The Rural Research Capacity Building Program 2010
Final Report for the Research Project

Health Workers' Management of Incontinent Clients in Rural NSW

"We Do What We Can"

Principal Researcher:
Louise Linke
Nurse Practitioner
Continence Advisor/ STN
Western NSW Local Health District
Bathurst Community Health Centre
Bathurst 2795
Ph: 02 6330 5676
Fax: 02 63
Louise.Linke@gwahs.health.nsw.gov.au

Table of Contents

Acknowledgements

I would like to acknowledge and express my gratitude to the following people for their support during the course of this project:

The health workers, who generously gave their time and shared their experiences and thoughts for this study.

Emma Webster and David Schmidt, who listened, supported and repeated their words of wisdom when I needed concepts explained several times so as to better understand research.

My mentor, Julie Tall, whose patience, knowledge and advice helped to make the research journey less rocky.

Managers at Bathurst Community Health, who encouraged and supported me to undertake the research project.

The 2010 fellow researchers, whose "team effort" and encouragement helped to get the project completed on time.

Funding for this project was made available by the Rural Research Capacity Building program of the NSW Health Education and Training Institute.

List of Abbreviations

Abbreviation	Meaning
AHS	Area Health Service
AI	Anal Incontinence
CETI	Health Education and Training Institute
CFA	Continence Foundation of Australia
CIAP	Clinical Information Access Portal
CHC	Community Health Centre
FI	Faecal incontinence
LHD	Local Health District
NCA	Nurse Continence Advisor
NSW	New South Wales
NP	Nurse Practitioner
UI	Urinary Incontinence
RRCBP	Rural Research Capacity Building Program

Glossary of Terms

Active management strategies	Can include managing constipation, monitoring fluid intake, teaching pelvic floor exercises, bladder training and education of incontinence management.
Anal Incontinence	The involuntary loss of flatus, liquid or solid stool that is a social or hygienic problem.[1]
Continence Aides	Equipment that is used to contain urine and/or faeces when a client is incontinent. This can include pads, pullup pants, uridomes, catheters, mattress protector.
Encopresis	The voluntary or involuntary passage of faeces in inappropriate places in a child four years of age or older after organic causes have been ruled out.[2]
Nocturnal enuresis	The intermittent incontinence of urine while sleeping.[2]
Passive management strategies	Providing continence aides or referring to specialist continence services without doing an assessment or discussing other management strategies.
Specialist continence service	Dedicated continence services with health workers trained in continence management.
Specialists Nurses	Are those nurses who specialise in a particular area of nursing e.g. women's health nurse, chronic care nurse
Urinary Incontinence	The complaint of any involuntary leakage of urine.[1]

Abstract

"We do what we can"

Health workers' management of incontinent clients in rural NSW

Background

Incontinence is a common problem and can significantly decrease a person's quality of life. The incidence of incontinence increases with age, with one in three women experiencing incontinence throughout their lifetime. In 2010, incontinence cost the Australian community approximately $42.9 billion dollars.[3] The management of incontinence is essential if people are to age at home.

Aim

The aim of this study was to determine how nursing and allied health clinicians currently provide continence services to clients of the Western NSW Local Health District (LHD) and how those services can be improved.

Methodology

The research was carried out using qualitative methods and a positivist approach. Seven one-on-one interviews and four focus groups were conducted with nurses and allied health clinicians who manage clients who are at risk of incontinence. Transcripts of the discussions were coded and thematically analysed.

Results

All clinicians believed they had a role to play in managing their clients who were incontinent. However this did not always translate into practice with the level of identifying, assessing and managing incontinence varying between the health clinicians.

Several factors affected the care delivered to clients with incontinence. This included the clinician's level of knowledge relating to continence care and their attitude towards continence management. Competing clinical priorities and lack of time made providing continence management more difficult for the community based nurses. A lack of continence specialist services was also identified as a barrier to providing continence services. The level of the client's knowledge relating to continence management influenced their attitude and whether they sought help for their incontinence. Clinicians identified continence education and an increase in specialised continence resources as enablers for them to improve continence care for their clients.

Conclusions

An increase in resources, education and support for the health clinicians who mange these clients is vital if they are to successfully manage incontinent clients.

Key words:

Incontinence, urinary incontinence, continence management, attitude, community care

Executive Summary

Background

Incontinence is a common problem and can significantly decrease a person's quality of life. The incidence of incontinence increases with age, with one in three women experiencing incontinence through out their lifetime. In 2010, incontinence cost the Australian community approximately $42.9 billion dollars.[3] With an aging population, the management of incontinence is essential if people are to age in the home. Ageing at home can decrease the risk of deteriorating health and quality of life.

Aim

Few studies have examined how continence services are managed in rural areas. Most of the previous studies have been based in metropolitan areas and overseas. The aim of the study was to obtain a better understanding of how nursing and allied health clinicians in the Western NSW LHD currently manage clients with incontinence. The study also aimed to identify the difficulties faced by clinicians in providing continence services to their clients and how those services may be improved.

Methodology

The research was carried out using qualitative methods and a positivist approach. This allowed for a more in-depth understanding of how the nursing and allied health clinicians perceived their role in continence management. Four focus groups and seven one-on-one interviews were conducted. Thematic analysis of the data was undertaken after the data was coded.

Participants included chronic and complex care nurses, community and district nurses, women's health nurses, psychologist, physiotherapist, nurses in acute facilities and occupational therapists. These clinicians manage a variety of clients including those with chronic disease and disabilities, postnatal and post-menopausal women, the frail and aged, and children who are at high risk of incontinence.

Findings

Overall most of the clinicians in the current study identified continence management as part of their role and several of the specialist clinicians provided this service. However there were several factors that hindered non- specialist clinicians from providing continence care. The lack of resources and time to address the complexity of the clients they have to provide care for, was a barrier for some of the community-based clinicians. The clinicians' lack of knowledge about continence management also impacted on how they provided continence care. Those clinicians who were knowledgeable and confident in continence management provided more active management strategies for their clients. However those clinicians who had less knowledge of continence management were also less confident in continence management and were more likely to provide passive management strategies. The client's attitude towards and knowledge of, incontinence management also impacted on whether they sought help for their incontinence.

Recommendations

Health clinicians have been identified as being ideally placed to improve outcomes for clients who are incontinent. An increase in resources, education and support for the clinicians who mange these clients is vital if they are to successfully manage incontinent clients. Note that all recommendations are necessary, as no single recommendation is likely to be sufficient to address continence care adequately.

Support for clinicians who manage clients with less complicated incontinence, so that the specialist continence service can then manage the more complicated cases of incontinence. Local continence "champions" will be identified to support local clinicians in continence care. These "champions" will be support by the specialist continence nurse.

Localised education and resources related to continence care will be available for clinicians. This may involve face-to-face, videoconferencing or Internet teaching. The Western NSW LHD specialist continence nurse and other personnel in the continence area are well placed to provide education. Teaching resources for the specialist continence service to provide the education to clinicians, such as teaching models, to assist in teaching catheterisation will be needed.

Guidelines and Pathways related to continence assessment and management of incontinent clients will be implemented. More formal referral pathways for the clinicians to use when providing care for their incontinent clients will also be developed.

Increase the number of clinicians specifically working in the continence specialist service, to help carry out these recommendations and assist the current continence specialist staff to manage the more complicated cases of incontinence.

Community-based education programs to inform the community about incontinence management and the availability of services will be offered.

Introduction

This report is a result of a two year research program carried out by the author whilst a research candidate with the Rural Research Capacity Building Program of the NSW Health Education and Training Institute (HETI), 2010-2012. The aim of the research was to establish how health workers in the Western NSW Local Health District (Western NSW LHD) manage their clients who are incontinent, what were the enablers and barriers for the clinicians providing this service, and how continence management could be improved.
The report will detail why there was a need to conduct the research, how it was carried out and recommendations for the future management of continence services in rural NSW.

Literature Search

The literature review was commenced in 2010 and the Clinical Information Access Portal (CIAP) was the database used for the literature search. The search was restricted to articles in English and full text. Due to high the number of articles found, only post-1985 articles were reviewed. Articles were selected when they discussed the impact of incontinence on the client, health workers attitudes towards incontinence and the role of health workers in managing incontinence. The key search terms included: incontinence urinary incontinence, faecal incontinence, health workers, nurse, and attitudes. Articles relevant to carrying out qualitative research were also selected.

Background and Literature Review

The International Continence Society has defined 'urinary incontinence' as the complaint of any involuntary leakage of urine and 'anal incontinence' as the involuntary loss of flatus, liquid or solid stool that is a social or hygienic problem.[1] The financial cost of incontinence on the Australian community was estimated to cost $42.9 billion dollars in 2010 or approximately $9,014 per person with incontinence.[3] In 2010, the total loss of productivity, such as missing days at work or needing to leave their workstation to go to the toilet more frequently due to incontinence was estimated to cost the community $34.1 billion.[3]

According to the Continence Foundation of Australia, over 4.8 million Australians experienced bladder and bowel incontinence in 2010.[3] The risk of incontinence increases as people age. For men up to 30% of men aged 70-84 years and 50% of those over 85 years experience urge incontinence. One in three women experience incontinence during their lifetime and are most at risk during the postnatal and postmenopausal stages of their life.[3] By 2030, it is expected that 27% of the population over the age of 15 years old will be incontinent due to the increase in the number of older people.[3] People with disabilities and neurological disorders are also at risk of developing incontinence.[3]

In the Western NSW LHD the proportion of people living in rural areas that are aged 60 years or older is 23%. Local government areas such as Cabonne, Cowra, Oberon and the Mid Western Region have greater than 25 % of their population over 60 years old.[4] Whilst in metropolitan areas, the total number of people over the age of 60 years is 17.6 %.[4] The higher proportions of aging population within the rural LHD

could potentially put added strain on the services that manage these clients who could become incontinent.

People living in Western NSW LHD have higher rates of alcohol intake, smoking and obesity. They also have lower levels of fruit consumption and physical activity, than the rest of the NSW population.[4] In addition there are higher rates of hospitalization from cardiovascular disease, diabetes and chronic obstructive pulmonary disease than the rest of the state[4]. Twenty five percent of people living in the Central West are classified as having a disability that requires assistance in one or more activities, compared to the rest of NSW rate of 19%.[5] Since these health behaviours and conditions are risk factors for incontinence, the residents of the Western NSWLHD are more at risk of incontinence than the rest of the state.

Between 2006 and 2011 there was an annual average of 705 episodes of care for urinary disorders (urinary tract infections, cystitis, urethritis, neuromuscular dysfunction and incontinence) in public hospitals and multi-purpose services across the Western NSW LHD. These episodes of care accounted for 1% of all episodes of care for all conditions for Western NSW LHD per year. Of the aforementioned urinary disorders, 55% of episodes of care were delivered in base hospitals, 29% in district hospitals and 16% in multi-purpose services. An annual average of 40 episodes of care was for incontinence. The male to female ratio for the selected urinary disorders was 1:2 and for incontinence alone was 1:16. Thus females are many times more likely to receive inpatient care for incontinence than males. Inpatient episodes of care occurred most frequently in those aged 70 years and older for all aforementioned urinary disorders, and in those aged between 40 and 74 years for incontinence alone.[6] Therefore providing improved incontinence management for the client whilst they are at home could help to prevent these avoidable admissions to hospital and the disruption to their lives.

Incontinence can have a negative impact on self-esteem, motivation, dignity and independence. Up to 20% of incontinence sufferers indicate that they experience depression, frustration, embarrassment and sadness while 26% chose to socialise less due to their incontinence.[7] Up to 65% of women and 30% of men that attend GP services report some type of urinary incontinence but only 31% report seeking help from a health professional.[8] Anal incontinence is also under-reported with up to 80% of people with this problem not telling their doctor due to embarrassment.[9] Incontinence and the inability to manage it at home are significant factors for older people being institutionalized.[10]

Previous research[11] has indicated that in general continence service delivery, particularly in rural Australia is insufficient to meet the needs of the community and this is the situation for the area serviced by the Western NSW LHD (incorporates an area from Oberon to Condobolin and Rylstone to Grenfell). These regions support a population of approximately 180,000.[5] The continence advisor also provides comprehensive stomal therapy services to clients. Part of the continence specialist role is to provide a collaborative approach to continence assessment and management of clients with incontinence. Williams[12] study showed that this type of service is effective in reducing incontinence symptoms and had high levels of client satisfaction.

Covering such a large geographical area means that the specialist continence advisor cannot provide regular clinics in some of the smaller towns and often clients are unable to travel to larger centres where regular clinics are held. These smaller towns have community nurses that provide a primary health care service who are often the first point of contact for clients with incontinence.
Previous studies indicate that up to 70% of clients with incontinence can achieve improvements in symptoms and quality of life when conservative treatment methods are used.[10, 13] These treatment methods included managing diet, fluid intake and weight, bladder and pelvic floor exercise training and education. Since nursing and allied health staff play a significant role in primary health care, such staff would be appropriate for delivering conservative continence therapy and thus be able to manage those clients with routine forms of incontinence. The continence nurse could then manage the more complicated incontinent clients.

However barriers have been identified that hinder primary health care staff from providing incontinence management care. Several studies[10, 14-17] have shown that the clinician's level of knowledge and attitude towards continence management, competing clinical priorities and the lack of time to complete incontinence care, impacted on the level of care that incontinent clients received from health care clinicians. Despite these barriers, studies[15, 18 - 22] have shown that nurses, given continence training and specialist support, can effectively manage clients with simple forms of incontinence.

Aims of the Research

Few studies have examined how continence services are managed in rural areas. The aim of this study is to find out how nursing and allied health clinicians in the Western NSW LHN currently manage clients with incontinence. The study also aims to ask the participants to identify enablers and barriers that affect how they provide care for the incontinent clients and to identify strategies to improve continence services. It was anticipated that any recommendations made could also be relevant for similar geographical areas.

Study design

The research was carried out using qualitative methods drawing from a positivist perspective.[23, 24] Positivist theorists believe that "the goal of knowledge is simply to describe the phenomena that we experience" (Trochim, 2006). [25] Using a positivist approach allowed for a more in-depth understanding of how the nursing and allied health clinicians perceived their role in continence management. This approach also gave clinicians an opportunity to share their experiences, express their needs and contribute to future directions in continence care for their clients.

Sampling

Purposive sampling was used in this study so that the participants were those who had had experience with incontinent clients.[24] They included nursing and allied health clinicians who managed clients that were incontinent or at risk of incontinence. Such staff included chronic and complex care nurses, community and district nurses, women's health nurses, a psychologist, nurses in acute facilities and an occupational therapist. The Western NSW LHD in either the community health centres or acute facilities employed all participants. Participants managed a variety of clients including those with chronic disease and disabilities, postnatal and post-

menopausal women, the frail and aged, and children at high risk of incontinence. Whilst incontinence may not be the main reason for referral of these clients to the participants' service, their assessment could include questions and dialogue relating to their clients' continence status**.** The participants had day-to-day access to clients with incontinence and were in a position to comment on current management practices and what was required to improve continence care for clients.

Recruitment of Participants

The managers of the potential focus group participants were contacted to ask if the investigator could speak to the staff about being involved in the study. The investigator spoke to the staff at their community health team meeting, inviting them to take part in the research (Attachment 1). These potential focus group participants could also opt to be involved in a one-on-one interview if it was more convenient for them or if they felt more comfortable in a one-on-one session.
Potential interview participants were invited to take part in the study via a letter (Attachment 2). Letters were also sent to the managers of potential participants, advising them that the clinician was being invited to take part in the study (Attachment 3). Involvement in the research was voluntary and participants could choose to withdraw at anytime.

Samples size

A sample size was important to ensure that that the investigator could collect sufficient "rich" data for analysis to answer the aims of the study[25]. To achieve this, the investigator proposed to run 4-6 focus groups, with 4-10 participants in each group and five to seven one-on-one interviews. This was also a realistic number of focus groups and one-on-one interviews for the investigator to manage within the timeframe of the study**.**

Data instruments

Questions and prompts for the focus groups and one-on-one interviews were developed and trailed with several health clinicians, who could also see clients who may be incontinent. Adjustments were made to the final questions before they were submitted to the ethics committee for final approval (Attachment 4).
A brief written questionnaire was given to participant at the beginning of the focus group and one-on-one interviews to determine the context in which continence services were provided. In particular the written questionnaire collected information from the participants relating to their current role and the types of clients they see in their practice. It also asked participants to rank their level of confidence in providing continence care to their clients and how often they referred incontinent clients to the specialist continence service (Attachment 4).

Data collection

Each focus group took between 25-55 minutes to complete and was digitally recorded. The transcript was de-identified for confidentially and transcribed verbatim. A scribe was available for one of the focus groups to record key findings.
Each one-on-one interview took between 15-45 minutes to complete and was digitally recorded. The transcript was de-identified for confidentially and transcribed verbatim.

All of the transcripts were checked against the digital recordings for accuracy. The participants, who consented, were sent a copy of the transcript to check that the content accurately represented their view. None of the clinicians contacted the investigator to ask for changes to be made to the transcript.
The investigator took field notes of the key experiences and observations that were identified during the focus groups and interviews immediately after they were completed.[24] The field notes were deliberately not completed during the interview process, so that the researcher could concentrate on the dialogue that was occurring.
The data was thematically analysed using an inductive approach.[26 -28] Data items were coded and organised into emergent themes. An experienced researcher confirmed the key themes that were identified by the investigator. Thematic saturation was achieved indicating that sufficient data was collected. This was reached at the second last interview.

Ethics Approval

In September 2011, the Greater Western Area Health Service Health Research and Ethics Committee granted approval (including Site Specific Assessment) for the research to be carried out - HREC/11/GWAG+HS/14. All participants who were asked to participate in the study provided written consent.

Findings of the study

Participants

There were 23 participants who took part in the study. The participants included nursing and allied health clinicians: chronic and complex care nurses, community and district nurses, women's health nurses, assistants in nursing, a psychologist, a physiotherapist and an occupational therapist who managed clients that were incontinent or at risk of incontinence. The nursing clinicians ranged in expertise from assistants in nursing to nurse practitioners.

Four focus groups agreed to take part and a mutual time was organised to conduct the interview at the participants' work place. Each group had between 3- 6 participants.
The participants who took part in the one-on-one interviews did not take part in the focus group interviews.
Seven participants agreed to take part in the one-on-one interview. The interview was held at the participant's work place and two were conducted via telephone, as this was more convenient for the participant.

Research setting

The clinicians at four-community health centres located in rural areas took part in the study. Two centres were made up of small multidisciplinary teams with visiting health services. The population in these centres ranged from 3,000 to less than 10,000 people. Two of the community health centres were based in regional cities with a population of greater than 35,000 people. These centres consisted of large multidisciplinary teams. The two acute hospitals involved in the study were also based in the same regional cities.

Clientele and location of service delivery

Clients seen by the nursing and allied health clinicians were predominately elderly adults, with two of the clinicians also providing services to children.

Clients received services mostly at the community health centre, in their home or at the local hospital. The occupational therapist usually provided services to the client in their home, whereas the women visiting the women's health nurse clinic or clients referred to the psychologist were generally seen at the community health centre.

Type of services provided by the clinicians

The community based nursing services provide ongoing monitoring of clients health and medications. The clients are generally elderly and at high risk of developing incontinence.

The women's health nurse provides well- women checks, screening and health advice to antenatal, postnatal, menopausal or older women, all of whom may experience bladder and bowel dysfunction.

The chronic care services see complex clients such as those with diabetes, heart failure and respiratory disease, all which increase the client's risk of incontinence.

Patients in the transitional care unit are involved in a graduated discharge process from the hospital to their home after surgery or a major health incident (stroke) and are provided with personalised health care programs. These patients may be incontinent or at risk of incontinence.

The cardio pulmonary nurses provide exercise programs and advice about health issues for clients who have had a cardiac event or lung disease. Many of these clients have co- morbidities, which increases their risk of incontinence.

The occupational therapist provides services to develop, restore and improve a client's independence, whilst the physiotherapist focuses on improving a client's movement and function. Improving mobility is essential for reducing the risk of incontinence.

Children who experience encopresis, faecal soiling and nocturnal enuresis are referred to the psychology service for behavioural management and counselling.

Current Incontinence Management Practices

Assessing continence status

Most of the clinicians were proactive in determining their client's continence status. The community-based nurses were prompted by questions on the minimum data set forms to routinely ask clients about their urine and anal continence status, whilst specialist nursing and allied health clinicians asked clients about continence whilst caring for them.

> *"It is definitely a question we ask when we see the clients... do they experience any problems with their continence? Do they have urinary frequency, urgency or nocturia? Whether they have incontinence when they cough or sneeze?" Abby*

Other participants were less proactive and more reactive in identifying the client's continence status and only raised the issue if their client exhibited signs of bladder or bowel dysfunction.

"Opportunities would be in our gym situation, if the client was going to the toilet frequently, then we would ask them if they were having any problems" Pat

In contrast, when some clinicians were asked if they enquire about their client's continence, they replied *"No, not as a rule" Pat*

The clinicians who asked the client about their continence status always asked about urinary incontinence, but they did not routinely ask about anal incontinence unless they were prompted by the client's symptoms or the client raised the subject.

"We talk about their bladder, but they don't actually get an opportunity to tell me about bowel problems" Betty

Providing incontinence intervention

All health workers interviewed believed they had a role to play in managing their clients who were incontinent.

"I think it's our responsibility to assess and get all the details, and implement where we can" Liz

The clinicians provided several aspects of continence management including offering advice and therapy and evaluating the client's progress.

"so we will look at if they are incontinent, how frequently are they incontinent, are they sitting in wet undies or pads all day and that moisture can create issues and looking at options" Marg

The clinicians offered suggestions to incontinent clients including completing a bladder diary, advice on continence aides, managing constipation, diet, fluids, and toileting regimes and funding schemes that help the clients buy continence aides.

"Working with the client on their behaviour, fluid intake, toileting, enuresis alarms, supporting parents and education about "normal" bladder habits" Jo

The level of the clinician's involvement in the incontinent client's care was often a product of the clinicians' level of expertise. Clinicians with higher levels of expertise carried out more comprehensive assessments and spent more time with the client developing treatment plans, offering advice and evaluating their client's progress before making the decision on whether to refer the clients onto the specialist's service.

"I ask them about their diet, I ask them how they manage it, have they had problems in the past and how have they managed it. I ask them about their fluid, food intake and aperient intake. I like to advise them to speak to their pharmacist and doctor. I talk to them about exercise and things they can do like pelvic floor exercise as well" Abby

The type of treatment offered by the clinician to the client depended upon the clinician's speciality area. For example the women's health nurse and physiotherapist discussed mainly pelvic floor exercises, whilst the occupational therapist looked at other strategies.

"….such as a commode or installing rails near the toilet" Marg

Less qualified clinicians tended to advise the client on toileting regimes or provide pads rather than taking a more holistic approach by assessing the clients and basing the client's management on clinical findings.

"My role would be to keep the person as comfortable as possible…so basically making sure the person has the right pad" Suzy

The community-based nurses tended to offer a variety of advice including life style modifications, management of constipation, diet and fluid intake and the use of continence aides.

The clinicians were asked about their referral patterns of incontinent clients. The pre interview questionnaire indicated that 57% of the participants referred clients to the specialist's continence service only occasionally, 26% frequently and 17% rarely. The specialist clinicians generally only referred after the management plan had been evaluated and felt that the client needed more specialised continence care for the continence service.

"I try and manage the women that come to me, before I pass them (onto the specialist continence service), otherwise she could end up seeing people who could be treated at a lower level" Barb

"If treatment isn't effective and it doesn't work, then when they come back and see me I will refer them on" Liz

Allied health clinicians referred clients onto the continence specialist services when they lacked the knowledge about other issues that were influencing the client's incontinence such as disabilities and mental health illness.

"If the client is complex and our skills haven't got their issues under control" Marg

Several clinicians indicated that as soon as their client experienced incontinence, they referred the client directly to the specialist service or GP without offering any advice or treatment.

"I would probably prefer to ring you... rather than get into the continence care" Ros

Most of the health workers liked to get feedback from the specialist service about their client's assessment and ongoing management. They commented that this information helped them to offer ongoing management and support to their clients.

"Feedback is good and it helps to fill in the picture a bit better" Linda

Enablers for continence management

Clinicians' attitude towards managing incontinent clients

Several of the clinicians strongly believed that it was everybody's role to identify and manage incontinent clients. They indicated that in order to manage their clients holistically they needed to also manage their incontinence.

"*I think with the increasing number of people in our community with chronic illnesses and obesity, I think it's going to have to be everybody's business to ask the question... I think it's a clinician's job to take a good history" Abby*

In the pre -interview questionnaire, 43% of the participants felt confident in providing continence services to their clients

"I try and trouble shoot as much as I can, so that I am not referring everyone to the doctor or continence service" Abby

Support and collaboration

Several participants indicated that support from the specialist continence service was important with helping them manage their incontinence clients by providing information, advice and a referral service.

"I use the continence service as a really big resource if I've got a question or a query at the moment I am fairly well set up, but if they ever left I would be in big trouble" Liz

Other clinicians talked positively about the support they got from their local peers when they needed help and advice.

"I usually talk to the girls- [referring to the other district nurses].. if I felt that some one was in dire straits" Von

Collaboration

Clinicians reported working collaboratively with other members of the health team to manage a client's incontinence.

"I would be working with other professionals, doing the teamwork" Jo

Knowledge

Some of the specialists clinicians felt that they their knowledge of continence management was good. They had completed training in the area of continence and found this to be a positive experience. This allowed them to feel more confident in assessing and developing management strategies with the client.

"The conference in Canberra this year.. it was put on by Continence Foundation……was really good. Really worthwhile" Liz

Client attitude towards their incontinence

Clinicians reported that some clients were motivated to seek help to improve their incontinence.

"The ones that bring it up are the men who have just had some prostate intervention" Linda

"A lot of our patients are elderly people with dementia and often it is the family that asks us to do something about it "Jo

Clinicians found it much easier to work with these clients developing individualised management plans. Furthermore, when a client's incontinence was well managed, clinicians found that the client was more likely to attend activities and exercises scheduled at the health facility.

"It (incontinence) stops more from exercising than the breathlessness... for these people with a suitable continence aid on, they feel more confident. ...They're more likely to come and do their exercises" Linda

Barriers to continence management

Limited specialist continence services

While some clinicians found the services of a single continence advisor to be adequate, most participants commented that having only one nurse continence advisor to cover a large geographical area was inadequate.

"I believe that one continence advisor can't deal with it"Libby

"You have a big area to cover and we do look at that, before referring" Cathy

Staff described that they were often reluctant to contact and refer to the nurse continence advisor due to her being "so busy".

"We think "is this a major problem or what else can we do without referring to you, when there is only one of you" Donna

"A lot of us do hesitate because we know how busy you are" Trish

Limited Time

Most participants reported that they did not have enough time to complete their work adequately.

"Time, you need a fair bit of time to fully explain what you are talking about" Von

Several of the clinicians remarked about the difficulty of managing their working day when they needed to see "x" number of clients within a certain time frame. They reported that sometimes they were unable to complete all their work when they spent extra time discussing incontinence with a client.

"You talk to them about that while you are doing the dressing. If the dressing takes ten-minutes, you can still be there half an hour later after you have finished doing it, because you are worried about their incontinence" Donna

"With older people, you can't go there and in an hour go "dididid" and then walk out on them. You need to go over the information again, which takes time" Von

Other clinicians chose not to discuss incontinence at length with their clients to ensure that they could complete their own work.

" I know I have x number of other people to see and I know it takes time to explain pelvic floor exercises properly or any other thing that they are entitled to" Libby

" it could be as simple as they are not drinking enough or they are constipated... that that could take half an hour to get that bit of information and you don't always have that time" Libby

Many of the participants described how much time it took to explain to their clients, about where to access funds and equipment to managing their incontinence.
They also talked about just "padding up" the incontinent client with continence aides, because they didn't have enough time to do an assessment or discuss management strategies with the client.

"Would you like use a pad" and if they said "yes" I would supply that to them" Ros

Lack of local health worker support

Part-time clinicians described frustration when their full-time peers were not around to offer support and advice in relation to managing incontinent clients. Part-time clinicians often worked on weekends, which added to their dilemma, as the full-time staff generally didn't work on the weekend.

"When [staff member] is away we can get a bit unstuck. Who do we ask then?" Vicky

The local specialist clinicians also expressed concern that the local health clinicians did not refer incontinent clients to their service for further assessment and management. Instead they were just "*padding the client up*"

"I have been frustrated in the past because I think that I should have got referrals from other health provider. Instead of just being given pad after pad, without any other sort of intervention, when that person may have benefited from pelvic floor exercises" Liz

Lack of knowledge and expertise

Several of the clinicians felt that they knew "*pretty well zip*" in the area of continence, and that their lack of knowledge impacted on the care of their incontinent clients.

"My knowledge of that [incontinence] isn't very good. It would be good to understand about incontinence a bit better" Von

Most of the participants had only attended in-services locally and those that felt that their knowledge was lacking were reluctant to offer advice to their clients. Instead the client was referred onto other specialist services without having an assessment or advice given to them.

"I have got basic knowledge but I would like to know more so perhaps I don't have to refer them quite as frequently" Sue

The limited knowledge of the clinician may have impacted on their level of confidence in delivering continence services. In the pre- interview questionnaire, 31% of participants indicated that they were "not very confident" in providing continence services and 22% were "not sure"

"I realise my limitations, I don't want to send them down the wrong path" Sue

The community-based nurses described themselves as "*jack of all trades*" and having to do "everything". Their generalist role meant they saw many clients with a variety of conditions but did not always have specific knowledge and skills to manage a particular disease or conditions such as incontinence. By contrast the specialist clinicians did not express the same concerns and felt better equipped to deal with more complex conditions.

Client attitude towards incontinence

Whilst some clients were proactive in seeking information and advice regarding their incontinence, staff also indicated that many clients thought incontinence was inevitable as they got older and that "nothing could be done" to help them. They saw it as a" normal" part of aging.

"I am getting old. This [incontinence] is what happens when you get old' Sue

These attitudes influenced how the clinician managed these clients with incontinence.

'No I'm ok.' She was interested in getting pads only, nothing else" Liz

The clinicians described women as being more tolerant of becoming incontinent, because they were used to wearing pads throughout the different stages of their lifetime and therefore they were less likely to seek treatment for incontinence compared to their male counterparts.

"Women are more accepting due to menopause, periods and childbirth" Zoe

"They are used to wearing pads" Angie

Clinicians reported that parents often delayed seeking treatment for their children because they believed that bladder and bowel dysfunction was acceptable and therefore not worthy of treatment.

"They will say that they also have a "weak bladder" or "that's what I used to do as a child" Jo

Several participants talked about the women just wanting the "pads" and not wanting to try other conservative management strategies to improve their incontinence.

"They say... 'No. I just go and get the pads. That's all I've ever done" Gay

Participants also commented that the lack of education and information in the public domain made the acceptance of incontinence more common in the community.

"I think there is ignorance about what causes the problems, and women don't realise that its simple things like being overweight and drinking a lot of coffee or just simply having been pregnant. I think there is a lack of education and information in the community about it" Barb

Clinicians observed that when their clients had multiple health issues, incontinence was less important to manage than other conditions and so clients tended to "put up" with being incontinent.

"It's just part of their journey… It's the least of their worries" Simone

Clinicians attitude towards incontinence

Participants commented that embarrassment sometimes hindered discussion about incontinence with the clients. If the clinician did not feel comfortable discussing incontinence, the client was less likely to be asked about their continence status.

"It's that topic of conversation that no one really wants to go there and if you aren't comfortable talking about it, then you are not going to be comfortable talking to someone else about it" Linda

Participants also indicated that some clinicians did not believe continence management to be part of their role, limiting the number of clients whose incontinence would be effectively managed. Other staff expressed frustration over this attitude.

"Well in don't know why I do it [continence management] and they don't [other health worker]. But I think the staff on the ground; our domiciliary staff need to take more responsibility regarding continence issues" Abby

Improvements to continence services

Education and training for staff

All participants agreed that they would benefit from further education and training relating to continence assessment and management.

" I would like to be skilled up a bit more" Vanessa

"I would like more information about how to educate people about improving their incontinence situation" Donna

Several of the topics requested by the clinicians included: the role of the health worker in managing incontinent clients; identification of risk factors for anal and urinary incontinence; assessment and management strategies, tools and flow-charts and access to continence information.

"To know what an AIN is expected to do" Ros

"I would like to know what other options there…what chemist they can go to. Just some sort of local network that is available" Peter

"Is there like a flow chart that we are meant to be following so if we get to this- then we do that?" Von

The specialist clinicians in particular asked for more specific information about alternatives, they could offer clients, "*Rather than the client going from pelvic floor exercises straight to surgery" Liz*

Furthermore all of the participants agreed that to have the education delivered locally was the most convenient option for them and felt that"*If training is local, you have a better chance of convincing your manager" Marg*

Making appropriate referrals

Some of the participants requested clarification about **"***when it was appropriate to refer clients to the specialist continence services and when it was best to manage at a local level? "Marg*

Other suggestions by the participants to improve care included the need for more specialists working in the continence area.

"More of you … room for another 2-3 people in the speciality" Vicky

Making continence standard practice

One of the clinicians acknowledged that time was a factor but felt that health workers needed to "make time" with the client to discuss incontinence and that it should be part of everybody's role.

> *"I think we always need to ask the questions about incontinence and make the time…..Next week when you come back we will talk about incontinence" Abby*

Discussion of Findings

Participants of the current study believed that they had a role to play in identifying and managing clients with incontinence, but this belief did not always translate into practice. The study identified several factors that determined whether a health clinician delivered continence care or not.

Levels of clinical expertise

A clinician's level of education and knowledge of continence management seemed to determine whether the clinician addressed the issue of incontinence with their client or not. This finding is consistent with that of other studies[12, 14, 18, 19, 29] which showed that the more experience and knowledge a clinician had with regards to continence management the more comfortable and confident they felt to discuss continence management and provide active incontinence strategies with their clients. In the current study the specialist clinicians believed it was the role of all clinical staff to identify and manage incontinent clients. They indicated that in order to manage their clients holistically, they needed to also manage their incontinence. This view is supported by Gray[18] who stated that specialist nurses such as nurse practitioners should assess and manage incontinence in their clients in addition to respiratory, cardiac and diabetes as part of routine care.

The current study established that those rural clinicians with less knowledge and experience in continence care, for example some of the community nurses, assistants in nursing and cardio- pulmonary nurses, were not as comfortable discussing continence management with their clients and were more likely to provide passive management strategies. These clinicians were more likely to provide containment aides to the client or refer directly to the specialist continence service without first assessing or offering active management strategies.

Previous studies[17, 18, 21, 30-32] also found that many clinicians perceive providing continence aides as sufficient management for their client, without an initial assessment being carried out. Those clinicians reported that "padding up" was a positive step in managing their clients with incontinence. In another study[19] the community nurses, identified providing "pads" as the easier option especially when other clinician priorities, poor staffing levels and low client expectations impacted on the delivery of continence management.

Whilst passive management strategies are common practice, several studies [12, 18, 19, 31, 33] have shown that clients provided with more active management strategies, such as lifestyle and behavioural modification to manage their incontinence episodes, were seen to have an increased improvement of up to 70% in symptom relief. Clients also reported that when they were given strategies to manage their incontinence they were more confident in socialising again and

hence their quality of life improved. Therefore clients would benefit from more active management strategies to improve their incontinence as well as their lifestyle.

Participants of this current study identified the importance of improving their knowledge as one strategy towards providing better continence assessment and management for their clients. They identified several topics that needed to be addressed including how to assess clients for incontinence, what incontinence management strategies were available, how to use continence management tools and understanding the role of each category of clinician in the care of incontinent clients. Study participants expressed a preference for education sessions to be delivered locally to minimise time spent on travelling to other venues and reduce the need to replace staff attending education sessions. Other studies[9, 14, 20, 34, 35] also found that there needs to be an increase in the clinician's level of knowledge to help improve the continence care for their clients. Indeed, Pearson's (2002) [9] , study encourages tertiary training institutions to include continence education as part of their curriculum.

However previous studies[17, 30, 36] have shown that education alone may not be sufficient to improve outcomes for the clients. These studies found that the provision of education alone did not automatically translate to the clinician providing continence assessment and management activities for their clients. While relevant and evidence- based education for key clinicians is essential, it is not necessarily sufficient. Several studies[16, 36, 37] identified time, resources and ongoing support as additional elements for improving continence care in the clinical setting,

Limited time and supports

The community-based nurses in the current study reported that competing clinical priorities often resulted in too little time to provide incontinence care to their clients. This finding was supported by previous studies [19, 32] where nurses reported not doing comprehensive continence assessment due to lack of time. In the current study, nurses described having to see a certain number of clients within a defined time frame and if they spent too much time discussing continence management with one client, the nurse would get behind with the rest of their workload. Cheater's (2008),[32] study found there had been an increase in the clinical complexity of clients being cared for by community- based nurses resulting in an increased workload, without an increase in resources**.**

Limited specialist continence resources

Another barrier to providing adequate continence management identified in this current study was that there was only one specialist continence clinician to whom clients can be referred. Staff reported that they were sometimes reluctant to refer clients for fear of overloading the service. This finding is supported by other Australian studies,[11] [9] that showed the current level of specialised continence services to be insufficient, especially in rural areas. The researchers reported that continence services do not have a high profile, clients were often unaware of the current continence service available to them and referral patterns were inconsistent leading to ad hoc patterns of service delivery. This current study along with several others [9, 11, 12, 38] recognised that increasing the resources of the specialist continence service would contribute to improving service delivery for incontinent clients.

Client's knowledge

Participants of the current study indicated that the client's level of knowledge relating to continence management impacted on their attitude towards seeking treatment. The less informed a client was about the causes and treatment for incontinence, the more their attitude was that "nothing could be done" and that incontinence was a "normal part of aging". These findings were supported by other studies [8, 9, 15, 16] where the less knowledge the client had about continence care the less likely they were to seek care for their incontinence. Participants in the current study also described that those clients with a pre-existing more life threatening condition did not perceive their incontinence as "serious" enough to be treated and were therefore less likely to seek help for their incontinence. Participants of the current study and other Australian studies[9, 11] reported that such clients were more likely to self- manage their incontinence by modifying their medication regime, toileting frequently and padding up with aids.

Consequently, some clinicians involved in the current study suggested educating the community and incontinent clients about continence management options and to dispel the myths surrounding incontinence care. Other studies [9, 11, 21] identified that a key feature in improving the community's knowledge about continence management was to provide information about what is "normal" and that the effects of incontinence can be reduced to help improve the client's quality of life.

Strength of the current study was that it was conducted in a rural health setting. Most other studies addressing incontinence both in Australia and internationally have been conducted in metropolitan locations. Consequently, the current study provided rural clinicians with an opportunity to discuss how they manage their incontinent clients and identified future directions for the development of the continence service in a rural setting. Improvements in education support and resources for clinicians are needed as well as improvements in the community's awareness of continence care and services.

A limitation of the study was that the investigator was also the specialist continence advisor who was previously known to the participants in this advisory role. Despite the investigator encouraging participants to speak openly and honestly there could have been some staff that felt uncomfortable discussing the method by which they carried out their role in continence care. Therefore, some participants may not have fully disclosed their practices or opinions.

Since incontinent clients were not interviewed for this study, the perspective of the client was reported by participating clinical staff rather than the client. Consequently, the views of the clients may have been misrepresented.

Conclusion

This study found that overall most clinicians of the current study agreed continence management was part of their role and several of the specialist clinicians reported providing this service. However there were several factors that hindered other clinicians from providing this service. The lack of resources and time to address the complexity of the clients they have to provide care for was a barrier for some of the community-based clinicians. The clinician's lack of knowledge and expertise in continence management also impacted on how some clinicians provided

continence care. Those clinicians, who were knowledgeable and confident, provided more active management strategies while those with less knowledge and confidence were more likely to provide passive management strategies. The client's level of knowledge relating to continence management also impacted on whether they sought help for their incontinence.

Recommendations

Health clinicians have been identified as being ideally placed to improve outcomes for clients who are incontinent. An increase in resources, education and support for the clinicians who mange these clients is vital if they are to successfully manage incontinent clients. Note that all recommendations are necessary, as no single recommendation is likely to be sufficient to address continence care adequately.

Support for clinicians who manage clients with less complicated incontinence, so that the specialist continence service can then manage the more complicated cases of incontinence. Local continence "champions" will be identified to support local clinicians in continence care. These "champions" will be support by the specialist continence nurse.

Localised education and resources related to continence care will be available for clinicians. This may involve face-to-face, videoconferencing or Internet teaching. The Western NSW LHD specialist continence nurse and other personnel in the continence area are well placed to provide education. Teaching resources for the specialist continence service to provide the education to clinicians, such as teaching models, to assist in teaching catheterisation will be needed.

Guidelines and Pathways related to continence assessment and management of incontinent clients will be implemented. More formal referral pathways for the clinicians to use when providing care for their incontinent clients will also be developed.

Increase the number of clinicians specifically working in the continence specialist service, to help carry out these recommendations and assist the current continence specialist staff to manage the more complicated cases of incontinence.

Community-based education programs to inform the community about incontinence management and the availability of services will be offered.

Further research

It is suggested that the implementation and outcomes of the above recommendations be evaluated as a means of monitoring continence care for clients in a rural health settings from both the client's and clinician's perspective.

References

1. Abrmas P, Cardozo L, Fall M, Griffiths D, Rosier P, Ulmsten U. The standardisation of terminology of lower urinary tract function: Report from Neurourology and Urodynamics 2002; 167-78.

2. Nevéus T, von Gontard A, Hoebeke P, Hjälmås K, Bauer S, Bower et al. The standardization of terminology of lower urinary tract function in children and adolescents: Report from the Standardisation. Committee of the International Children's Continence Society. *Journal of Urology*. 2006; 176: 314-324.

3. Continence Foundation of Australia. Quotable facts and stats. Accessed 10th December 2011 www.continence.org

4. NSW Department of Health. The health of the people of NSW. Accessed 15th May 2012 from http://www.health.nsw.gov.au/pubs/2010/pdf/chorep_summary_2010

5. Australian Bureau of Statistics. 2006. Accessed June 2012 from http://www.abs.gov.au

6. Centre for Epidemiology and Research, Population Health Information Branch. The HOIST System, NSW Ministry of Health. http://hoist.health.nsw.gov.au/ Accessed 9/6/2012. Collated by J. Tall, Population Health, Western NSW & Far West Local Health Districts.

7. Fultz N, Herzog A. Self reported social and emotional impact of urinary incontinence. *Journal of the American Geriatrics Society.* 2001; 892-9.

8. Norton PA, Sedgwick PM, Stanton SL. Distress and delay associated with urinary incontinence, frequency and urgency in women. *British Medical Journal*. 1988; 187-189.

9. Pearson J. Incontinence: why people do not seek help.: Prepared for the Department of Health and Ageing. 2002. Accessed 6th January 2011 from http://www.bladderbowel.gov.au/doc/InfoEvidence/4Researchintoreasons.pdf

10. Pearson J. Incidence of incontinence as a factor in admission to aged care homes. Prepared for the Department of Health and Aging. Canberra: Australia. 2003.

11. StJohn W, James H, McKenzie S. Health service provision for community-dwelling people suffering urinary incontinence: A case study of neglect. *Australian Journal of Primary Health.* 200; 31-7.

12. Williams K, Smith N, Jagger C, Perry S, Shaw C, Dallosso H et al . Development, implementation and evaluation of a new nurse-led continence service: a pilot study. *Journal of Clinical Nursing*. 2000; 566-73.

13. Sumuelsson E, Victor A, Tiblin G. A population study of urinary incontinence and nocturia among women aged 20-59. *Acute Obstetrica and Gynecologica Scandinavia*.1997; 74-80.

14. Brooks T. Evaluating the knowledge of health professionals in rural and remote South Australian around continence Issues. 2006. Accessed from 8th May www.bladderandbowel.com.au

15. O'Brien J, Austin M, Sethi P, et al. 'Urinary incontinence: prevalence, need for treatment and effectiveness of intervention by a nurse. *British Medical Journal*. 199; 1308-12.

16. Smith C. Attitudes of health workers to incontinence. *Journal of Community Nursing.* 1998.

17. McDertmott P. Review of the factors influencing contience care. *Journal of Community Nursing*. 2010.

18. Gray M. The importance of sceening, assessing and managing urinary incontinence in primary care. *Journal of the American Academy of Nurse Practitioners.* 2003.

19. Hughes M. Continence and the community nurse. *Journal of Commuity Nursing.* 1998.

20. Collette C, Bravo G, Tu L. Development of a urinary incontinence educational program using a competency-based approach and case method. *Journal for Nurses in Staff Development*. 2009; 5(4):E5-E10.

21. Hope C. Promoting continence positively. *Journal of Community Nursing*. 2007.

22. Newman D, Denis L, Gruenwald C, Millard R, Roberts C, Sampselle K, et al Continence Promotion: Prevention, Education and Organisation. Incontinence. 2005. Accessed 2nd May 2012 from www.icsoffice.org

23. Crotty M. The Foundations of Social Research. Allen & Unwin.1998.

24. Rice P, Essy,D. Qualitative Research Methods. A Health Focus. University Press: Oxford. 2001.

25. Trochim W. Research Methods Knowledge Base. 2006. Accessed 20th June 2012 from http://www.socialresearchmethods.net/kb/positvsm.php

26**.** Braun C. Using thematic analysis in psychology. *Qualitative Research in Psychology*. 2006; 77-101.

27. Tong A, Sainsbury P, Craig J. Consolidated criteria for reporting qualitative research (COREQ): a 32-item checklist for interviews and focus groups. *Journal of Qualitative Health Care.* 2006; 349-57.

28. Ryan G, Bernard R. Techniques to identify themes in qualitative data. Accessed from www.Analytictech.com/mb870/ readings/ ryanbernard_techniques_to_identify.

29. Michie C. Nurses deliver on urinary continence in primary care. *International Journal of Clinical Practice*. 2011; 65(6): 635-7.

30. Dingwell L. Promoting effective continence care for older people: a literature review. *British Journal of Nursing*. 2008;17 (3):166-172.

31**.** Du Moulin MF, Paulus JP, Berendsen A, Halfens R. The role of the nurse in community continence care: a systematic review. *International Journa lof Nursing Studies*. 2005;479-92.

32. Cheater F, Baker R, Gillies C, Wailoo A, Spiers N, Reddish S, et al. The nature and impact of urinary incontinence experienced by patients receiving community nursing services: A cross-sectional cohort study. *International Journal of Nursing Studies.* 2008;45(3):339.

33. Dougherty M, Dwyer J. Pendergast J. A behavioural management for continence intervention reduced urinary incontinence symptoms for older rural women. *Research Nursing Health*. 2002; 29(3).

34. Yuan H, Willianms B, Lui M. Attitude towards urinary incontinence among community nurses and community dwelling older people. *Journal of Wound, Ostomy Continence Nurse*. 2011;184-9.

35. St John W, Wallis M, Griffiths S, McKenzie S. Daily living- management of uruinary incontience. *Journal of Wound, Ostomy, Continence Nurse*. 2010; 80-90.

36. Rigby D. The value of continence training. Does it change practice? *British Journal of Nursing*. 2003; 2(8): 484-486,488-492.

37. Flynn D. Improving continence care: searching the evidence. *Journal of Community Nursing*. 2005; 19(3).

38. Albers-Heitner P, Lagro-Janssen T, Venema P, Berghmans B, Winkens RR, de Jonge A, et al. Experiences and attitudes of nurse specialists in primary care regarding their role in care for patients with urinary incontinence. *Scandinavian Journal of Caring Sciences.* 2008;25(2): 303-10.