamination.

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- Trial Respondent, Customer Preference Study Faecal Liner, October - November 2010.

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Peer review

A collaborative alliance supports quality in a continence nursing service

Abstract

This collaborative project between clinicians from a district nursing service and nurse academics supported quality improvement in a continence nursing service. This project was supported by an action research method. It was dynamic and informed by literature and integration of data collected during interviews with district nurses, an audit of client notes and field observations. The main outcome was a change in the delivery of continence nursing service using generalist nurses to a service provided by specified nurses with an identified interest in continence management. A further outcome was the introduction of nurse-led clinics within a specialist urology and gynaecology setting. Triage of initial referrals by a specialist nurse also proved beneficial. This project demonstrated the value of this type of collaborative alliance between industry and education institutions.

Keywords: Collaboration, incontinence, nursing, research methods, quality improvement.

Introduction

The New Zealand Ministry of Health service contracts require District Health Boards to provide a continence service. However, there is concern because in New Zealand there are no national standards and no consistency between the existing services. A National Service Specification, was developed in 2001, and outlines the service specifications, eligibility and referral processes for continence service provision (including continence supplies), and response times according to perceived level of risk of the client. In New Zealand, the District Nursing Services provide continence services according to the National Service Specification, which requires services to provide assessment, ongoing management and the provision of incontinence products (if necessary) to referred clients living within the community but does not include clients in an aged care institution.

During 2008, a New Zealand District Nursing Department chose the continence nursing service for a quality improvement project. The Nursing Department of the local polytechnic was approached for assistance. This resulted in a collaborative project with the aim to implement improvements within existing resources and the normal operations of both departments.

This paper discusses the review of the literature, data from a focus group of district nurses, audits of client notes and field observations, which informed the process and outcomes of the project. Implications for practice are explored.

The New Zealand experience

Incontinence refers to involuntary faecal or urinary leakage. Although this condition affects a large number of New Zealanders, there are no current statistics available on the prevalence of this condition. The New Zealand Continence Association website refers to statistics from the 1996 census, which indicate that 18% of adult women in New Zealand experience urinary incontinence. This is supported by the international literature, which suggests that in women of all ages living in the community 15 to 50% will have urinary incontinence problems. The figures are much higher in the Maori population, with 46% of adult...
females being affected. Many women do not seek help, either because they are embarrassed or because they view incontinence as a normal part of the ageing process.

Research from the United Kingdom (UK) also suggests that while many people are eligible for continence services, very few actually take advantage of the services available. This could be extrapolated to New Zealand as people in general do not seek help for incontinence. In New Zealand, incontinence in the elderly is one of the major risk factors for admission to long-term residential care and there is a need to address the issue to assist the elderly to remain in their own homes. In 2006, New Zealand Ministry of Health data on older people’s health acknowledged incontinence as a significant health indicator but did not cover this issue because of lack of accurate data.

In New Zealand, district nurses provide home-based care including continence assessment. Under the National Service Specification, assessment is required to be completed within two weeks. The local District Nursing Service protocol requires that the assessment include urinalysis and that the client keep a fluid volume chart. Once completed, the assessment is discussed with the clinical nurse specialist continence (CNSC) and a client management plan developed. The title of CNSC is one unique to the local District Nursing Service. The plan may or may not include bladder-retraining, referrals to other health professionals or a urology clinic, or provision of continence supplies. The majority of clients are assessed at home but some may prefer to attend a nursing clinic at the District Nursing Service's base.

Anecdotal evidence suggested that the nursing management of clients referred to the continence service could be improved. There was a perception that routine continence assessments were not a high priority and that this lack of priority led to a protracted assessment period, often involving several nurses resulting in delayed diagnosis and the instigation of a plan of care. The local District Nursing Department elected to implement a quality improvement project aimed at investigating these issues and, if necessary, make changes to improve the service provided to clients.

Method

This quality improvement initiative was informed by an action research approach. The intent of using an action research method is to enable description, interpretation and explanation while endeavouring to change for the better. McKernan identified Lewin as the first theorist to propose this type of approach. Lewin suggested that a number of steps should occur in action research. These include planning, fact-finding, execution and analysis. A timeline demonstrated the steps as the project unfolded and included the dates of data collection, and of action points (meetings), and the major changes to practice that occurred as this project progressed.

Validity in action research is promoted by ensuring that findings fit reality and reliability is promoted by agreement between the researcher and participants. The project team was made up of collaborators from the nursing service practice area and academics. Regular project meetings were held to plan, discuss findings, and to make decisions regarding progress of the project. A focus group was held with a purposive sample of 12 district nurses who regularly provide continence care in the course of their work. The nurses identified and discussed barriers to providing good continence nursing care and put forward ideas to improve the service.

Project members from the local polytechnic provided advice regarding the project plan and process, and assistance with evaluation, presentation of the data collected and compiling the report. The project was approved by the Polytechnic’s Research Committee.

According to Swaffield, audit is a key part of a quality assurance process aimed at improving continence management. On three occasions – at baseline, at three months after improvement strategies were implemented and at six months post implementation – client records were audited using an existing audit tool developed by the District Nursing Service. These records were of clients who were current to the service at the time of audit. Descriptive statistics were used to analyse and present all audit data.

Nurses attending the focus group were supplied with an information sheet outlining the project. Consent was implied through completion of the questionnaire and attendance. The nurses completed a short questionnaire eliciting demographic and other quantitative data as identified in Table 1. A semi-structured interview schedule with open-ended questions was used to guide the discussion during the focus group.

The project members held regular meetings and discussed progress of the project. Meetings were also held with the local polytechnic members of the team to support progression of the project and identify required actions by the project members. Minutes were kept on discussion, decisions and required actions. These meetings were vital in evaluating progress and assimilating the data gathered over the course of the project. The clinical project members kept brief field notes (on observations and meetings) during the project. Field notes assisted in making the problem-solving process transparent. A descriptive summary was developed from these observations.
Literature review

Bibliographical databases including: CINAHL; Proquest Nursing; Medline and Google Scholar were searched using the MeSH terms such as: incontinence; best practice; nurse-led service; specialist nursing in community and nursing management. The abstracts of articles including primary research, qualitative evaluations, published government and peak body information and reports, and systematic reviews published between 1990 and 2008 in English were retrieved. Letters to the editor, conference and symposia abstracts were excluded.

Results

Literature review

Of the all the articles reviewed, 29 met the inclusion criteria. The international literature suggests that continence is a major health issue. The largest group experiencing continence problems is adult women who usually report symptoms of urinary incontinence. Williams et al. recommend that essential information in a continence assessment include a frequency volume chart, pad test (24 hour), urinalysis, mid-stream urine sample (MSU), bladder scan; and for women, a genital examination. Depending on the diagnosis, the main treatment of urinary incontinence in women involves bladder training and pelvic floor muscle exercise.

Many studies report management of incontinence involving nursing services and the use of experienced nurse specialists in educative or clinical roles. Borrie et al. report that counselling by specialist nurses (including support for behavioural interventions and pelvic muscle exercise regimens) reduced the frequency of incontinence and of pad usage. Williams et al. report reduced symptoms of incontinence following specialist nurse-led intervention. A recent systematic review on the role of the nurse in community continence care reviewed 12 randomised controlled trials involving clinical and economic outcomes. It was found that there was minimal evidence that nursing intervention resulted in an improvement in incontinence and there was no evidence for cost reduction. However, the review suggested there was evidence of improved health outcomes and patient satisfaction. The improved patient satisfaction with specialist nurse intervention was well supported in the literature.

The results of research on a new nurse-led service in the UK suggest that when setting up a nurse-led service, it is essential to have clear documentation about the proposed process of assessing and managing clients, a plan for developing the education preparation of nurses providing the service and for continence management to be evidence-based. Nurse-led services demonstrated that good communication skills supported a client’s compliance with treatment directives. A focus on best evidence to support practice is also apparent in a clinical practice project in a Healthcare Trust in London.

Chart audit

After the first audit of client records, gaps in some of the continence service processes were identified and strategies implemented to improve the service. The data from the first audit of client records (Table 2) along with the initial literature review and district nurse perceptions informed the first changes to practice, which were the introduction of a ‘special interest’ nurse in each team to manage continence care and triage of referrals by the CNSC.

The second audit (Table 3) of 42 client records was undertaken following these changes. This audit included all notes of clients from a three-month period who met the criteria for entry to the

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<thead>
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<th>Number of Respondents (n=12)</th>
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<tr>
<td>40–49</td>
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<td>&gt;50</td>
<td>9</td>
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<tr>
<td>16–20</td>
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</tr>
<tr>
<td>21–25</td>
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<tr>
<td>&gt;25</td>
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<td>Postgraduate diploma/certificate</td>
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<tr>
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</tr>
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</tr>
<tr>
<td>Other</td>
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* Responses not all mutually exclusive
### Table 2. Client record Audit 1.

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<th>Audit 1 (n=50) Audit statements</th>
<th>Yes (n=)</th>
<th>%</th>
<th>No (missing or incomplete) (n=)</th>
<th>%</th>
<th>Not applicable (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Continence assessment and care plan (required) – the following were completed</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Contacted within the time frame</td>
<td>41</td>
<td>82%</td>
<td>9</td>
<td>18%</td>
<td></td>
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<tr>
<td>Continence assessment form</td>
<td>26</td>
<td>52%</td>
<td>24</td>
<td>48%</td>
<td></td>
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<tr>
<td>Management plan</td>
<td>37</td>
<td>74%</td>
<td>13</td>
<td>26%</td>
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<tr>
<td>Urinalysis (Multistix/MSU)</td>
<td>28</td>
<td>56%</td>
<td>22</td>
<td>44%</td>
<td></td>
</tr>
<tr>
<td>Frequency volume chart</td>
<td>24</td>
<td>48%</td>
<td>12</td>
<td>24%</td>
<td>14</td>
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<tr>
<td>Discussed with CNSC</td>
<td>49</td>
<td>98%</td>
<td>1</td>
<td>2%</td>
<td></td>
</tr>
<tr>
<td>Bladder scan</td>
<td>24</td>
<td>48%</td>
<td>13</td>
<td>26%</td>
<td>13</td>
</tr>
<tr>
<td>Assessment performed by one nurse</td>
<td>25</td>
<td>50%</td>
<td>25</td>
<td>40%</td>
<td>5</td>
</tr>
<tr>
<td><strong>2. Outcomes</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bladder retraining (including pelvic floor exercises)</td>
<td>6</td>
<td>12%</td>
<td>3</td>
<td>6%</td>
<td>38</td>
</tr>
<tr>
<td>Referrals (other health professionals)</td>
<td>17</td>
<td>34%</td>
<td>2</td>
<td>4%</td>
<td>31</td>
</tr>
<tr>
<td>Referral urology/continence clinic</td>
<td>8</td>
<td>16%</td>
<td>6</td>
<td>12%</td>
<td>36</td>
</tr>
<tr>
<td>Continence Supplies</td>
<td>44</td>
<td>88%</td>
<td>6</td>
<td>12%</td>
<td></td>
</tr>
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</table>
continence service. (The previous group of clients audited were not included as their notes had already been audited.)

The third audit (Table 4) of a further 45 client records was carried out when the first changes had been in place for six months. The population characteristics of the second and third audit groups differed from the first because they were recent referrals.

**District nurse perceptions from focus group**

The data from the focus group questionnaire indicated that only four nurses had specific education in continence management including a post-basic certificate, stomal therapy certificate, and specific education from the CNSC (Table 1).

As well as collating the perceptions from the district nurses’ focus group, it was decided that data from field notes would inform the quality improvement project. Six project meetings were held over the 10-month period of the data collection and feedback was given to the district nurses. Effective communication through feedback at staff meetings is recommended as crucial to limit barriers to implementation of changes in continence nursing services16. Meetings were also held with the continence specified nurses for continence care once these roles were introduced. The main action points and outcomes captured from the nurses’ feedback included the introduction of continence specified nurses in each team, triaging of new referrals by the CNSC, and establishing a nurse-led clinic in a specialist urology and gynaecology setting.

**Field notes**

Field notes made by the District Nursing Project members showed that “… documentation has improved, one nurse is involved in each assessment and appropriate and timely interventions are being put in place”. There was a perception that there was an increase in the number of clients discharged from the service than previously, better client education and an increased focus on bladder retraining. Overall management of clients referred for continence services appeared to be improved. This perception was supported by the second and third audit (Tables 3 and 4).

**Discussion**

The project team identified the introduction of continence specified nurses to manage continence care, as a key strategy to address the issues identified during the chart audits and nurse focus group. The decision to implement this role was supported by the literature. Although not specialist nurses, the two nurses appointed as specified continence nurses were interested in continence management and willing to learn more about this area of care. The outcome was a structure for the continence

<table>
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<tr>
<th>Audit 2 (n=42)</th>
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<th>Not applicable</th>
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<tr>
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<td>%</td>
<td>(n=)</td>
</tr>
<tr>
<td>Contacted within the time frame</td>
<td>42</td>
<td>100%</td>
<td>0</td>
</tr>
<tr>
<td>Continence assessment form</td>
<td>39</td>
<td>93%</td>
<td>3</td>
</tr>
<tr>
<td>Management plan</td>
<td>41</td>
<td>97%</td>
<td>1</td>
</tr>
<tr>
<td>Urinalysis (Multistix/MSU)</td>
<td>39</td>
<td>93%</td>
<td>3</td>
</tr>
<tr>
<td>Frequency volume chart</td>
<td>28</td>
<td>67%</td>
<td>5</td>
</tr>
<tr>
<td>Discussed with CNSC</td>
<td>41</td>
<td>97%</td>
<td>1</td>
</tr>
<tr>
<td>Bladder scan</td>
<td>35</td>
<td>83%</td>
<td>4</td>
</tr>
<tr>
<td>Assessment performed by one nurse</td>
<td>42</td>
<td>100%</td>
<td>0</td>
</tr>
<tr>
<td><strong>2. Outcomes</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bladder retraining (including pelvic floor exercises)</td>
<td>13</td>
<td>31%</td>
<td>1</td>
</tr>
<tr>
<td>Referrals (other health professionals)</td>
<td>15</td>
<td>35%</td>
<td>27</td>
</tr>
<tr>
<td>Referral urology/continence clinic</td>
<td>3</td>
<td>7%</td>
<td>39</td>
</tr>
<tr>
<td>Continence supplies</td>
<td>10</td>
<td>24%</td>
<td>32</td>
</tr>
</tbody>
</table>
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*3M Data on File
nursing service in which the CNSC worked closely with the two specified continence nurses. These were nurses interested in providing the continence service.

The incorporation of qualitative and quantitative data sources provided a holistic picture of the nursing continence service and informed the decisions on change to the service. Information from literature, data from district nurses, meetings, and audits of notes were used to inform this quality initiative as the project progressed.

The focus group proved valuable identifying barriers to good continence care. The nurses saw the system of self-referrals was an issue, noting that many patients should be assessed by a general practitioner (GP) before being admitted to the district nursing service. One nurse commented, “Often these clients could have been treated by a GP and not required our service”. To improve the admission process to the district nursing service for clients with incontinence symptoms it was decided that all referrals be assessed by the CNSC. It was expected that referrals by the CNSC would expedite assessment and prioritise referrals. The CNSC stated, “I am more in control of continence assessments … have knowledge about what is happening … how each patient is being managed and the outcome”. The second and third chart audit supported this improvement in timely assessment following referral (Table 3 and 4). The focus group identified that a lack of time to follow up clients was an issue as was the need to build a rapport with clients to support them with what was a very personal problem. In addition, clients with health issues such as dementia also needed more time to be spent with them to assess and manage their care.

The initial audit of patient notes revealed problems as many notes had significant areas of data missing or incomplete, and clients were not being assessed in a timely manner. Often more than one nurse was involved in the assessment process. The district nurses supported the concept of nurses ‘specialising’ in continence care who could overcome many of the issues related to documentation. These positive perceptions towards specialisation in community nursing are supported in the literature, especially in regard to the positive impact on client care and assistance to the generalist nurses25,26. The lack of interest and the lack of priority of continence assessments in a generalist setting, identified in the focus group, was also noted in the literature27.

Another key strategy, following one of the project meetings, was the co-location of the continence specified nurses at a clinic

Table 4. Client record Audit 3.

<table>
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<tr>
<th>Audit statements</th>
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<th>Not applicable</th>
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<tbody>
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<td>%</td>
<td>(n=)</td>
</tr>
<tr>
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<tr>
<td>Continence assessment form</td>
<td>42</td>
<td>93%</td>
<td>3</td>
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<tr>
<td>Management plan</td>
<td>43</td>
<td>96%</td>
<td>1</td>
</tr>
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<td>Urinalysis (Multistix/MSU)</td>
<td>38</td>
<td>84%</td>
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<td>32</td>
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<td>39</td>
<td>86%</td>
<td>3</td>
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<td>37</td>
<td>82%</td>
<td>4</td>
</tr>
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<td>45</td>
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<td>Bladder retraining (including pelvic floor exercises)</td>
<td>9</td>
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<td>37</td>
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<td>Referral urology/continence clinic</td>
<td>3</td>
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<td>Continence supplies</td>
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</tr>
</tbody>
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with easy access to urology and gynaecology support, rather than at the district nursing base. The free use of a clinic room at a urology clinic expedited this move. Clients who were unable to attend the clinic were still visited at home. Situating a nurse-led continence clinic with specialist urology and gynaecology services is supported by the literature. Mackay suggests that interprofessional collaboration is essential to support nurses in new roles and promote an effective service and that physical integration is one approach to support this type of collaboration. Burns and Pauly advocate that co-location of care may improve communication, promote learning and help resolve differences in practice. Field notes from the district nursing project members suggest that this change in service delivery has resulted in improvements in clients accessing timely urological or gynaecological assessment or CNSC support. Interprofessional collaboration and the knowledge and skill level of the nurses involved in continence management have also improved.

Quality improvement

The aim of the quality improvement project was to review and, if necessary, make changes to improve the continence service using available resources. The protocol for the continence nursing service at the end of the project retained all the items of the initial protocol and added items such as triage of referrals by the CNSC, assessment and management of referred clients being undertaken by specified continence nurses and the implementation of a nurse-led continence clinic.

A stated aim for the project was to make changes within available resources. This was achieved. This project did involve considerable time spent by project members; however, involvement in quality improvement and research activities are within normal parameters of the roles of the project members.

Limitations

The information gained from this project is only useful to the nursing service that commissioned the project. It is impossible to generalise any findings to other continence services. However, there may be lessons that are useful for other District Nursing Services not the least of which is the use of action research as an effective agent of change.

Recommendations

It is recommended that the local District Nursing Service continue to review and develop its continence service. Areas for development include updating the documentation audit tool and a focus on bladder training and pelvic floor exercises.

Engaging academics in clinical project areas may help to ground academics in the lived experience of current nursing practice.
while at the same time provide clinicians with support for academic processes. The action research method supports the integration of the two elements. Further research into this type of collaboration and methodology would be worth exploring.

Conclusion
The initial impetus for this project was speculation that routine continence assessments were not high priority for district nurses and that this lack of priority led to a protracted assessment period, often involving several nurses in the assessment, delayed diagnosis and the instigation of a plan of care. A quality project was carried out with assistance from the local polytechnic nursing academics. The project proved to be fluid and dynamic, which is integral to an action research approach. The project began with a review of the literature and data collected via client record audits, a focus group and feedback from the district nursing team. The outcomes of the project included changes to service delivery, including the introduction of continence specified nurses in each team, triage of referrals by the CNSC and co-location of nurse-led clinics within a specialist urology clinic. These changes were carried out within existing resources and demonstrated the value of a collaborative alliance between education and clinical service areas.

References
Peer review

Juniper berries, prayer and pelvic floor exercises: managing male incontinence across the ages

Abstract

Management of female incontinence has evolved in a scientific way in recent years. For men, however, strategies based on female research are loosely adapted and applied. Containment for male incontinence has some advantages over female containment. Pelvic floor exercises have also been adapted from the female model to the male without evidence basis. This paper presents a brief overview of the history of incontinence management and a discussion of the development of pelvic floor exercises for men.

Keywords: men’s health, urinary incontinence, pelvic floor, history of medicine.

Introduction

Today, urinary incontinence is both a social and a medical problem. Many men view it as a return to an infantile state or as a disfigurement of self. While urinary incontinence is less common in men than women, it affects up to 13% of Australian men. A recent survey of men’s attitudes to incontinence has shown that the loss of urine into clothing can provoke a response of revulsion and subsequent perceived loss of social status in the eyes of others. Throughout the ages, people who suffered from incontinence and those who have attempted to treat symptoms have tried to find cures and management strategies for this embarrassing problem.

Many of our treatments in urology have their roots in ancient cultures and medical practices. To learn more about the history of management of men’s incontinence, electronic databases were searched using the search terms continence management, bladder, enuresis, incontinence, urology and historical. From these articles, original papers were sourced where possible. Chapter headings and indexes of medical and nursing textbooks predating electronic databases were reviewed for the same terms. Of the 67 articles and books found, 42 references were studied in depth to find the origins of men’s incontinence management. Although not exhaustive, the results that are described and discussed should be representative of the eras.

Incontinence management through the ages

Ancient times

The ancient Egyptian Papyrus Ebers (1550 BC) describes urological conditions and remedies “to remove the urine which runs too often” and “to remove constant running of the urine”. Roman and Egyptian physicians have been recorded as using reeds as catheters to overcome blockages and the use of catheters to relieve retention was described in India and China as well. Hippocrates devoted a lot of time to the study of urology in his work Aphorisms where he notes that, “Diseases about the kidneys and bladder are cured with difficulty in old men”.

A wide range of treatments for managing urinary dysfunction were described throughout the ages, many put forward with more hope than logic. It highlights the desperation incontinence can cause and the lengths gone to in order to present oneself as continent.

Some treatments described by Byzantinian Paul of Aegina include:

- Shaving down the testicles of the hare into a fragrant wine.
- Infusing the flowers of the white chrysanthemum.
- Adding tepid water to the powdered burnt crop of the cock.
- Drinking a mixture of catmint and myrrh as an aperitif before supper.

Getliffe described physical treatments that included:

- hydrotherapies
- body-worn urinals
- douches to the lower spine
- penile clamps and vaginal pessaries.

One unusual remedy for managing "the water that runs at night", Getliffe found was “…tying a frog around the waist”.

Europe and the Middle Ages

When all else failed, people who experienced incontinence sought relief through prayer. From the Middle Ages, praying...
and pilgrimage was also used to evoke a cure. St Catherine of Alexandria was popular, as she was the patron saint for urinary incontinence4.

The Renaissance
A more modern investigative approach into urinary incontinence seems to have started with Goldberg in 16169. Goldberg classified urinary continence into problems with storage and problems with emptying, and recognised detrusor versus outlet functional issues. These classifications are still currently valid10. However, Goldberg did not proffer any treatment for these carefully classified problems.

Modern times
It was not until the mid-18th century, that the German physician Michael Ernst Ettmüller documented some treatments for the management of “an incontinency of urine”9. He recommended prescriptions of astringent, nerve and antiparalytick medications. These medicines are precursors of desmopressin, acetylcholine and oxybutinin, all commonly used to manage symptoms of incontinence today. The use of blisters was common for many illnesses, and to manage incontinence placing one on the sacrum was thought to help11.

Other management strategies centred on containment (Figure 1)5:

In an incontinency of urine, from whatever the cause, a piece of sponge ought to be worn, or a bladder applied in such a manner as to prevent the urine from galling and excoriating the parts.12

p. 331.

Remedies such as hydrotherapy, including the use of cold-water baths, douches and aromatic waters were used as treatments for incontinence in the 18th and 19th centuries5,13. Where the cause of the incontinence was due to enlargement of the middle lobe of the prostate, incontinence was considered intractable, “These forms of the affection are but little amenable to treatment, as the cause is usually irremediable”14. Compression of the urethra is described using techniques to constrict the area around the base of the penis or via an anal plug15. The former was not (and is still not) recommended ... “And cases abundantly ratifying this decision may be found on record”15.

In the care of older people it was recognised that urinary incontinence could lead to skin problems, and remedies such as almond oil applied to the skin were recommended16. Stress incontinence was not considered curable. CM Clarke, as cited in Wall, wrote in 181417:

... [the bladder] will be acted upon by every sudden and strong contraction of these [abdominal] muscles, and a part of its contents will be expelled ... For this case there is no remedy. Flat sponges sewed into the folds of a napkin should be constantly worn.

In 1882, Mosso and Pellacani invented a readily reproducible method of evaluating bladder function9,18. Water cystometry, or urodynamics, is still used today to assess bladder function, albeit with the addition of rectal pressures, urethral flow rates and sphincter electromyography. It allows for considered assessment of bladder function so that treatments can be tailored to the condition. However, until after the turn of the 20th century, treatment for incontinence remained in the hands of the medical profession. Nursing staff were encouraged to ensure patient dignity was maintained, but beyond basic care no specific treatments were described11. Pads, catheters and drainage apparatus were the mainstays of conservative treatment. It is not until the 20th century when patients were encouraged to be active participants in their recovery that pelvic floor muscle exercises were introduced.

Pelvic floor exercises
Pelvic floor exercises had been recognised by many indigenous cultures for centuries19. Midwives taught new mothers how to tighten the muscles over distended fingers several days after childbirth in Borneo and India, and in parts of Africa resumption of intercourse was not allowed until the midwife deemed the muscles strong enough19. In the 20th century most of the descriptions in the literature of pelvic floor muscle exercises have been focused on women20-25. It wasn’t until the late 1960s that pelvic floor exercises were considered valid for men26.

History of pelvic floor muscle exercises
Prevention of damage to pelvic floor muscles after childbirth by careful avoidance of strain on these muscles is first described in the literature by Young in 192227. Young suggested that the exercising of perineal muscles by older women could prevent urinary incontinence, and described this as “cutting off the flow of urine and retaining urine as long as possible”13. In 1933, Kolischer mentioned resistance practised with a straight urethral sound or probe. Success could be evidenced by “digital palpation
of the hyperplasia of the sphincter muscle ... felt as a protruding ridge"22. At the same time Arvedson suggests as a treatment for paresis or paralysis of the bladder. “Crook-half-lying knee-closing and parting with pelvis-lifting to strengthen and improve the tone of the muscles of the pelvic floor”20. Arvedson was also one of the first to suggest a link between the pelvic floor muscles and the lower abdominal muscles (Transversus abdominis):

An exercise which may be given quite early is to ask the patient to contract the abdominal and thigh muscles at the end of a deep inspiration. The muscles of the pelvic floor take part in this20.

Prosser, basing her work on that of Arvedson, also used whole body and leg exercises to strengthen the pelvic floor by association23. Prosser advocated crook-lying with hip adduction and outdrawing and pelvic lifting against resistance and wrote that:

... the value of the associated movement of the pelvic muscles which takes place with adduction is obvious; it is used in all cases where there has been stretching and consequent weakness of the pelvic floor23.

These exercises would later be elaborated upon by Kegel, a gynaecologist who invented the Kegel Perineometer (used for measuring vaginal pressure) and Kegel exercises. In 1948, Kegel gave pelvic floor exercises his name as well as their popularity21. Two years later Kegel suggested that stress urinary incontinence could be treated non-surgically by exercising the pelvic floor muscles.

Pelvic floor muscle exercises for men

In 1968, Hall first discussed the use of pelvic floor exercises with men. Hall defined these as “perineal exercises” and were described for the patient as:

... trying to imagine that he is trying to stop a bowel movement and, at the same time, to cross his legs at the ankles, to tighten the gluteal and abdominal muscles, and to squeeze his legs together tightly24.

Exercises taught to women at this time were specific to the pelvic floor and women were discouraged from using auxiliary muscles28.

Pelvic floor exercises were occasionally recommended clinically for men with stress urinary incontinence29. The earliest paper identified by this current review which described treating stress urinary incontinence (SUI) in men was by Burgio in 1989. Men with post-prostatectomy incontinence were diagnosed as having SUI, urge urinary incontinence (UUI) or continual leakage30. Pelvic floor muscle training was used as one of the behavioural training methods to treat their incontinence. They were taught to “tighten the sphincter muscle”; at times, combined with biofeedback assisting in ensuring the correct action was achieved. Training regimes were similar to those used in women. Most protocols had a recipe of ‘X’ number of contractions ‘Y’ times per day11-14.

The protocol for pelvic floor muscle training (PFMT) in men has changed little in the last two decades. Papers describe...
PFMT as tightening and lifting the pelvic floor muscles for a set number of times. Only two papers describe adapting PFMT to be patient-specific and individualised. The research trial Men After Prostate Surgery running in the UK, revises the duration of the hold of the maximum contraction at each appointment. The other recent paper compared personalised treatment to a set routine of pelvic floor contractions. The personalised group recovered continence earlier. Even though the mechanism by which pelvic floor muscle training might improve continence is not clear, there are sufficient positive findings to motivate researchers to continue.

From a physiological point of view, to improve continence status if muscle weakness is diagnosed as the cause, exercises should aim to strengthen the male PFM. In order to strengthen muscles, exercises should involve increasing the load to force more of the muscle fibres to be activated leading to hypertrophy. Endurance should be trained when leakage occurs after longer activity, and functional exercises seem to improve continence quicker as well.

No evidence has been found to date, showing one method of training the pelvic floor is better than another. Balmforth et al. found that after an intense, 14-week strength training programme, women with SUI leaked less. Their bladder neck position at rest was more cephalad on ultrasound. This implies that the resting tone of the pelvic floor is a key to improving stress incontinence, not strength development. There are some major problems applying this to the male population as there are no studies indicating that bladder neck position is important for maintaining continence.

Grading the pelvic floor

In 1996, the validity of digital testing of the strength of pelvic floor muscles was first studied in men. A tripartite validation score was used to test the reproducibility of the contractions of the bulbocavernous muscle, the external anal sphincter and the puborectalis muscle. Muscles were scored on strength, endurance and exhaustion. Wyndaele found that digital testing of pelvic floor muscles in a male population was reliable and useful clinically. The same five-point scale was suggested by Laycock in 1994 for women. This scale continues to be used in assessing men by many researchers and clinicians.

Dorey suggested the need for an extra grade when assessing pelvic floor muscle strength in men. More recently, the International Continence Society document on standardisation on terminology of Pelvic Floor Function has recommended a less subjective grading of a four-point scale due to high interobserver variability. Anal manometry was also found to be a reliable measure of anal pressure, though whether this is reflective of pelvic floor strength is untested. Once the testing of the pelvic floor muscles was validated, a number of studies using strength as an outcome measure were published. Strengthening the pelvic floor was shown to improve continence outcome measures in men postoperatively.

Conclusion

Continence management has advanced considerably since the days of juniper berries and beer. Both containment and management now have a scientific basis and refinements to male continence treatment have made this embarrassing problem more solvable. Perfecting pelvic floor muscle training and prevention of the problem in the first place are areas that need further research. Treatment of male incontinence lags behind female incontinence management in terms of research output but an increased incidence of post-prostatectomy incontinence is driving research efforts to correct this. Looking at where incontinence management has come from helps to clarify its future direction.

References

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Australian news

World Continence Week 2011
After 12 months of planning, the CFA was very excited to launch Australia’s first World Continence Week in Adelaide, on Friday 17 June 2011. This event was attended by 75 CFA supporters and was used as a forum to launch three key initiatives:

- The Deloitte Access Economics report *The economic impact of incontinence in Australia*.
- The Pelvic Floor First campaign.

The Access Economics report highlighted the need to continue to dedicate funding and resources toward the prevention, management and treatment of incontinence, in light of the projected increase of incontinence in the Australian population over the next two decades. The key findings of the report showed that:

- In 2010, the total financial cost of incontinence (excluding the burden of disease) was estimated to be $42.9 billion.
- This applies to the estimated 4.8 million Australians* currently living with incontinence.
- The prevalence of urinary, faecal and mixed incontinence is estimated to increase to over 6.4 million Australians* by 2030.
- This will increase the financial cost of the issue in terms of health system expenditure, lost earnings, costs of formal and informal care and aids and equipment.

*Please note that these figures encompass the general community and residential aged care.

World Continence Week also highlighted how we can think outside the square in terms of continence promotion, with Pelvic Floor First presenting a perfect example. We hope to feature a number of examples of the innovative ways in which this year’s topic was promoted around Australia in the next edition of the Journal and share what we learnt with our New Zealand colleagues who adopted the same theme.

Exercise and the Pelvic Floor forum
On 24 June 2011 the CFA held a multidisciplinary forum on Exercise and the Pelvic Floor to support World Continence Week 2011. This event was attended by 200 health and fitness professionals and provided a great opportunity for professionals to learn about each other’s practice – and how this relates to continence promotion and care. It also demonstrated how much we have achieved in terms of creating links between health professionals who treat incontinence and the fitness industry. We look forward to continuing to strengthen this link, in order to support pelvic floor safe exercise for all Australians with – or at risk of – incontinence.

Pelvic Floor Fitness videoconference
On 22 June 2011 the CFA National Office, in partnership with the Jean Hailes Foundation for Women’s Health, made its first foray into the world of videoconferencing, hosting a Pelvic Floor Fitness forum that was broadcast across Australia.

This topic was met with overwhelming enthusiasm and interest, with 37 remote sites registering for the event. We hope to do a lot more work in this area over the next few years, utilising videoconferencing, webinars and other technology to reach our colleagues in rural and remote Australia.

Paediatric continence education
On 3 June 2011, the CFA held a Paediatric Bowel Dysfunction study day in Brisbane. The health professionals attending this event included continence nurse advisors, continence and women’s health physiotherapists, occupational therapists and stomal therapists. The programme covered topics including the assessment and management of children with bowel dysfunction, diagnostic testing and pharmacological and surgical interventions for treatment resistant constipation.

This event was one of a series of study days that will be rotated across Australia and cover the topics of bowel dysfunction, bladder dysfunction and nocturnal enuresis. To find out more about these events, email education@continence.org.au

National bladder and bowel health promotion about to take off!
CFA National in conjunction with CFA State Resource Centres and State Branches are in the final stages of recruiting five new health promotion officers to be based in New South Wales, Victoria, Queensland, South Australia and Western Australia.

These exciting new roles have been funded under the Bladder Bowel Collaborative and will focus on promoting continence at a grass roots level. This will enable the CFA to continue to raise community awareness about bladder and bowel health and the prevention of incontinence, facilitate education for people about the treatment and management options for incontinence and encourage people to seek professional help.
All five recruits should be on board and ready to go by the end of July, with the first having commenced in Western Australia on 11 July 2011. Exciting times ahead!

Continence scholarships open for 2011
Applications for the 2011 National Continence Scholarship Programme are now open, with 10 scholarships available to support nurses and physiotherapists working in rural and remote Australia to attend the 20th National Conference on Incontinence.

Applicants must be currently registered and be able to demonstrate that continence management is a key part of their role.

For further information visit www.continence.org.au or email scholarship@continence.org.au

Continence Carer of the Year Award
The Carer of the Year Award acknowledges the challenging role that many unpaid carers face when dealing with the continence needs of a family member or friend. Generously sponsored by TENA, this year’s award is open to all unpaid carers looking after a person with incontinence. Nominations are invited from around Australia and you as health professionals are ideally placed to identify and nominate any outstanding carers you work with.

Applications close Friday 30 September 2011. For further information or to apply, visit www.continence.org.au

Barry Cahill, CEO CFA

New Zealand news

World Continence Week (WCW) is over for another year. It was a very hectic lead-up to the week and a busy time dealing with the media. Pelvic Floor First, the programme devised by the Continence Foundation of Australia and sponsored by the Australian government was an excellent initiative that they kindly allowed us to join and we were able to convert their resource into a New Zealand version.

This will be an ongoing initiative and is just the beginning of a process of educating fitness professionals by getting them more involved with screening clients and teaching appropriate pelvic floor safe exercise. We managed to get a four-minute interview on the Breakfast Show and a five-minute exercise segment, each morning of World Continence Week, on TVNZ’s Good Morning. The Breakfast Show interview is on our website.

We ran three, one-day education sessions for fitness professionals and midwives in the run-up to WCW and the Auckland one was postponed until next month. We are getting enquiries from other fitness professionals in those areas who have heard the feedback but we don’t have plans to repeat these in the near future. The CFA as part of the Pelvic Floor First initiative has developed an excellent PowerPoint presentation, again including NZ stats that was only available in the middle of WCW but can be used by physios and experienced continence advisors for future education events. This would take one to two hours to present. If you are in this group and would like to use this resource, please contact email NZCA zoe@continence.org.nz and we will send you a DVD. This programme is copyright to the CFA and cannot be shared or copied.

The CFA released a report on the economic cost of incontinence in Australia during WCW. We wrote up a report based on this and extrapolated the figures. This shows that the economic cost of incontinence to the NZ economy to be $8 billion per annum. Both the report and media release are available on the website. I lobbied hard with the media to get them to cover this but without success at this point. Both the NZ Herald and Herald on Sunday reporters were keen but they couldn’t get it approved at their planning meetings. TVNZ’s response was that it would be better covered by print media, rather than TV. I had a 37-year-old woman and an older man prepared to talk to the media, which is difficult to arrange, so the outcome was disappointing especially considering the media coverage of the sick penguin ‘Happy Feet’ a week or so later.

Jackie Brown has written a children’s book titled A wee secret. This has excellent illustrations and is a great resource for parents and caregivers. This was funded through the KEEA division of the NZCA and is available for $15 from our website www.continence.org.nz

Jan Zander, CEO NZCA

Nominations sought for Peer Review Panel

Experts from the disciplines involved in continence treatment, management and promotion and those who are expert in research methods and statistical analysis are invited to nominate to join the Australian and New Zealand Continence Journal Peer Review Panel.

Peer review was introduced to the journal in 2004 and began an exciting new era in our publication. Peer review of articles is aimed to increase the calibre of academic and research papers published and to raise the standing of the journal.

The journal is proud to promote Australian and New Zealand scholarship.

For details regarding the Peer Review Panel, please email Jacinta Miller jacmil@bigpond.com

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Calendar of events

2011

29 August – 2 September
41st Annual Meeting of the International Continence Society (ICS)
Glasgow, Scotland, UK
Web: www.icsoffice.org

9–11 September
The 15th Australasian Menopause Society Congress
Brisbane, QLD
Web: www.ams2011.com.au

12–15 September
Aged and Community Services Australia (ACSA) 2011 National Conference
Are we listening to older Australians?
Sydney, NSW
Web: www.agedcare.org.au

14–17 September
AUGS 32nd Annual Scientific Meeting
Rhode Island Convention Centre, Providence, Rhode Island, USA
Web: www.augs.org

18–22 September
21st World Congress on Ultrasound in Obstetrics and Gynecology
Hyatt Regency Century Plaza, Los Angeles, California, USA
Email: Lawrence Platt congress@isuog.org

19–22 September
Men’s Health Gathering 2011 includes 9th National Men’s Health Conference
Australian Men’s Health Forum
Pan Pacific Hotel, Perth, WA
Web: www.workingwithmen.org.au

23–24 September
ICCS course: Paediatric Incontinence into Adulthood
Taipei, Taiwan
Web: www.i-c-c-s.org

27–30 September
9th International Scientific Meeting (RCOG)
Athens, Greece
Information: Royal College of Obstetricians and Gynecologists
Email: info@rcog2011.com

11–13 October
Urogynz 2011 Evidence Based Urogynaecology Conference
Queenstown, NZ
Web: www.akhlimited.co.nz/urogynz/

14–15 October
Australian Gynaecological Endoscopy Society (AGES) Focus Meeting 2011
Gynaecological Complexities and Conundrums
Perth, WA
Web: www.ages.com.au

18–20 October
Diagnostics and treatment of children’s incontinence
Moscow, Russia
Organised by the International Children’s Continence Society and the Russian Association of Pediatric Surgery.
Web: i-c-c-s.org

19–21 October
Community and Primary Health Care Nursing Conference
Royal College of Nursing Australia
Hobart, TAS
Web: www.renau.org.au

23–25 October
9th International Association of Gerontology and Geriatrics (IAGG) Asia/Oceania Regional Congress
Ageing Well Together: Regional Perspectives
Melbourne Convention and Exhibition Centre, Melbourne, VIC
Web: www.ageing2011.com

27–30 October
Physiotherapy Conference 2011
Australian Physiotherapy Association
Convention and Exhibition Centre, Brisbane, QLD
Web: www.physiotherapy.asn.au

16–19 November
20th National Conference on Incontinence
Crown Convention Centre, Melbourne, VIC
Web: www.continence.org.au

27–30 November
RANZCOG 2011 Annual Scientific Meeting
Today’s Science, Tomorrow’s Practice
Melbourne, VIC
Web: www.ranzcog2011asm.com.au

8–11 December
15th World Congress on Controversies in Obstetrics, Gynecology & Infertility (COGIFTM)
Sanya Hainan Island, China
Web: www.congressmed.com/cogichina/
Electronic submission of manuscripts to the journal

The Australian and New Zealand Continence Journal now offers authors the ability to submit articles via a web-based system.

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- Enter your personal details: all fields must be completed.
- Confirm your details.

Submitting an article

- Step 1 – Type the title, type of paper and abstract. Select publication – ANZCJ.
- Step 2 – Confirm author. Add co-author details (all fields) if applicable.
- Step 3 – Upload files. Please ensure your document contains the required information and is formatted according to the author guidelines. PLEASE NOTE THAT AUTHOR DETAILS SHOULD BE ON A SEPARATE COVER PAGE. DO NOT INCLUDE AUTHOR(S) NAME(S) IN THE BODY OF THE ARTICLE.
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- Step 5 – Review your information then click submit.

Once submitted, the manuscript is reviewed by the editor and, if acceptable, sent for peer review.

Peer review

Peer reviewers will be asked to review the manuscripts through the electronic process.

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