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Is Continence Promotion in Care of the
Older Person in the Community Worthwhile?

A survey of knowledge and attitudes

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**Is Continence Promotion in Care of the
Older Person in the Community Worthwhile?**

A survey of knowledge and attitudes.

Eileen Donovan

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Health Sciences
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Supervisor: Ms Marie Thérèse Cooney

A survey of knowledge and attitudes
Order of the Community Workforce
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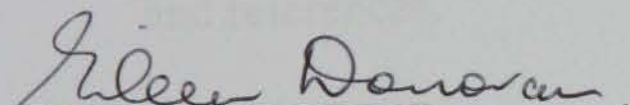
Supervisor: Dr. Marie Thérèse Conroy

DECLARATION

This dissertation is submitted to the University of Dublin Trinity College in part fulfilment for the degree of Master in Science in Gerontological Nursing. It has not been submitted for a degree at this or any other University.

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Eileen Donovan

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Abstract

This study was undertaken to survey knowledge and attitudes of Public Health Nurses to Continence Promotion in Care of the Older Person in the Community.

The study design uses a quantitative approach.

The tool used was a questionnaire. Its design included questions to examine knowledge of assessment and management of incontinence and to survey attitudes of Public Health Nurses to continence promotion in Care of the Older Person in the Community.

The questionnaire was divided into three sections. These are demographic details, knowledge and attitudes.

In spite of considerable advances in the management of urinary incontinence, in recent years, education still focused predominantly upon palliative rather than therapeutic or rehabilitative nursing strategies.

Results indicated that many nurses appeared to lack sufficient knowledge about incontinence upon which informed nursing practice should be based.

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CHAPTER 1

Introduction

Introduction

Title

Is Continence Promotion in Care of the Older Person in the Community worthwhile?

A survey of knowledge and attitudes.

1.2 Rationale for the Study.

Urinary incontinence is a common health problem with not only physical, but profound psychological and social implications for the sufferers, their families and carers (Norton 1986).

Thomas et al (1980), in discussion of the prevalence of urinary incontinence, stated that the problem increases with age, particularly in the very elderly (80 years or more).

“Epidemiological research has shown that the number of people suffering from incontinence in some form or other far exceeds the number of cases reported to health professionals” (Smith, 1988: 209).

Urinary incontinence, the consequence of a breakdown in eliminatory function, or the failure to acquire continence is a symptom encountered in almost every sphere of nursing practice.

Southern and Henderson (1990) in their discussion on tackling incontinence realised, from a study they did with nurses working with elderly people, that up to 80% of

nursing activity in dependent elderly peoples' wards, was related to unsuccessful toileting and incontinence.

In the past two decades there has been considerable expansion in knowledge about the assessment and treatment of urinary incontinence. The adequacy of the knowledge possessed by nurses has been questioned (Royal College of Nursing, 1982). In 1975 Wells surveyed nursing problems encountered in caring for elderly people. Her response rate was low (35%) but her results indicated that nurses know little about the causes of the problem.

The author's research is carried out to survey knowledge and attitudes of Public Health Nurses caring for older people in the community.

1.3 Quantitative Study

A quantitative study was undertaken to ascertain Public Health Nurses knowledge of and attitudes to continence promotion in care of the older person in the community.

The quantitative study involved the use of a questionnaire, the details of which are elaborated in this study.

1.4 Aims and Objectives.

Aim

The aim of this study is to determine is it worthwhile to promote continence in the older person residing in the community.

Objectives

1. To ascertain Public Health Nurses' knowledge of the significance of assessing older people in identifying the type of incontinence.
2. To evaluate whether Public Health Nurses recognise the importance of accurate diagnosis to plan and implement a treatment programme for the promotion of continence and management of incontinence.
3. To measure attitudes of Public Health Nurses on the ongoing evaluation of the management of incontinence.
4. To elicit nurses attitudes towards specific aspects of caring for incontinent people.

1.5 Outcome.

Overall, educational preparation was found to be that the majority of Public Health Nurses had received education on continence promotion.

Public health Nurses had varying levels of knowledge in the promotion of continence in caring for the older person. In the community, knowledge of appropriate interventions that are available to restore continence, or effectively to manage the problem is required.

The outcome of the survey of Public Health Nurses' attitudes indicated that nurses tended to agree with statements which reflected rehabilitative/therapeutic attitudes and disagreed with items which implied less-positive, palliative attitudes towards continence management.

CHAPTER 2

LITERATURE REVIEW

2.1 Introduction

A literature review was conducted using CINAHL (Cumulative Index Nursing Allied Health Literature) and Medline (Medical Literature Analysis and Retrieval System on Line). A manual search was performed using medical and nursing journals.

Incontinence is an unpleasant and distressing symptom. Those affected often feel embarrassed, ashamed and alone. Many people with incontinence hide their problem from society, from their family and friends, from health professionals, even from themselves. From the playground to the continuing care facility, incontinence attracts ridicule and blame, the incontinent person is often ostracised and avoided. According to Lucas (1993) urinary incontinence brings with it indignity, nursing and social isolation, it being one of the most unpleasant symptoms that anyone can suffer.

Hence the study of continence promotion is important both from a psychological and physical point of view.

In asking whether continence promotion is worthwhile we ask The Concise English Dictionary if it is worth the time, money or effort spent. The meaning of worthwhile

in Collins Thesaurus (1995) is - beneficial, constructive, expedient, gainful, good, useful, valuable or worthy.

“Incontinence can have widespread ramifications for the individual, for family and friends and for society. Some cope reasonably well with little apparent disruption of lifestyle. Others experience anxiety, embarrassment, sexual difficulties, unwilling to undertake a wide range of activities” (Norton, 1988:3). Helping people to achieve continence or manage incontinence is a core nursing skill, which all nurses will need at some point, and which many will use on a daily basis. There is a growing body of research evidence and specialist consensus on which to base clinical practice. This is an area of care where the use of skilled nursing can have a tremendous impact on each individual patient. The knowledgeable and skilled nurse has many tools with which to promote continence.

Incontinence is often regarded as an inevitable condition, rather than a symptom of an underlying disorder. It has been largely ignored as a research topic until recently, and there are still insufficient clinics or resources to help incontinent people, “Nurses have a major responsibility to provide education in the prevention of incontinence and to help restore continence” (Cheater, 1991: 23)

According to Resnick et al (1985:802) “ The elderly are more susceptible to incontinence than younger people because of the additional pathological, physiological, pharmacological and psychological factors from which they are at risk.”

Lucas (1993) appears to disagree with Resnick et al (1985).

Lucas (1993 P1) states that “ the problem affects all age groups, 10% of people over 65 years, 6% of children between 5 and 14 years and 40% of all institutionalised patients in the U.S.A.”.

According to Dowling-Castronovo (2001) it is estimated that urinary incontinence affects more than 13 million Americans. Urinary incontinence increases with age, but is not a normal part of the ageing process “It is the second leading risk factor for institutionalisation – 80% of long term care residents require assistance with toileting and 54% are incontinent” (Dowling-Castronovo, 2001:6).

The psychosocial impact of incontinence on older people is a relatively poorly recognised area of continence care, especially in care settings where incontinence is not a primary concern. Although continence is fundamental in almost all areas of nursing practise, it can be something about which nurses become complacent. Edgley (2002) agrees that the prevalence of incontinence is likely to increase within an ageing population and greater consideration should be given to the psychosocial impact on older individuals.

The impact of ageing on the maintenance of continence is unclear.

In the community, family caregivers report that care tasks are difficult and tiring and that family relationships are negatively affected by incontinence. Many times, community-living elderly persons with incontinence will not use the services of health care professionals, as incontinence is dismissed as a normal part of ageing.

The problem of incontinence carries a social stigma. Many individuals are often embarrassed and reluctant to report this condition during health examinations, even when directly questioned. "Many older adults misperceive incontinence as a normal part of ageing, believing that the problem cannot be corrected" (Wyman, 1988 P177).

Brittain et al (2001) wrote about the four reasons why women with incontinence do not seek help. "First incontinence is perceived to be trivial or a 'normal' aspect of ageing and thus little medically can be done about it. Second, people learn how to manage and control their incontinence. Third, people experience difficulties talking about these sort of symptoms to healthcare professionals. They feel embarrassment and have difficulty finding the right terminology to talk about symptoms. Fourth, patients are not always aware of the availability of medical help for incontinence" Britain et al (2001).

Although much is known about why people with incontinence do not seek help for their symptoms, little is known about why they eventually seek help.

Healthcare professionals should take note of what triggers individuals to seek help during the process of clinical assessment.

2.2 WHAT IS INCONTINENCE?

The definition of incontinence by Norton (1996) states that at the simplest level, continence is passing urine and faeces only in a socially acceptable place, and incontinence is doing so in the 'wrong' place. If urine or faeces are passed in the wrong place, whether into clothing, in bed or onto the ground, or into the wrong receptacle, this will usually be called 'incontinence'.

All nurses deal with incontinence at some time in their career, and recognise only too well the wet bed, the puddle on the floor, and the tell tale odour.

Some nurses deal with incontinence many times each day. Yet, how many could offer a clear definition of the term? Incontinence is not to do with the fact of excretion, but with its location and timing. Continence very much depends on society's rules for acceptable excretory behaviour. Those who cannot or will not abide by their rules are thereby defined as 'incontinent'. This will obviously vary between cultures and over time.

Some definitions note the fact that incontinence is 'voluntary' - the individual cannot help it. The distinction between voluntary and involuntary excretion in the wrong place is largely academic and the results are similar. The International Continence Society (1987) takes the definition a step further and defines urinary incontinence as the involuntary loss of urine, which is objectively demonstrable, and a social or hygienic problem.

It is important to recognise that incontinence is a symptom not a diagnosis. It gives an indication that something has impaired the individual's ability to comply with societal norms, but of itself does not constitute an explanation, nor give a clear indication of what the cause is, or what can be done about it.

Incontinent individuals are often reluctant to seek help because they view it as a normal part of the ageing process. Many do not report this problem until they have had the symptoms for a long time. Unfortunately, those who seek help frequently do not receive the attention they deserve. This, in part, attributes to the attitudes of health care providers towards urinary incontinence and their lack of knowledge regarding appropriate methods for diagnosis and management. Health care professionals may see only a small part of the misery and distress that accompany incontinence. Cheater (1991) in her discussion of health care providers thought the real problem in dealing with urinary incontinence is their attitudes.

Traditionally the management of incontinence has belonged to nursing, both in the hospital and community setting. Quality of nursing care has often been judged by the number of incontinent patients and the presence or absence of urine odour on a nursing unit. Because urinary incontinence is no longer considered an inevitable consequence of the ageing process, but rather a potentially reversible disturbance of urinary elimination, it has received increased medical attention in recent years. Yet

for many affected adults, especially those of advanced age with multiple chronic conditions, urinary incontinence may have multiple causative factors or a symptom of unmet dependence needs Morishita (1988). The complex interaction of the person and environment, especially individuals at risk, calls for a biopsychosocial approach to symptom management. Nursing skills of assessment, administration and evaluation of treatment modalities are crucial. "Many Health Care Professionals lack in-depth knowledge about the causes and management of incontinence and passively accept the symptom in people who come into their care" (Cheater, 1991:23). The literature indicates that in general health professionals' attitudes contain many misconceptions about incontinence, which in turn may lead to their failure to take appropriate steps towards its prevention and effective management.

Palmer (1990) states that the relevance of urinary incontinence among sub groups in the population indicates that it is a major health problem and there may be multiple biopsychosocial factors that increase susceptibility to this description.

Asking questions about the problems of incontinence is not as simple as one may think. Although community awareness is increasing the patient or family does not understand the word 'incontinence'. Clients may also deny "bladder accidents", thinking that their problem is not that serious and also that these accidents are normal.

Often, however, patients will admit to “bladder trouble”. This seems a more acceptable phrase and can be an opening to asking the patient and family to describe the length and duration of the “trouble”, and when leaking occurs.

Age related changes that alter bladder and urethral function include a decrease bladder capacity making the urge to void more frequent: a delayed onset of the desire to void, which makes it more difficult to delay voiding, and increase in residual urine volume, placing an individual at risk for development of urinary tract infections; and an increased number of involuntary bladder contractions, which contributes to the symptoms of urgency, frequency and incontinence. Decreased urethral and bladder compliance and decreased maximal urethral closure also occur. Benign prostatic hypertrophy, a normal change in older men and atrophic vaginitis resulting from the lack of oestrogen in postmenopausal women are associated with urine leakage. “In addition functional changes in mobility and dexterity which make it difficult to reach the toilet and disrobe in time for voiding may contribute to the development of incontinence. Visual difficulties that impair one’s ability to locate a bathroom may also be a factor. Although none of these changes alone causes incontinence, they can place a person at risk for its development” (Wyman, 1988:169).

2.3 CONTINENCE ASSESSMENT

“Urinary incontinence is a complex condition that can result from multiple interacting causes including physiological, behavioural, emotional, social and environmental factors” (Ouslander et al, 1986:408).

Successful management is dependent on a thorough evaluation that accurately characterises the type of incontinence and, if possible, identifies the underlying aetiology. The assessment process includes a history and physical examination measurement of post-void residuals, voiding diary.

“Sensitivity to the importance of accurately identifying and efficiently treating incontinent adults cannot be stressed enough” (Palmer, 1985:144)

Incontinence carries a social stigma. Many individuals are often embarrassed and reluctant to report this condition during health examination, even when directly questioned. As noted earlier, many older adults misperceive incontinence as a normal part of ageing, believing that the problem cannot be corrected.

The medical and nursing assessments should look for symptoms of conditions such as urinary tract infection, atrophic vaginitis, and faecal impaction. If dysuria, urgency, frequency, or haematuria is present, a urinary tract infection should be suspected. If a woman has a vaginal discharge, itching or dyspareunia, the nurse should look carefully for signs of atrophic vaginitis during the pelvic examination. Obtaining

information on bowel patterns and factors that might cause constipation can be helpful in assessing whether the patient is likely to have a faecal impaction.

According to Morishita (1988) it is crucial to assess the patient for symptoms associated with reversible causes of incontinence. A history and physical examination are also important components to assessment.

Morishita (1988) stressed the importance of focused history-taking and patient observation in accurately identifying incontinent individuals. The nurse should obtain a history from the patient as well as from household members and caregivers to confirm data. The history should include past medical conditions, including abdominal rectal and pelvic surgeries, vaginal deliveries and current medications. During the interview, information about the individual's attitude towards the urine loss and its impact on everyday life should be gleaned as well as the individual's motivation or interest in improving continence. Morishita (1988) also noted that subjective reports of severity of incontinence and the quantified amount of urine loss is poorly correlated. Objective testing is necessary to quantify urine loss, such as weighing perineal pads. Weighing used pads indicates volume of urine output. Pads are disposable incontinence wear and contain super absorbent material.

“A careful review of medications, including over-the-counter medicines must be conducted as drugs can affect bladder function and may cause incontinence. Anticholinergic medications can cause urinary retention that leads to overflow incontinence. Alpha-adrenergic blockers can decrease bladder neck tone, causing stress incontinence. Sedatives and analgesics often have side effects, such as confusion or sedation, which lead to an inability to toilet appropriately. Diuretics

commonly cause frequency or urgency, leading to urge incontinence". (Morishita, 1988:193).

Cheater (1991) suggests two helpful questions in discerning the type of incontinence the client has are (i) 'Do you have trouble making it to the bathroom in time?' and (ii) 'Do you ever leak urine when you sneeze, laugh, cough, or move from a sitting to a standing position?' Clients who state that they have a difficult time controlling the urge to urinate or who say, "when I gotta go, I GOTTA GO"! are describing urge symptoms. Clients who report leaking when there is an increase in intra-abdominal or intra-thoracic pressure are describing stress symptoms. Clients may also have a mixture of symptoms. It is important to understand the specific symptoms if an effective individualised treatment programme is to be designed.

At times, it is obvious from odour upon entering the home that the client has a problem with incontinence. However, many families and clients try to hide the fact that incontinence is a problem. Clients may fear the shame of others knowing their problem. Many elderly clients believe that incontinence is a symptom that occurs at the end of the lifespan and something that "you don't really talk about". Often, families hide this problem because they want to protect the "dignity" of their loved one.

For successful management of urinary incontinence and prevention of further deterioration of elimination functioning, a careful assessment for the causes of incontinence and other contributing factors is necessary. "An important component of assessment is identification of the pattern of urine loss" (Palmer, 1990:408). A record

or diary of the time of voiding, amount of urine loss, and fluid intake over several days is necessary.

Dowling-Castronovo (2001) recommends that a bladder diary is the best tool to collect information regarding urinary incontinence. She also recommends that screening questions provide a framework for guiding assessment.

Information about antecedent behaviours or conditions to incontinent episodes should also be investigated. For example, did the person suddenly become incontinent? Was the urine loss associated with a change in position? Was the person aware of the need to void? How long could the person delay voiding? Was a toilet accessible?

Wyman (1988) indicates that several clinical algorithms for diagnosis of incontinence are available. To determine defects in bladder emptying, post void residual urine should be obtained, especially in individuals with conditions that could lead to peripheral neuropathy of the bladder. An amount of 50 to 100 mls could indicate a disruption in bladder emptying. This can be measured by Nelaton Catheters and Bladder Scanners.

“Urodynamics testing for defects in urethral closing, bladder filling and emptying and sensation of the need to void are available” (Norton, 1996:74).

Wyman (1988) says the key to effective management of urinary incontinence is a comprehensive evaluation that accurately characterises the type of incontinence, and, where possible the underlying aetiology is identified.

2.4 IMPACT ON QUALITY OF LIFE

Bladder diaries and screening questions may identify the presence or risk of incontinence but these instruments do not shed light on the impact of incontinence on an individual's quality of life.

2.4 IMPACT ON QUALITY OF LIFE

Palmer (1988) discusses how faecal or urinary incontinence has devastating consequences for the affected older adults and their caregivers.

“Incontinence has been cited as a major reason for institutionalisation in the United States and other countries” (Ouslander et al, 1986:405).

White (1997) in his discussion of the general psychosocial effects of incontinence stated that even though physical effects of incontinence may not be clinically life-threatening, the symptoms can have a devastating effect on the quality of life of the sufferer, their friends and family.

Sufferers may become socially isolated due to the fear that an ‘accident’ might happen. They may also want to avoid the feeling of stigmatisation.

Besides displacement from one’s home and the sequel of the relocation, incontinence often causes psychological distress, lowered self-esteem, and withdrawal from society and social activities. Physical effects of incontinence have also been reported, including skin breakdown, especially with faecal incontinence.

Incontinence is also associated with other conditions of debilitation such as dementia, impaired mobility and falls. The National Parkinson Foundation (1980) reports that 71% of elderly persons with Parkinson’s disease are incontinent. Incontinence is also a serious complication of cerebral vascular accidents. Detrusor instability, as well as speech, motor, and sensory deficits, accounts for the high occurrence of incontinence in patients who have had a stroke. Older people have to cope with these conditions as well as coping with incontinence.

Mittiness (1987) states that older adults think it is futile to seek medical help and will use a variety of home remedies to prevent accidents and detection by others.

These remedies often include limiting fluid intake, frequently voiding regardless of whether the urge to void is present, use of sanitary pads or adult briefs and makeshift toilets.

A study by Norton et al (1988) investigated 201 women aged 16 to 86 undergoing an initial urodynamic assessment at clinics in two London hospitals. The findings showed that embarrassment and a reluctance to discuss the problem with general practitioners caused delay in seeking help, commonly for over a year. There are many misconceptions about incontinence. Many people with urinary incontinence problems feel that once continence is lost, control could not be regained and that little or nothing could be done to treat or cure the problem.

According to Keller (1999) in the USA 120 women aged 55 who completed a questionnaire agreed incorrectly with a questionnaire statement that urinary incontinence is a normal part of the ageing process and one third of them agreed that urinary incontinence develops in most people by the age of 85 years. These findings suggest that women delayed seeking medical advice due to the misconception that their symptoms were normal.

According to Harris (1986) caregivers in the institutional setting, the majority of whom are ancillary personnel, express a range of attitude from frustration to sympathy toward affected older adults.

Under reporting of incontinence by affected individuals often occurs because of embarrassment, fear of the consequences of disclosing this information or even a sense of futility.

Mobility or the lack of mobility is also associated with incontinence. Edelman (1983) reported that physically disabled patients were six times more likely to be incontinent than those who were physically able.

In the United States, preliminary data from the supplement on Ageing to the National Health Interview Survey (1984) revealed that 90% of non-institutionalised adults 65 years of age and older had problems controlling urination. A study of 5,637 respondents who were 65 years of age and older indicated that those with incontinence had more health problems and poorer health status than did those who were continent. The report suggested that incontinence be examined in context with limitations and medical conditions. The data from the cross-sectional survey revealed that incontinence was more common in women and became more severe with advancing age.

Mittiness (1987) suggested many older adults may go to elaborate lengths to hide or disguise their incontinence in the community.

Burton (1984) found that reporting the symptoms to their physician is seen as infrequent with more than half of the patients with incontinence.

For some patients incontinence is only a minor irritation. Others view incontinence as a severe problem, as in the case of the patient who states, "I am so nervous about having an accident that going out with friends is not worth the worry". The patients' perception of the severity of the problem must be considered in determining how aggressive the diagnostic investigation and treatment should be.

"Urinary incontinence is espoused as the second leading cause of institutionalisation of the aged" (Smith, 1988:207).

Urinary incontinence in adults is generally considered unacceptable by society. Incontinent persons are often embarrassed and tend to withdraw from others, hiding their difficulties. Incontinence takes a heavy toll in terms of the individual's psychological health and social well being. "The toll urinary incontinence has taken on the psychological well-being and quality of life of affected adults has not been quantified, although there are reports that psychological stress and social isolation are a result of incontinence for some individuals" (Wyman, 1987:178).

Incontinence in the elderly often provides the impetus for placing the patient in a nursing home. Within the institution however, the older patient frequently encounters experiences that do not promote continence. Much of the care within the institution, in fact, tends to foster incontinence procedures rather than strategies to decrease the incidence of incontinence. Elderly persons residing in institutions are being done a disservice unless an aggressive nursing approach is adopted that attempts to decrease or eliminate incontinent episodes.

The National Health Interview Survey on Ageing 1984 provides data that support the theory that there is a difference in the degree of social participation between community-dwelling elderly people with urinary incontinence and those without incontinence. These social participation activities include contact with friends or relatives either by phone or getting together, religious services or to participate in other recreational activities. The sample of 5,637 subjects was stratified into two age groups: those 65-74 years and those 75 years of age and older. In both groups, persons with urinary incontinence participated less in all social activities than did those with no urinary problems.

“The social consequences of incontinence may be perceived by staff, family and patients as disruptive, embarrassing or repulsive” (McCormick, 1988:137). This can lead to ostracism from informal and formal social settings. The consequences of ostracism can range from isolation to sensory deprivation to severe depression.

One quarter of a survey sample (Norton, 1988) avoided other people and avoided going far from home using public transport due to the incontinence symptoms or the threat of symptoms. If the sufferer can be confident in managing to stay dry and odour-free, he or she can feel more ‘normal’.

Urinary problems are more prevalent with age, and often trigger the need for institutionalisation (Harris, 1986).

Urinary incontinence appears to be one of the most psychologically distressing and socially disruptive problems faced by elderly persons. It also appears to be one of the most prevalent conditions experienced by this age group. According to Abdallah

(1988:292) “available statistics indicate that 5 to 10 per cent of elderly people living in the community experience some urinary incontinence, whereas 40% to 50% of elderly people in nursing homes are incontinent”. Given demographic trends that suggest an increasingly large elderly population in the future, the magnitude of this problem is likely to increase.

McCormack, Burgis (1984) and Ouslander (1989) concur that much of the incontinence seen in women and older adults is reversible.

2.5 NURSING IMPLICATIONS

The nursing implications should focus on treating the physical, psychosocial and environmental aspects of incontinence.

The need to educate the practitioner that incontinence is a treatable condition that may arise in the community dwelling elderly is great.

Needs for further research and development, as well as the dissemination of some successful assessment and treatment strategies will continue as we witness the growth of the elderly population and an increase in the number of people becoming incontinent.

It is important that nurses are able to identify incontinent older adults and those at risk for developing incontinence. A heightened awareness of patient and environmental characteristics that facilitate continence helps nurses to target subgroups for health teaching and intervention.

Staff acceptance on the part of both medical and nursing personnel appears to be a contributing factor in the under-reporting and accurate identification of reversible incontinence. The literature indicates that incontinence is both under-reported and under-valued.

The nurse must be particularly cognizant of and sensitive to the emotional issues underlying the problem of incontinence, and how they may influence the diagnostic and management process (Wyman, 1988).

The nurse must be aware that the problem of incontinence may be defined differently in different individuals.

Terminology used in determining whether a person is incontinent is critical to facilitate sensitivity around the problem. In some people use of the words “bladder control difficulties” will be sufficient in other individuals it may be necessary to ask if they ever “wet themselves unexpectedly” or “have trouble making it to the bathroom in time”.

According to Morishita (1988:189) “Nurses are in a prime position to make a positive impact on the care of elderly patients with urinary incontinence”.

Morishita (1988) discusses the fact that the nurse is an excellent candidate to identify incontinent patients. Nurses are the health professionals who spend the most time with patients and can develop a trusting relationship with them. Nurses are coordinators of care, communicating with family, other caregivers, and members of the healthcare team. For many years, continence status and functional status have been standard components of any nursing assessment.

Nursing assessments are routinely performed upon initial contact with the patient in the clinic, or other community setting.

Other characteristics such as relationship of the client make a nurse a likely professional to deal with incontinence. Although most incontinent elderly persons are women, most physicians are men. Ouslander et al (1987:410) maintains "that incontinent women may be more reluctant to admit incontinence to a man than to a woman".

Since the majority of nurses are women, nurses may be more likely to be approached by incontinent patients. Once incontinence is identified as a problem the nurse can educate patients and encourage them to seek assessment.

The role of the Continence Advisor, who is a clinical nurse specialist, is to detect patients with incontinence or to receive referrals from others in the health care system. Also to assess patients and make treatment recommendations, to refer patients for further medical work-up, educate the community and health professional and participate in research.

Treatment of urinary incontinence is a collaborative effort involving the nurse, patient, family, physician and at times other members of the multidisciplinary team.

The nurse may recommend any of several treatment modalities including pelvic floor exercises, habit training, bladder training. Nurses play an important role in ensuring that reversible problems such as faecal impaction and urinary tract infection which contribute to incontinence are properly treated. Measures for adapting the environment to enhance continence should be suggested.

Smith (1988) suggests that in Continence Promotion the first step is simply the recognition and the desire for the nurse to facilitate change.

Wells (1995) discussed the level of contentment nurses have with “change rounds” during which patients who soil themselves are routinely cleaned. This appears to be supported by Petrille et al (1988) who state that the process of managing urinary incontinence as an ongoing process must be built into daily care routines.

A fundamental aspect of nursing care is to assist the patient in meeting basic personal hygiene needs. Although all hygiene needs are of an intimate nature, none has a more demanding and aesthetically unpleasant nature than caring for patients who are chronically incontinent of urine. This problem is most difficult and discouraging for staff, as well as embarrassing and demoralising for patients. For the most part, the focus of nursing care has been on managing elderly patients with incontinence. This is carried out by frequent diaper and clothing changes rather than considering a more proactive orientation by recognising the underlying causes of the problem and promoting or providing active treatment. Effective interventions are available. According to Colling (1989) research based evidence and new knowledge raise difficulties for nursing practice.

A number of factors help to explain the prevailing focus of management of incontinence as opposed to its active treatment. They are important to identify because they represent attitudes that must be recognised and overcome if a different

norm is expected to replace the prevailing one. Perhaps the most critical factors related to the present focus of incontinence care are the values about continence that are so strongly held in our society. Soiling oneself is against all established norms for adults. Nurses, like the society of which we are a part, tend to believe that patients would not be incontinent if they could in any way prevent it. "The strategy has been to minimise physical and emotional discomfort to patient by becoming very efficient about "managing the problem" through use of a multitude of absorbent padding supplies and by conveying verbally that it is "ok" to be incontinent" (Colling, 1989:280).

A second factor is the misconception that incontinence is a natural consequence of ageing. Because incontinence is known to become a more common problem among older adults, it is considered an expected event and treatment is not, therefore, believed to be possible.

For instance a recent national survey by American Nurses' Association (1986) of over 2000 registered nurses working with elderly patients in a number of different care settings revealed that, from a list of ten critical clinical issues needing study, incontinence ranked seventh. It was cited by only 7.3 per cent of the nurses in the study as an important clinical issue. Thus for many nurses, incontinence is perceived as an accepted state, particularly in older persons, rather than a condition deserving diagnosis and treatment like any one of a number of other conditions the older person might develop.

A third factor contributing to the prevailing focus on incontinence management is the history of limited research on incontinence and inconsistency in the terminology used to classify incontinence. Historical and cultural factors have contributed to nurses learning to manage incontinence rather than to recognise its underlying causes and institute treatment. Now, however, there is a growing body of literature that can be used by nurses to diagnose and treat patients.

Particular emphasis should be placed on interventions which nurses can implement, that are consistent with nursing treatments. The old myths and stereotyping about incontinence among older people and of patients with incontinence need to be dispelled, by incorporating the result of recent research into nursing curricula. This effort would, however, take several years before its impact was seen in practice. In addition Cheater (1992) suggests that this effort may be hampered by the fact that over half of the nursing faculty responsible for teaching Care of Older Person content in schools of nursing, have had no formal education with regard to incontinence. Even if basic information is incorporated into all nursing curricula, there is still a need to educate those who have already graduated and are in practice.

“ Incontinence is a difficult and costly problem that deserves increased attention in academic settings” (Colling, 1989:280).

Nurses who care for residents with incontinence need programmes tailored to meet their needs. Some aspects of an educational programme designed for nurses caring for community dwelling persons with incontinence may be similar to that designed for nurses caring for residents with incontinence in institutions. There are two compelling reasons why it should differ.

Firstly most community patients can co-operate with their treatment programme and can toilet themselves according to Ouslander (1987) whereas most patients with incontinence residing in Nursing Homes require intensive and long-term involvement of nursing staff, because they cannot toilet themselves independently.

Secondly, a continence programme for those persons residing in institutions must involve education for all levels of nursing staff, in order to be successful. Although the individual treatment plan will almost certainly be planned by Registered Nurses, the responsibility for carrying out continence promotion may lie with nurses' assistants rather than Registered Nurses.

“An active treatment programme for continence, instituted by nurses, advances the nursing care of these patients, from custodial nursing care to therapeutic nursing care” (Colling, 1988:282).

Educational strategies to modify the beliefs and values of health care providers in institutional settings would be an important primary prevention activity. The promotion of independent functioning and decision making by individuals residing in institutional settings would require changing of existing attitudes about ageing, philosophies of care, and social environments. Ouslander et al (1987) discusses the fact that the primary prevention approach also helps to extinguish feelings of personal shame and failure over disturbances in urinary elimination and helps to remove incontinence from the erroneous context of irreversible decline in function because of ageing.

It is reported by Cheater (1992) that many nurses lack specific knowledge which is necessary to carry out a comprehensive continence assessment. The majority of

nurses, irrespective of grade, appeared to have only a limited appreciation of the range of factors which should be considered in order to ensure that a systematic assessment of incontinence is carried out.

Nurses who work in hospitals are in an ideal position to observe the patient's ability to carry out the many skills necessary for independent toileting.

2.6 COST IMPLICATIONS

In managing incontinence “the prevalence of the problem is enormous, as are the costs that accompany it”(McCormick, Scheve, Leahy, 1988:137).

The nurse in the community needs to recognise that incontinence is a treatable condition of older persons. Furthermore, in caring for the patient in hospital the nurse needs to be able to assess, manage and treat incontinence. In managing incontinence, “the nurse may be the most cost-effective health care provider to deal with urinary incontinence along with appropriate referral to other members of the health care team” (Morishita, 1988 P191).

Without a systematic method of identifying and evaluating patients with incontinence, many affected patients return to the community or other health care settings with their condition undetected and untreated. In the design to control hospital costs by means of faster and earlier hospital discharges it enhances the magnitude of the problem for the affected adult, the nursing staff and community caregivers (Palmer ,1988).

Care of incontinent patients have certain implications with respect to staff resources, utilisation and cost. The labour costs associated with urinary incontinence have been analysed in a number of studies. “Estimates range from 1.20 dollars to 5.5 dollars per day for labour alone” (Cella, 1988:159).

Some American studies have examined the additional costs of supplies and laundry. “These range from 0.18 dollars to 2.30 dollars per day for incontinent residents” (Cella, 1988:159).

“Not surprisingly, labour accounts for the largest share of the cost of incontinence; the care delivered to a patient with incontinence is very often limited to tending to the patients needs after an episode of urinary incontinence” (Abdellah, 1988:292).

Until quite recently, incontinence was believed to be impossible or unnecessary to treat except through the use of absorbent pads and diapers. The cost of this type of management in terms of laundry, labour, and supplies, as well as to the patients’ well-being is very high. Laundry and supply costs can be reduced by treatment programmes that can be taught to carers and some incontinent patients can benefit from this.

“The U.S. Surgeon General has estimated that 8 billion dollars of federal dollars is spent on incontinence in the United States. In Great Britain, it is estimated that incontinence accounts for up to one third of the costs of care in geriatric wards” (Abdellah, 1988:291).

Ouslander et al (1985:405) reported that in the United States “ incontinence care in nursing homes added 3 to 11 dollars to the daily cost of care”.

There is a major problem to be considered according to Lucas (1993). The population served by an average district general hospital in the United Kingdom (approximately 250, 000) is likely to have upwards of 70, 000 incontinence sufferers. The cost to the N.H.S. has been estimated at £73 million per annum.

In the United Kingdom, “In 1987-88 financial year, £2 million worth of nursing time was spent taking people to the toilet even when they did not use it, or caring for the individual following an episode of incontinence” (Southern et al, 1996:208).

CONCLUSION

Urinary incontinence is not a part of the normal ageing process. Although it is reversible, it is often neglected by health care providers. Appropriate assessment must be done in order to diagnose and treat urinary incontinence effectively. A practical approach to assessing and treating incontinence has been presented. Nurses, with the skills to detect, assess and treat the problem are in an ideal position to promote continence in the older person.

Chapter 3

Methodology

3:1 Introduction

Research is “the systematic investigation into and study of materials and sources in order to establish facts and reach new conclusions” (Oxford Dictionary: 1999).

Burnes and Grove (1999) describe research as diligent, systematic inquiry or study to validate and refine exiting knowledge and develop new knowledge.

Research links theory education and practise.

“The focus of quantitative research is primarily upon numbers often aggregated into statistics, qualitative research concentrates on words in the form of speech or writing”

(McCormack 1999:113)

A quantitative research method was used to survey knowledge and attitudes of Public Health Nurses to Continence Promotion in the Care of the Older Person in the community.

Cormack(1996) in discussion states that a quantitative approach provided a more objective knowledge base to guide practise. A collection of numerical and measurable information was a priority and this study so the researcher used a quantitative approach. The study used a structured questionnaire.

A prominent feature of the data collected using the quantitative approach is that they can be measured and quantified by statistical analysis.

Parahoo (1997) refers to the methodology within research as the design. This he believes should provide an outline sketch of the research process, for the purpose of this study it included:-

- **Research Instrument**
- **Ethical Consideration**
- **Pilot Study**
- **Data Collection**
- **Data Analysis**

Research Instrument is the device that a researcher uses to collect data (eg. questionnaire scales, observation schedules).

Ethical consideration is the degree to which research procedures adhere to professional, legal, and social obligations to the study participants.

Pilot Study is a small scale version, or trial run done in preparation for a major study.

Data Collection is the gathering of information needed to address a research problem.

Data analysis is the systematic organisation and synthesis of research data.

3.2 Research Instrument

The instrument used in this study was a questionnaire. This questionnaire was developed initially and used to study Registered Nurses' knowledge and attitudes towards aspects of caring for people with incontinence in one District Health Authority in the U.K. Midlands.

The questionnaire consisted of sixteen questions. These were fourteen closed questions and two open-ended questions.

Questions one and two indicate demographic details of the sample.

Questions three to sixteen excluding question fourteen identify knowledge base.

Question fourteen was designed to measure nurses' attitudes, which consisted of nineteen five-point Likert-type statements.

A Likert-scale consists of several declarative statements expressing a point of view on a topic Likert (1932) as cited by Cheater (1991:23).

Sudman et al (1982) discusses how the level of awareness has its effects on attitudes.

Before attitudes can be determined it is often necessary to determine the level of awareness.

It was used and altered with permission of the author (Cheater, 1987) to suit the sample in this research study.

Due to geographical reasons a postal questionnaire was selected. Anonymity and confidentiality were assured. Therefore the researcher gave time and consideration to the advise of Oppenheim (1992) where the questionnaire was relatively short and designed to address three specific areas:-

- (i) Professional experience and education
- (ii) Knowledge and
- (iii) Attitudes

Oppenheim (1992) claims that the questionnaire must be a finely grained process that closely relates to the aims of the study.

◆ Reliability and Validity

Measuring of nursing phenomena is a major concern of nursing researchers. The two common standards for the quality of measurement in the social sciences are reliability and validity. Issues of reliability and validity are of central concern to the researcher as well as the critiquer of research. . The measurement tools that are used in a research study must be evaluated in terms of the extent to which reliability and validity have been established. Oppenheim (1992) claims that one should focus on the area of reliability prior to examining the validity.

◆ *Reliability*

The reliability of an instrument is the degree of consistency with which it measures the attribute it is supposed to be measuring (Polit, Hungler 1995). Polit and Hungler (1995) and Parahoo (1997) agree that bias may inadvertently reduce the reliability of the study.

In an article published by Cheater in 1991 the designer of the questionnaire used in this research study found that inter-rater reliability was 100% on 15 of the items and 91.7% agreement was obtained for the remaining item (Cheater 1991:25).

◆ *Validity*

Validity refers to the degree to which an instrument measures what it is supposed to be measuring (Polit and Hungler, 1995). The questionnaire used for this study was shown to have acceptable levels of face validity (Cheater 1991).

3.3 Ethical Considerations

Irrespective of the research methodology employed one should question the study in terms of its ethical implications. The final clause within An Bord Altranais (1988) code of professional conduct addresses the issue of research in nursing.

“In taking part in research the principles of confidentiality must be safeguarded. The nurse has an obligation to ascertain that the research is sanctioned by the appropriate body. The nurse should be aware of the ethical policies and procedures in his/her area of work” (An Bord Altranais, 1988 :4)

In relation to this study, every effort was made to apply the rules of privacy, anonymity and confidentiality. This assurance was not just limited to the individual participants but also to the selected Health Board area. If the particular Health Boards were to be identified this would be seen as compromising the organisation and would consequently affect their anonymity (Brennan 1995). This could potentially victimise the particular Health Boards involved.

Approval for conducting the pilot study and the main study was given by the Directors of Public Health Nursing in the Health Boards involved. This permission was given orally. Assurance was given to conduct the research and to forward the questionnaires to the sample selected. There was no ethics board from which to seek consent. The participants gave their consent to be included in the study by

completing and returning the questionnaire. An assurance of confidentiality and anonymity were given to each of the Public Health Nurses sampled.

If the findings of the results of the questionnaire were published there could be no trace ability of the origin of the findings.

When the questionnaires were returned to the researcher storage was in a locked filing cabinet. Only the author had access to this.

The researcher was available and accessible to the respondents. They were aware of the researchers work location and telephone number. Respondents were free to withdraw from the survey without any penalty incurred. The completed questionnaires were destroyed following completion of data analysis.

3.4 Pilot Study

Polit and Hungler (1997) define a pilot study as a small-scale study or trial run done in preparation for a major study. Presly (1991) similarly explains a pilot study as testing the practicality of the research.

For the purpose of this research a pre-test was carried out prior to the pilot study. Pre-test was done to collect data before the experimental intervention.

Five sample questionnaires were distributed personally to five Public Health Nurse colleagues who were not included in the main study (the helpful response of the Public Health Nurses is gratefully acknowledged here).

As changes were made following pre-test. A pilot study was conducted in a community care area of a Health Board, which was excluded from the main study. The sample used for the pilot study was similar to that used in the main study. It consisted of twelve Public Health Nurses. A questionnaire was posted to each area registered Public Health Nurse with a covering letter and a stamped self-addressed envelope for returning via An Post to the researcher. The covering letter addressed to each Public Health Nurse sampled, briefly outlined the research process and confidentiality was assured.

The overall response rate to the pilot study was 50%.

A letter was sent to remind and encourage the Public Health Nurses to complete the questionnaires. Following the pilot study one change was made to Question 14, which examined Public Health Nurses' attitudes. A new statement was added, which

facilitated obtaining attitudes to management of incontinence as distinct from attitudes to assessment of incontinence.

3.5 Data Collection

Polit and Hungler (1997) refer to data collection as the logical sequence of the determined plan. It begins with an explanation of the study to the participants and then gains the individuals acceptance to take part.

◆ Sample Selection

The sample, convenience, used for this study consisted of all Area Registered Public Health Nurses within one Health Board Region in Ireland. Therefore an entire population was used. The sample was 64 (N= 64).

“ Convenience sampling is the use of the most readily accessible persons or objects as subjects in a study” (Lobionda Wood and Haber, 1994:253).

Sixty four Area Registered Public Health Nurses were selected from within one Health Board area to participate in the Study, asking the question “Is Continence Promotion in Care of the Older Person in the Community Worthwhile?” A survey of knowledge and attitudes. This was the total population of this Health Board area.

As a descriptive study one would hope that the data would aptly describe the phenomenon under review. Parahoo (1977) claims that descriptive research seeks to describe who is responding and how they respond.

The first section of the study provides demographic details based on the data collected in questions 1 and 2. The indicator utilised included those of age and total length of nursing experience as a Public Health Nurse. Questions 3-9 elicits what preparatory knowledge Area Registered Public Health Nurses had obtained, whereas questions 10 to 16 excluding question 14 portrays continence practise knowledge.

Question 14 measures attitudes of Public Health Nurses on the ongoing evaluation of the management of incontinence and towards specific aspects of caring for people with incontinence.

◆ *Distribution*

The Directors of Public Health Nursing kindly facilitated the researcher with a list of names of all Area Registered Public Health Nurses in the Health Board Region.

It would have been impossible for the researcher to approach the participants due to radius of Health Board region. A convenient way to limit problems of time and distance according to Moser and Kalton (1971) and Barker (1991) is through the employment of a postal questionnaire. Therefore, this was the rationale for employing this particular method of data collection for this study.

Questionnaire packages were posted to each area Registered Public Health Nurse in the Health Board.

A questionnaire package consisted of :-

1. A letter of introduction to the individual participants.
2. The questionnaire.
3. An A4 sized brown envelope with stamp personally addressed to the researcher.

The letter of introduction to the individual participant was designed to explain who the researcher was and to provide a rationale for the study. The participants were

asked to help the researcher by filling in the enclosed questionnaire. Each participant was assured of confidentiality. A low response rate to postal questionnaires is widely recognised within the literature as being a cause for concern (Moser and Kalton, 1971; Barker, 1991; Oppenheim, 1992; Anema and Brown, 1995; Polit and Hungler, 1997).

Therefore, sending out reminder letters to the participants was necessary and was carried out on two occasions.

Anema and Brown (1995) Asch, Jedrzejewski, Christakis (1997) believe that response rate can be improved by 13% when individual reminders are sent to the participants. The second reminder letter was posted to extend the closing date and to facilitate people on annual leave.

3.6 DATA ANALYSIS

Data is just data until it is analysed. This fact is acknowledged in the literature (Polit and Hungler, 1997; Parahoo, 1997). The wise researcher according to Parahoo (1997) will address this pro-actively during the design phase of a study. This allows errors to emerge and be rectified (Oppenheim 1992).

“From the viewpoint of the research consumer, the analysis of the results interpretations, and generalisations that a researcher generates from a study becomes a highly important piece of the research project”. (Lobiondo-Wood and Haber, 1998 :390).

Lobiondo-Wood and Haber (1998) highlight that it is after the analysis of the data that the researcher puts the final pieces of the jigsaw puzzle together to view the total picture with a critical eye. “This process is analogous to evaluation, the best step in the nursing process”. (Lobiondo-Wood and Haber 1998:390)

“The consumer of the research may view these last sections as an easier step for the investigator, but it is here that a most critical and creative process comes into use. It is in these final sections of the report after the statistical procedures have been applied, that the researcher will interrelate the statistical or numerical findings to the theoretical framework, literature methods, hypotheses and problem statements”. (Lobiondo-Wood and Haber 1998:390)

Within this study, it was thought that the most succinct and optimal way to analyse the data set was through the use of frequency distributions.

Polit and Hungler (1997) discuss frequency distributions as a means of imposing some order on a mass of numeric data.

Polit and Hunger (1997) describe frequency distributions as a systematic arrangement of numeric values from the lowest to the highest, together with a count of the number of times each value was obtained.

◆ **Procedures**

The procedure was to survey knowledge and attitudes of area registered Public Health Nurses towards caring for older persons with incontinence in the community.

◆ **Instrument**

The questionnaire used included 2 questions relating to demographic details of the sample. It also included 13 questions on knowledge of continence promotion and 1 19-part question on attitudes to continence promotion when caring for the older person in the community.

◆ **Data Management**

The data were analysed using the statistical package for the Social Sciences (SPSSX). All questions were statistically analysed separately. The statistical analysis included frequency values and median scores.

Question 14 relating to attitudes is discussed using pie charts.

Chapter 4

4.0 Results

Sixty-four Registered Public Health Nurses, an entire population, were selected from within one Health Board Region, to participate in the study “Is Continence Promotion in care of the older person in the community worthwhile? A survey of knowledge and attitudes”.

Of the sixty-four questionnaires distributed forty-four were returned. The overall response rate equalled 67%.

4.1 DEMOGRAPHIC DETAILS

Table 4:1 Age

Age Approximate	Frequency	Valid %	Cumulative %
Valid Less than 25 years	1	2.4	2.4
25 to 30 years	1	2.4	4.8
31 to 35 years	4	9.5	14.3
36 to 45 years	11	26.2	4.5
Over 45 years	25	59.5	100.0
Total	42	100.0	
Missing 0	2		
Total	44		

Age was broken down into intervals of 5 years. The majority of nurses who responded to this question within the sample were aged over 45 years. (N= 25 56.8%).

Table 4:2 **Indicates total length of time practising since qualifying as a Registered Public Health Nurse**

No of Years practising as a Registered Public Health Nurse		People Frequency	Valid %	Cumulative %
	1	3	7.0	7.0
	2	1	2.3	9.0
	3	1	2.3	11.6
	4	1	2.3	14.0
	5	1	2.3	16.3
	7	1	2.3	18.6
	8	1	2.3	20.9
	9	2	4.7	25.6
	10	1	2.3	27.9
	11	1	2.3	30.2
	12	1	2.3	32.6
	13	1	2.3	34.9
	15	2	4.7	39.5
	18	2	4.7	44.2
	19	2	4.7	48.8
	20	4	9.3	58.1
	21	1	2.3	60.5
	22	2	4.7	65.1
	23	1	2.3	67.4
	24	2	4.7	72.1
	25	3	7.0	79.1
	26	1	2.3	81.4
	27	1	2.3	83.7
	28	1	2.3	86.0
	29	2	4.7	90.7
	30	3	7.0	97.7
	32	1	2.3	100.0
	Total	43	100.0	
Missing	0	1		
Total		44		

Table 4:2 illustrates the length of time a respondent has been practising as a Public Health Nurse. Almost half of the nurses (N=18 41.9%) have been in their current position for 20 + years.

4.2 KNOWLEDGE

Table 4:3 Indicates completion of a Contenance Promotion Course

Have you completed a Contenance Promotion Course	Frequency	Valid %	Cumulative %
Valid Yes	25	58.1	58.1
No	18	41.9	100.0
Total	43	100.0	
Missing	1		
Total	44		

In analysing the section of the questionnaire to ascertain Public Health Nurses knowledge over half of the Public Health Nurses (N=25), 58.1% have completed a Contenance Promotion Course. One respondent did not answer that question, she did however complete subsequent questions within that section of the questionnaire.

The questions following were asked to ascertain other relevant education to care of the older person with incontinence.

Table 4:4 Indicates attendance at Contenance Management Lectures/Seminars

Contenance Lectures/Seminars	Frequency	Valid Percent	Cumulative Percent
Valid Yes	35	81.4	81.4
No	8	18.6	100.0
Total	43	100.0	
Missing	1		
Total	44		

81.4% (N = 35) had attended continence management lectures/seminars.

Table 4: 5 Indicates whether PHNs' had any lectures relating to the subject of Continence/Incontinence during PHN Course.

Lectures during PHN Course	Frequency	Valid %	Cumulative %
Valid Yes	21	50.0	50.0
No	20	47.6	97.5
Other	1	2.4	100.0
Total	42	100.0	
Missing	2		
Total	44		

50% (N = 21) had received lectures relating to the subject of Continence/Incontinence during the Public Health Nurse Course.

Table 4: 6.1 Indicates the completion of a Post-Graduate Course in Gerontological Nursing.

Course in Gerontological Nursing	Frequency	Valid %	Cumulative %
Valid Yes	5	11.4	11.4
No	39	88.6	100.0
Total	44	100.0	

11.4% (N=5) had post-graduate education in caring for the older person.

88.6% (N=39) had no post-graduate education in caring for the older person.

Table 4: 6.2 Indicates Gerontological Course and Year Taken

Course and Year taken	Frequency	Valid %	Cumulative %
Valid 0	39	88.6	88.6
Evening course by Gerontologist 5 year	1	2.3	90.9
Faculty of Nursing Gerontology 1994	1	2.3	93.2
Gerontology Faculty of Nursing 1995	1	2.3	95.5
Midland Health Boar and Bord Altrainais	1	2.3	97.7
Mountmellick Hospital 1996-1997	1	2.3	100.0
Total	44	100.0	

11.4% (N = 5) have completed a post-graduate course in Gerontological Nursing.

Table 4: 7.1 Indicates membership of Continence Group or Association

Continence Groups	Frequency	Valid %	Cumulative %
Valid 0	1	2.3	2.3
Yes	1	2.3	4.5
No	42	95.5	100.0
Total	44	100.0	

Table 4: 7.2 Indicates which Association

Which associations	Frequency	Valid %	Cumulative %
Valid 0	44	100.0	100.0

In response to the question on whether the Public Health Nurse belonged to any group or association, 2.3% (N=1) was a member of a continence group but this person did not complete section (b) of this question to indicate which group or association.

Table 4: 8 The following indicates how well prepared PHN's feel concerning Continence Education

Table 4: 8.1 Causes of Incontinence

Causes of Incontinence		Frequency	Valid %	Cumulative %
Valid	Well Prepared	15	34.9	34.9
	Fairly Well Prepared	25	58.1	93.0
	Not Very Well Prepared	3	7.0	100.0
	Total	43	100.0	
Missing	0	1		
	Total	44		

93% (N=40) felt prepared concerning the causes of incontinence. 34.9% (N=15) were well prepared and the other 58.1% (N=25) were fairly well prepared. The remaining 7% (N = 3) felt not very well prepared.

Table 4: 8.2 **Indicates ability to assess incontinence.**

Ability to assess incontinence	Frequency	Valid %	Cumulative %
Valid Well Prepared	9	20.9	20.9
Fairly Well Prepared	23	53.5	74.4
Not Very Well Prepared	11	25.6	100.0
Total	43	100.0	
Missing 0	1		
Total	44		

Ability to access incontinence did not indicate levels of preparation to be as high. 74.4% (N=32) were prepared, whereas 25.6% (N=11) felt unprepared. One respondent did not reply.

Table 4: 8.3 **Indicates awareness of methods to promote Continence**

Methods to promote incontinence	Frequency	Valid %	Cumulative %
Valid Well Prepared	10	23.8	23.8
Fairly Well Prepared	26	61.9	85.7
Not Very Well Prepared	5	11.9	97.60
Not at all Prepared	1	2.4	100.0
Total	42	100.0	
Missing 0	2		
Total	44		

Concerning abilities to promote continence 85.7% (N=36) felt prepared - 23.8% (N=10) were well prepared and the remaining 61.7% (N=26) were fairly well prepared.

14.3% (N=6) of the sample felt unprepared with their level of knowledge to promote continence.

Table 4: 8.4 **Indicates preparation for Management of Urinary Incontinence**

Management of Urinary Incontinence	Frequency	Valid %	Cumulative %
Valid Well Prepared	7	16.7	16.7
Fairly Well Prepared	25	59.5	76.2
Not Very Well Prepared	8	19.0	95.2
Not at all Prepared	2	4.8	100.0
Total	42	100.0	
Missing 0	2		
Total	44		

76.2% (N = 32) of the respondents felt prepared to manage incontinence. This is three quarters of the Public Health Nurses in the sample.

Table 4: 8.5 **Indicates knowledge about Aids to Continence**

Aids to Continence	Frequency	Valid %	Cumulative %
Valid Well Prepared	18	42.9	42.9
Fairly Well Prepared	19	45.2	88.1
Not Very Well Prepared	3	7.1	95.2
Not at all Prepared	2	4.8	100.0
Total	42	100.0	
Missing 0	2		
Total	44		

88.1% (N = 37) felt they were knowledgeable about aids to continence, 11.9% (N = 5) of the responses indicated they were not very well or not at all prepared in the area of aids to continence.

Table 4: 8.6 Indicates preparation for indwelling catheter management

Indwelling catheter Management		Frequency	Valid %	Cumulative %
Valid	Well Prepared	15	34.9	34.92
	Fairly Well Prepared	22	51.2	86.0
	Not Very Well Prepared	4	9.3	95.3
	Not at all Prepared	2	4.7	100.0
	Total	43	100.0	
Missing	0	1		
	Total	44		

In the last section of this question 86% (N = 37) felt they could care for older persons with indwelling catheters. The remaining 14 % (N = 6) felt not very well prepared or not at all prepared for indwelling catheter management.

Table 4: 9.0 Indicates what contributes to knowledge relating to incontinence

Contribution to knowledge relating to incontinence		Frequency	Valid %	Cumulative %
Valid	Teaching during PHN training	1	3.3	3.3
	Conference/study day	6	20.0	23.3
	In-service education	13	43.3	66.7
	Community experience	7	23.3	90.0
	Post-graduate course	3	10.0	100.0
	Total	30	100.0	
Missing	0	14		
	Total	44		

In questioning the Public Health Nurses about how they had attained most of their professional knowledge relating to incontinence almost half of them 43.3% (N = 13) received it from in-service education, 23.3% (N =7) stated that community experience contributed most to their knowledge relating to incontinence from conference/study days.

10% (N=3) of the respondents received their knowledge from postgraduate courses. 3.3% (N=1) conveyed that most of her knowledge relating to incontinence was from teaching received during Public Health Nursing training.

Table 4:10.1 Indicates if there are problems relating to caring for clients who are incontinent in the Community Care Area.

Problems caring for Clients		Frequency	Valid %	Cumulative %
Valid	Frequency	13	31.7	31.7
	Sometimes	16	39.0	70.7
	Occasionally	8	19.5	90.2
	Rarely	4	9.8	100.0
	Total	41	100.0	
Missing	0	3		
Total		44		

93.2% (N = 41) responded to this question. 100% (N = 41) of these respondents experience problems when caring for clients who are incontinent. 31.7% (N = 13) have problems frequently whereas 39% (N = 16) express experiencing problems sometimes.

Table 4:10.2 (see Appendix 1) **Indicates what the main problems are when caring for older people with incontinence.**

There was a 90.9% (N = 40) response rate to explain what were the main problems experienced. There are 40 main problems listed in the frequency distribution. The problems ranged from client-centred needs to attitudes of clients and carers to incontinence and incontinence wear. They also experienced difficulty recording frequency volume charts for accurate assessment, and there were references to lack of time to do proper assessments.

Table 4: 11.1 **Indicates who the PHNs think should be MAINLY responsible for promoting continence/management of incontinence in the community**

Responsible for promoting continence	Frequency	Valid %	Cumulative %
Valid Nursing Staff	13	31.7	31.7
Specialists (e.g. Continence Advisor)	18	43.9	75.6
Medical and nursing staff	10	24.4	100.0
Total	41	100.0	
Missing 0	3		
Total	44		

Almost half of the respondents 43.9% (N = 18) stated that specialists eg continence Advisors should be mainly responsible for promoting continence/management of incontinence in the community.

31.7% (N = 13) replied that nursing staff should be mainly responsible and 24.4% (N = 10) thought medical and nursing staff should be responsible.

Table 4: 11.2 Indicates who the PHNs think should be MAINLY responsible for the Assessment of Incontinence in the community

Responsible for assessment of incontinence		Frequency	Valid %	Cumulative %
Valid	Nursing Staff	9	25.0	25.0
	Specialists (e.g. Continence Advisor)	11	30.6	55.6
	Medical and nursing staff	8	22.2	177.8
	Multidisciplinary team	8	22.2	100.0
	Total	36	100.0	
Missing	0	8		
Total		44		

The majority 30.6% (N = 11) think that specialists eg Continence Advisors should be mainly responsible for assessment of incontinence in the community. The remaining 69.4% (N = 25) revealed equal importance for nursing staff, medical and nursing staff and multidisciplinary team assessments.

Table 4: 12.0 (see Appendix 11) Indicates what factors the PHNs think are important when assessing a patient in the community

The three most frequently mentioned factors were (i) type of incontinence (ii) fluid intake and output (iii) access to toilet. There were 38 factors listed as being important for assessment. These varied from age profile, physical and mental condition, environmental and psychosocial factors and medical condition. Other factors mentioned were clients and carers attitudes and compliance with assessment of incontinence.

Table 4: 13.0 Indicates how important PHNs think it is for Registered PHN to have the Opportunity to attend courses/study days/conferences etc. relating to continence/managing incontinence

Opportunity for Continence Education		Frequency	Valid %	Cumulative %
Valid	Very important	41	93.2	93.2
	Important	3	6.8	100.0
	Total	44	100.0	

100% (N=44) answered this question and portrayed that attendance at courses/study days and conferences was significant.

Table 4: 15.1 Indicates whether nurses use any written guidelines for the assessment of incontinence in the community.

In the Community do nurses use any written guidelines for assessment of Incontinence		Frequency	Valid %	Cumulative %
Valid	Yes	42	95.5	95.5
	No	2	4.5	100.0
	Total	44	100.0	

95.5% (N = 42) stated they use written guidelines for assessment of incontinence and the remainder 4.5% (N = 2) do not use written guidelines.

Table 4: 15.2 Indicates whether nurses use any written guidelines for the management of incontinence in the community.

In the Community do nurses use any written guidelines for the management of Incontinence		Frequency	Valid %	Cumulative %
Valid	Yes	33	75.0	75.0
	No	11	25.0	100.0
	Total	44	100.0	

75% (N=33) use written guidelines for the management of incontinence and 25% (N=11) quoted that they do not use written any guidelines.

Table 4: 16.0 **Indicates definitions of Urinary Incontinence**

Definition of Urinary Incontinence		Frequency	Valid %	Cumulative %
Valid	Uncontrol	1	2.3	2.3
	0	6	13.6	15.9
	Accidental	1	2.3	18.2
	Any client	1	2.3	20.5
	Anyone who	1	2.3	22.7
	Classified	1	2.3	25.0
	Inability	4	9.1	34.1
	Incontinent	2	4.5	38.6
	Involuntary	7	15.9	54.5
	It is the	2	4.5	59.1
	Lack of co	1	2.3	61.4
	Leakage of	2	4.5	65.9
	Socially I	1	2.3	68.2
	The inappropriate	2	4.5	72.7
	The involuntary	5	11.4	84.1
	The leakage	2	4.5	88.6
	The message	1	2.3	90.9
	The patient	1	2.3	93.2
	Unintended	1	2.3	95.0
	Voiding of	1	2.3	97.7
	When a person	1	2.3	100.0
	Total	44	100.0	

13.6% (N = 6) of the respondents did not answer this question.

27.3% (N = 12) completed this question by saying it was involuntary loss of urine and /or faeces

Other terms used to define incontinence included:-

Inability	9.1%	(N = 4)
Leakage	9.0%	(N = 4)
Inappropriate	4.5%	(N = 2)

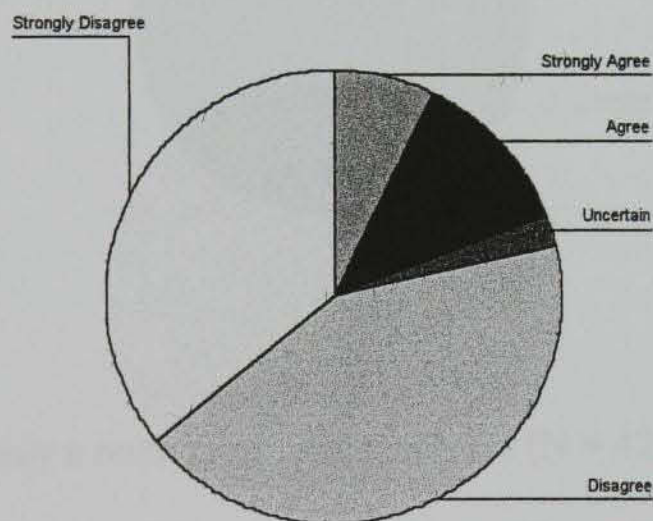
Other terms used less frequently included, uncontrol, accidental, unintended.

4.3 Attitudes Question 14 (see Appendix 111)

The nurses primary role caring for patients with incontinence should be concerned with supplying appropriate aids.

Table 4:14.1 Outlines the results of the statement above.

Supply of appropriate aids		Frequency	Valid %	Cumulative %
Valid	Strongly Agree	3	7.1	7.1
	Agree	5	11.9	19.0
	Uncertain	1	2.4	21.4
	Disagree	18	42.9	64.3
	Strongly disagree	15	35.7	100.0
	Total	42	100.0	
Missing	0	2		
	Total	44		



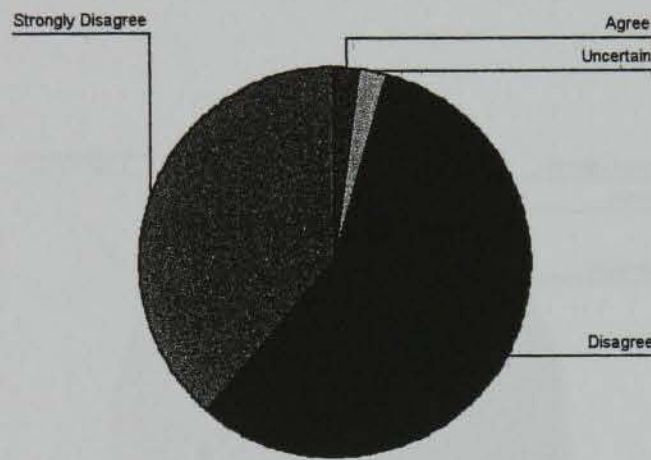
78.6% (N = 33) disagree with what the nurses primary role should be when caring for incontinent patients.

19% (N = 8) agree or strongly agree that the nurses should supply appropriate aids as their primary role.

Incontinence is really only a nursing problem.

Table 4: 14.2 Outlines the results of the statement above.

Incontinence is really only a nursing problem		Frequency	Valid %	Cumulative %
Valid	Agree	1	2.3	2.3
	Uncertain	1	2.3	4.5
	Disagree	25	56.8	61.4
	Strongly disagree	17	38.6	100.0
	Total	44	100.0	



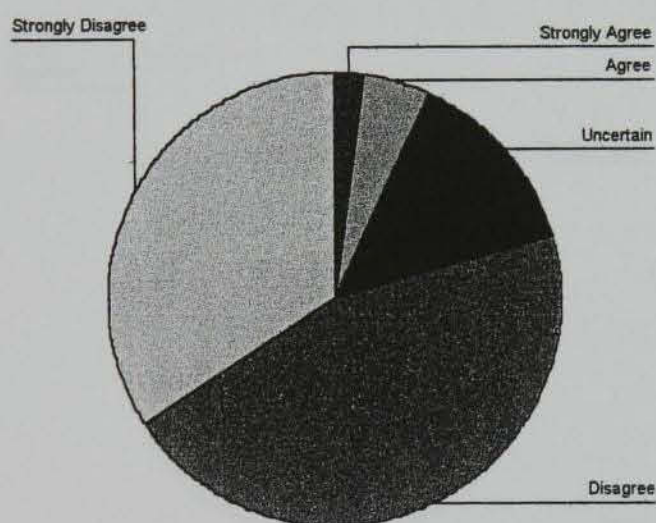
Incontinence is really only a nursing problem. 95.4% (N = 42) disagree or strongly disagree that incontinence is really only a nursing problem. The majority of Public Health Nurses feel other disciplines should be involved.

Only 2.3% (N = 1) feels that incontinence is really only a nursing problem and the remaining 2.3% (N = 1) are uncertain.

During the early phase of stroke rehabilitation bladder problems are best dealt with by a catheter.

Table 4: 14.3 Outlines the results of the statement above

Catheter for stroke rehabilitation		Frequency	Valid %	Cumulative %
Valid	Strongly Agree	1	2.3	2.3
	Agree	2	4.5	6.8
	Uncertain	6	13.6	20.5
	Disagree	20	45.5	65.9
	Strongly disagree	15	34.1	100.0
Total		44	100.0	

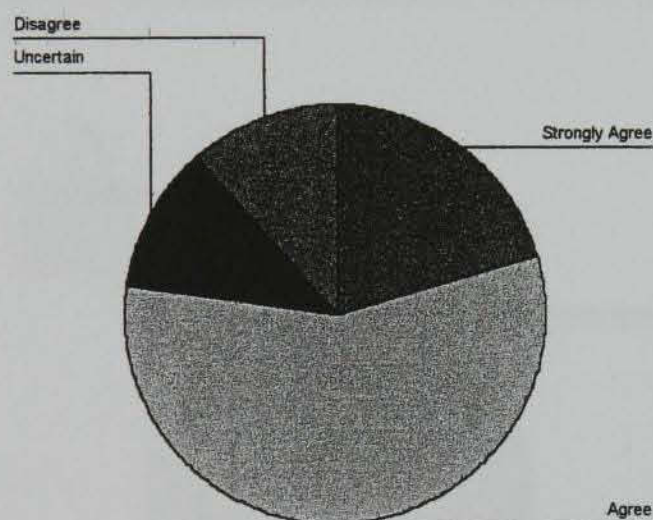


79.6% (N = 20) Disagree or strongly disagree that early stroke rehabilitation bladder problems are best dealt with by a catheter. 6.8% (N = 3) agree and 13.6% (N = 6) are uncertain.

The assessment of incontinence is most suited to a multidisciplinary team approach

Table 4: 14.4 Outlines the results of the statement above

Assessment multidisciplinary	Frequency	Valid %	Cumulative %
Valid Strongly Agree	9	20.5	20.5
Agree	25	56.8	77.3
Uncertain	5	11.4	88.6
Disagree	5	11.4	100.0
Total	44	100.0	



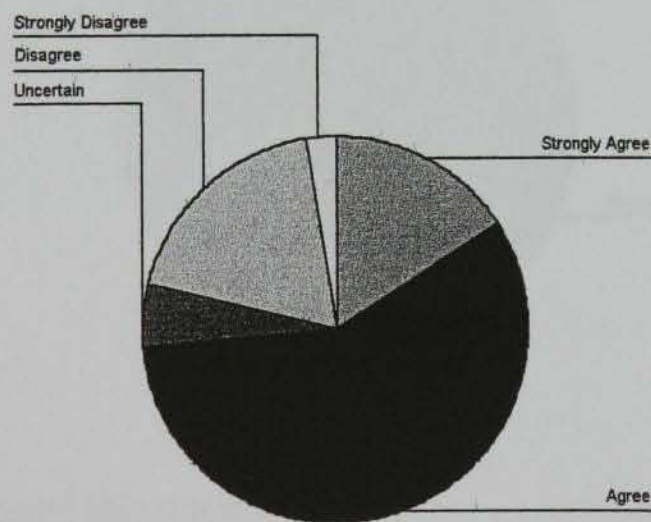
77.3% (N = 34) agree or strongly agree with the above statement.

11.4% (N = 5) are uncertain and 11.4% (N = 5) disagree that the assessment of incontinence is most suited to a multidisciplinary team approach.

The management of incontinence is most suited to a multidisciplinary team approach

Table 4: 14.5 Outlines the results of the statement above.

Management multidisciplinary		Frequency	Valid %	Cumulative %
Valid	Strongly Agree	6	15.8	15.8
	Agree	22	57.9	73.7
	Uncertain	2	5.3	78.9
	Disagree	7	18.4	97.4
	Strongly disagree	1	2.6	100.0
	Total	38	100.0	
Missing	0	6		
	Total	44		



73.7% (N = 28) feel that management of incontinence should be carried out with a multidisciplinary team approach.

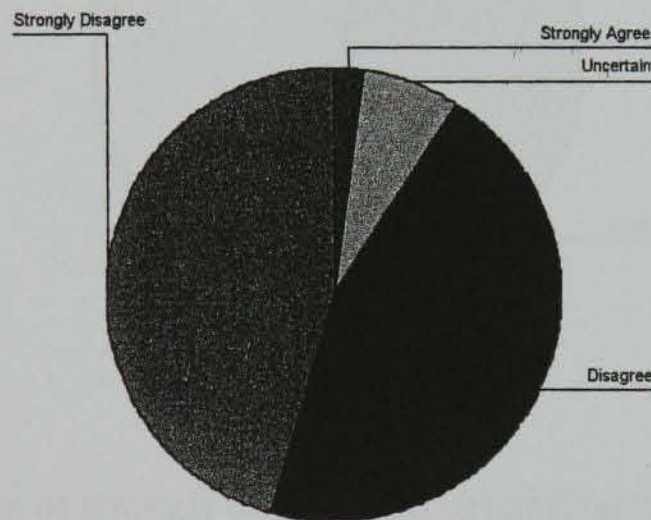
21% (N = 8) disagree with this statement, while 5.3% are uncertain.

13.6% (N = 6) did not reply to this question.

**The only effective ways to achieve continence are surgery
and drug therapy**

Table 4: 14.6 Outlines the results of the statement above.

Surgery and drug therapy		Frequency	Valid %	Cumulative %
Valid	Strongly Agree	1	2.3	2.3
	Uncertain	3	6.8	9.1
	Disagree	20	45.5	54.5
	Strongly disagree	20	45.5	100.0
	Total	44	100.0	



All respondents completed this question.

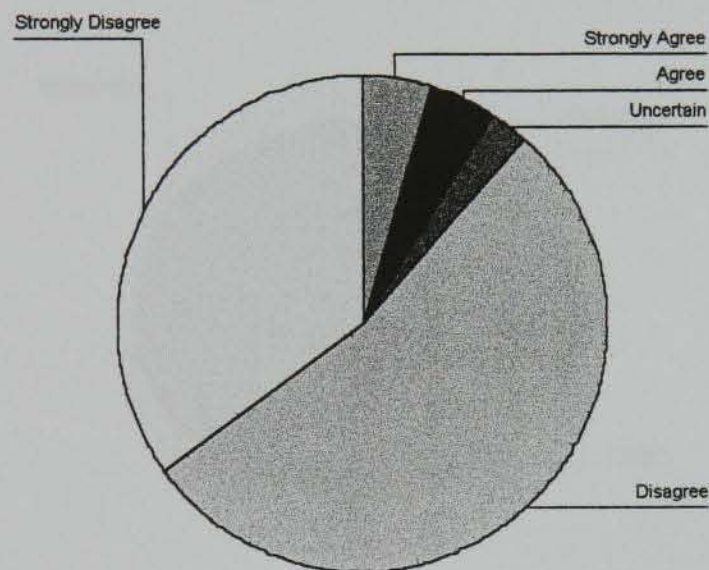
91% (N = 40) do not agree that surgery and drug therapy are the only effective ways to achieve continence.

2.3% (N = 1) agrees and 6.8% (N = 3) are uncertain.

Rehabilitation is the task of the Physio and OT and should not be an additional workload for nursing staff

Table 4: 14.7 Outlines the results of the statement above.

Rehabilitation		Frequency	Valid %	Cumulative %
Valid	Strongly Agree	2	4.7	4.7
	Agree	2	4.7	9.3
	Uncertain	1	2.3	11.6
	Disagree	23	53.5	65.1
	Strongly disagree	15	34.9	100.0
	Total	43	100.0	
Missing	0	1		
	Total	44		



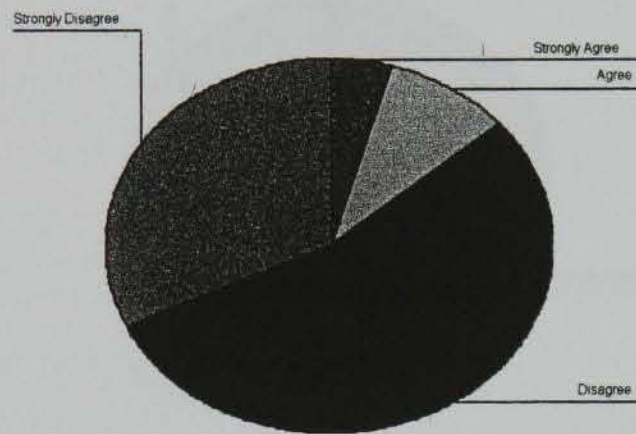
88.4% (N = 38) disagree or strongly disagree that rehabilitation should be left to Physio and Occupational Therapist.

9.4% (N = 4) Agree, and 2.3% (N = 1) is uncertain.

Pelvic Floor Exercise is the task of Physio and Occupational Therapist

Table 4: 14.8 Outlines the results of the statement above.

Pelvic Floor Exercises		Frequency	Valid %	Cumulative %
Valid	Strongly Agree	2	4.5	4.5
	Agree	4	9.1	13.6
	Disagree	24	54.5	68.2
	Strongly disagree	14	31.8	100.0
	Total	38	100.0	

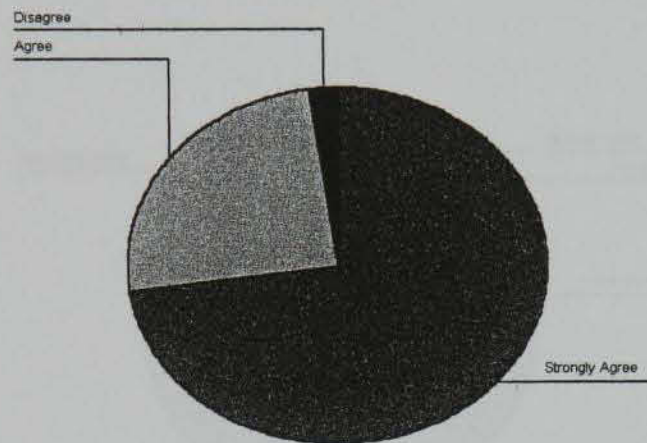


The majority of Public Health Nurses, 86.3% (N = 38) who responded to this question expressed that they disagree that pelvic floor exercises are the task of Physio and OT 13.6% (N = 6) agree that OT and Physio should be motivating and encouraging pelvic floor exercises.

Incontinence should always be investigated

Table 4: 14.9 Outlines the results of the statement above.

Investigations - incontinence		Frequency	Valid %	Cumulative %
Valid	Strongly Agree	32	72.7	72.7
	Agree	11	25.0	97.7
	Disagree	1	2.3	100.0
	Total	44	100.0	

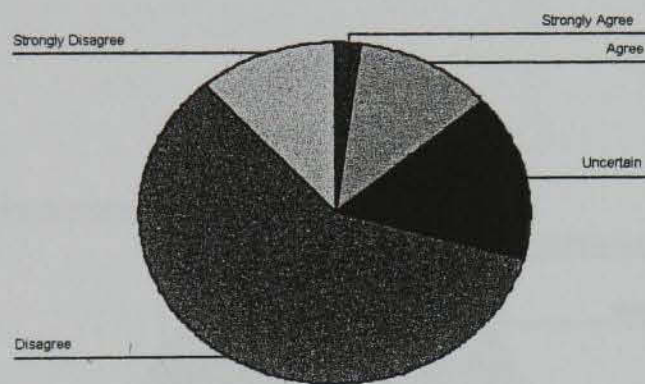


Almost all the Public health Nurses 97.7% (N = 43) agree incontinence should be investigated. 2.3% (N = 1) disagreed that incontinence should always be investigated.

Two hour toileting and incontinence aids are the only realistic ways to promote continence in the elderly

Table 4: 14.10 Outlines the results of the statement above.

2 Hourly Incontinence Aids		Frequency	Valid %	Cumulative %
Valid	Strongly Agree	1	2.3	2.3
	Agree	5	11.4	13.6
	Uncertain	7	15.9	29.5
	Disagree	26	59.1	88.6
	Strongly disagree	5	11.4	100.0
	Total	44	100.0	

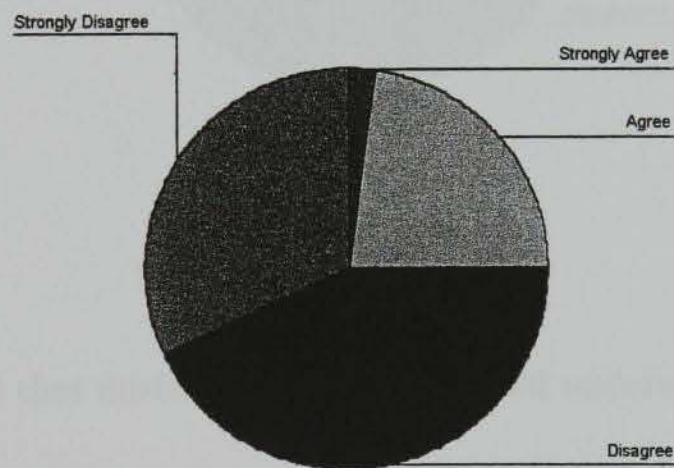


Almost three quarters of the respondents 70.56 % (N = 31) disagree with two hourly toileting and incontinence aids as being the only realistic way to promote continence. 13.7% (N = 7) agree with two hourly toileting and continence aids whereas 15.9% (N = 7) were uncertain

Patients are often incontinent due to laziness

Table 4: 14.11 Outlines the results of the statement above.

Patients are often incontinent due to laziness		Frequency	Valid %	Cumulative %
Valid	Strongly Agree	1	2.3	2.3
	Agree	10	22.7	25.0
	Disagree	19	43.2	68.2
	Strongly disagree	14	31.8	100.00
	Total	44	100.0	



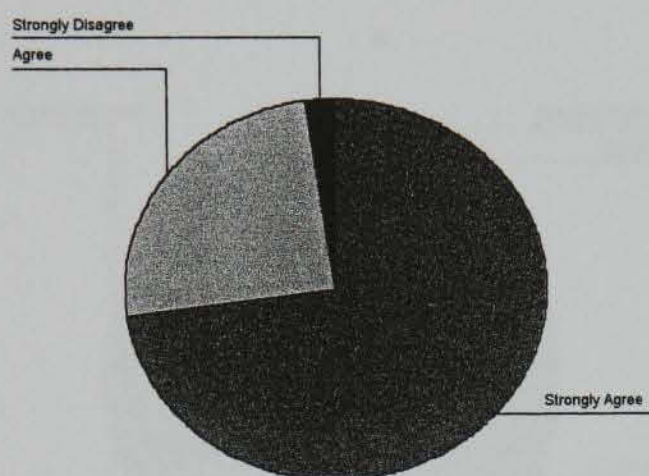
75% (N = 33) which is exactly three-quarters of the respondents disagree that patients are incontinent due to laziness.

The remaining 25% (N = 11) agree.

**It is important for all nurses to have a good understanding
about the causes of incontinence**

Table 4: 14.12 Outlines the results of the statement above

Understanding causes of incontinence		Frequency	Valid %	Cumulative %
Valid	Strongly Agree	32	72.7	72.7
	Agree	11	25.0	97.7
	Strongly disagree	1	2.3	100.0
	Total	44	100.0	

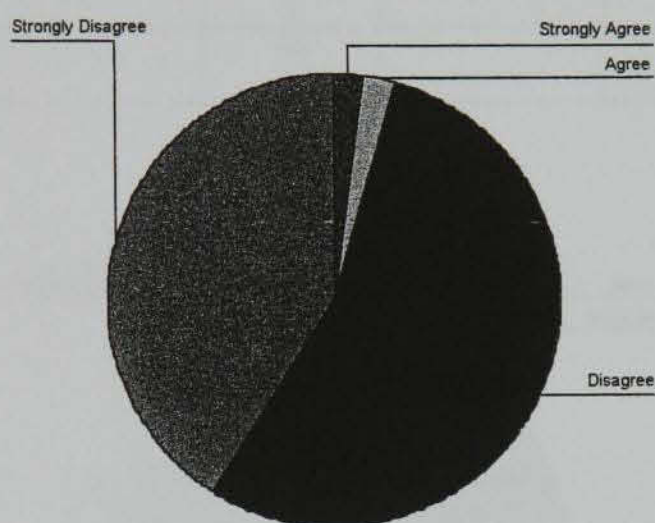


97.7% (N = 43) agree that nurses should have a good understanding about the causes of incontinence. 2.3% (N = 1) disagree.

**Elderly people with longstanding incontinence problems
do not usually require investigation**

Table 4: 14.13 Outlines the results of the statement above.

Investigating incontinence		Frequency	Valid %	Cumulative %
Valid	Strongly Agree	1	2.3	2.3
	Agree	1	2.3	4.5
	Disagree	24	54.5	59.1
	Strongly disagree	18	240.9	100.0
	Total	44	100.0	



All respondents replied to this question, with almost all Public Health Nurses 95.4%

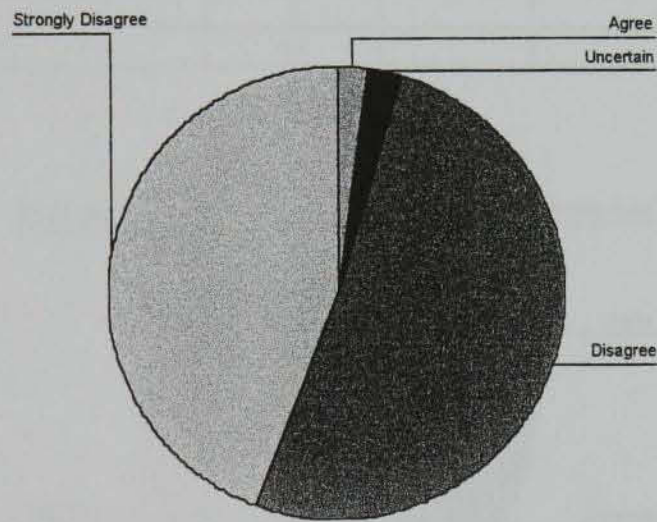
(N = 42) disagreeing that they do not require investigation.

4.6% (N = 2) agree that they do not require investigation.

Incontinence is an inevitable part of the ageing process

Table 4: 14.14 Outlines the results of the statement above.

Incontinence is an inevitable part of the Ageing process		Frequency	Valid %	Cumulative %
Valid	Agree	1	2.3	2.3
	Uncertain	1	2.3	4.7
	Disagree	22	51.2	55.8
	Strongly disagree	19	44.2	100.0
	Total	43	100.0	
Missing	0	1		
Total		44		



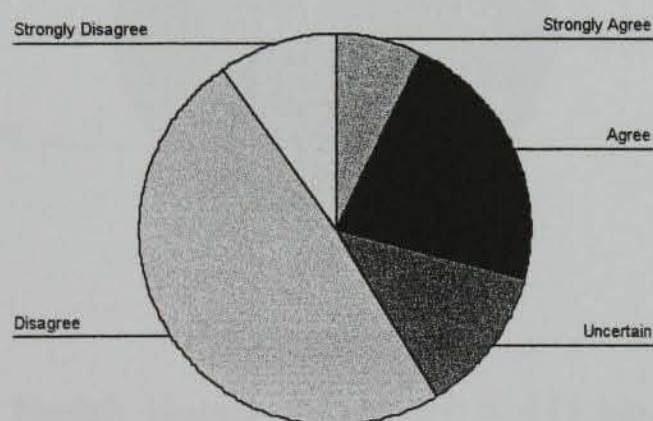
95.4.% (N = 41) disagree or strongly disagree with this statement.

2.3% (N = 1) agrees and 2.3% (N = 1) is uncertain.

Continence promotion is a specialised skill and should therefore be left to people such as Continence Advisors

Table 4: 14.15 Outlines the results of the statement above.

Continence/Continence Advisors		Frequency	Valid %	Cumulative %
Valid	Strongly Agree	3	7.3	7.3
Valid	Agree	9	22.0	29.3
	Uncertain	5	12.2	41.5
	Disagree	20	48.8	90.2
	Strongly disagree	4	9.8	100.0
	Total	41	100.0	
Missing	0	3		
	Total	44		



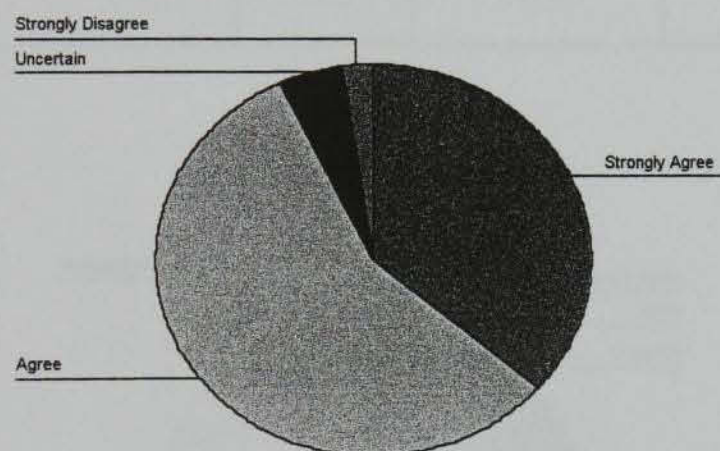
58.6% (N = 24), which is just over half of the Public Health Nurses, who responded to this question disagreed with Continence Promotion being left to Continence Advisors.

29.3% (N = 12) agree to leave this work to Continence Advisors, 12.2% (N=5) are uncertain and 6.8% (N = 3) Public Health Nurses did not respond.

Continence is a realistic goal for many incontinent elderly people

Table 4: 14.16 Outlines the results of the statement above.

Continence is a realistic goal		Frequency	Valid %	Cumulative %
Valid	Strongly agree	16	36.4	36.4
	Agree	25	45.8	93.2
	Uncertain	2	4.5	97.7
	Strongly disagree	1	2.3	100.0
	Total	44	100.0	



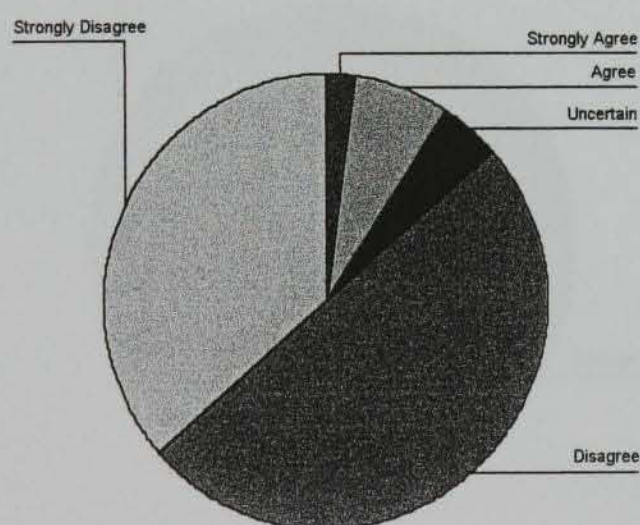
Almost all the Public Health Nurses 93.2% (N = 41) agree that continence is a realistic goal for many incontinence elderly people.

4.5% (N = 2) are uncertain and 2.3% (N = 1) disagree.

**I find it demoralising looking after incontinent patients
because there is little I can do to help**

Table 4: 14.17 Outlines the results of the statement above.

Demoralising looking after incontinent Patients		Frequency	Valid %	Cumulative %
Valid	Strongly Agree	1	2.3	2.3
	Agree	3	6.8	9.1
	Uncertain	2	4.5	13.6
	Disagree	22	50.0	63.6
	Strongly disagree	16	36.4	100.0
	Total	44	100.0	

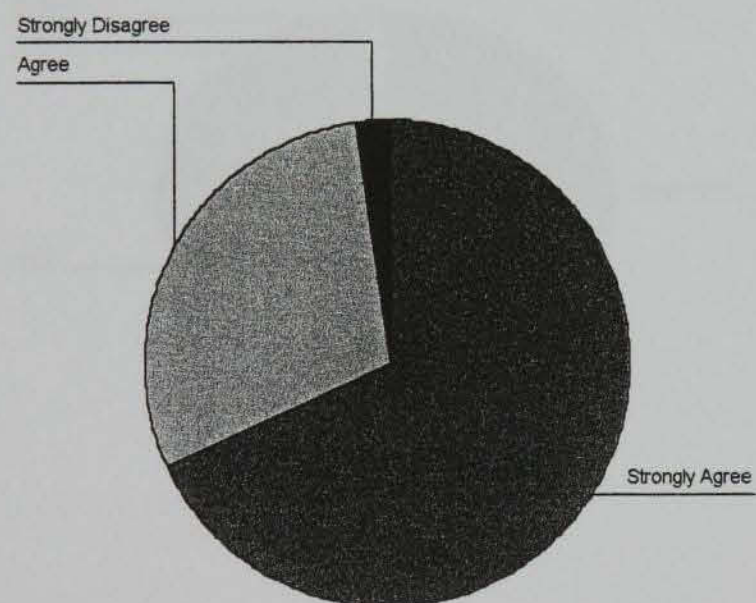


9.15% (N = 4) agree and feel that there is little they can do to help, whereas 86.4% (N = 38) disagree and feel their contribution is worthwhile. 4.5% (N = 2) are uncertain.

Incontinence is distressing for the older person

Table 4: 14.18 Outlines the results of the statement above.

Incontinence is distressing for older person	Frequency	Valid %	Cumulative %
Valid 1	30	68.2	68.2
2	13	29.5	97.7
5	1	2.3	100.0
Total	44	100.0	



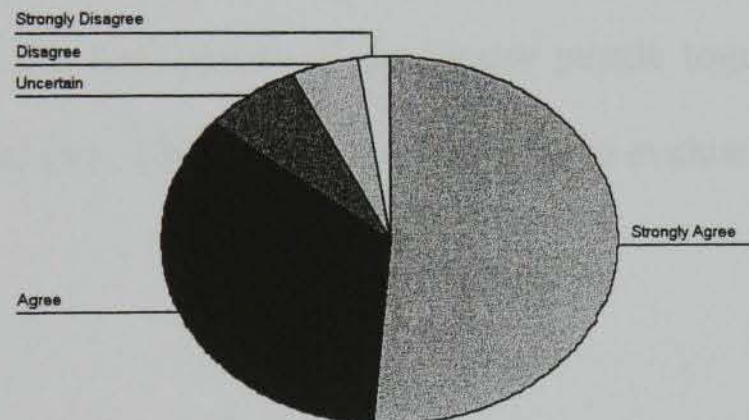
Almost all 97.7% (N = 43) agree that incontinence is distressing for the older person.

2.3% (N = 1) disagrees.

Health professionals attitudes determine the appropriate steps necessary for the prevention and effective management of incontinence

Table 4: 14.19 Outlines the results of the statement above.

Attitudes determine appropriate steps.		Frequency	Valid %	Cumulative %
Valid	Missing	1	2.3	2.3
	Strongly agree	22	50.0	52.3
	Agree	15	34.1	86.4
	Uncertain	3	6.8	93.2
	Disagree	2	4.5	97.7
	Strongly disagree	1	2.3	100.0
	Total	44	100.0	



84.1% (N = 37) agree that health professionals attitudes determine the appropriate steps necessary for the prevention and effective management of incontinence.

6.8% (N=3) disagree and 6.8% (N = 3) are uncertain.

CHAPTER 5.

Discussion

5:1 Quantitative Study

According to Lobiondo-Wood and Haber (1998) the analysis of the results, interpretations and generalisations that a researcher generates from a study is a highly important part of the research project from the viewpoint of the research consumer.

Lobiondo-Wood and Haber (1998) highlight that it is after the analysis of the data that the researcher puts the final pieces of the jigsaw puzzle together to view the total picture with a critical eye. This process is analogous to evaluation, the last step in the research process.

“The consumer of the research may view these last sections as an easier step for the investigator, but it is here that a most critical and creative process comes into use. It is in these final sections of the report, after the statistical procedures have been applied that the researcher will interrelate the statistical or numerical findings to the theoretical framework, literature methods, hypotheses and problem statements”.
(Lobiondo-Wood and Haber 1998 : 400).

This study set out to survey Public Health Nurses' knowledge and attitudes to Continence Promotion in Care of the Older Person in the Community. The objectives of the study were to elicit Public Health Nurses' attitudes towards specific aspects of caring for people with incontinence and to measure these attitudes on the ongoing evaluation of the management of incontinence. The study also attempted to ascertain Public Health Nurses knowledge of the significance of assessing older people in identifying the type of incontinence and to evaluate whether Public Health Nurses recognise the importance of accurate diagnosis to plan and implement a treatment programme for the promotion of continence and management of incontinence.

The study design using a quantitative approach met these objectives by means of a questionnaire. The questionnaire formed the investigative tool, which was used in the quantitative study.

The author's search for a suitable questionnaire to investigate the research question was successful. The questionnaire was reviewed and adapted to suit the sample being used in this study.

The questions employed in this study were similar to those used in the original questionnaire and adjustments were made to survey knowledge and attitudes of nurses caring in the community.

Literature publication on knowledge and attitudes of Health Care Professionals is limited. Very little research has been carried out. There are no recent publications on Medline and only three available on a search of CINAHL.

The first section of the study provides demographic details based on the data collected in questions 1 and 2. The indicators utilised included those of age and total length of experience as a Public Health Nurse.

Questions 3-9 elicit the educational preparation Public Health Nurses had obtained, whereas questions 10 to 16 (excluding question 14) ascertain knowledge concerning continence promotion.

Question 14 measures attitudes of Public Health Nurses on the ongoing evaluation of the management of incontinence and towards specific aspects of caring for people with incontinence.

Pilot Study

A pre test was carried out prior to the pilot study. Five sample questionnaires were distributed personally to five Public Health Nurses, colleagues, who were not included in the main study. No alterations were made following pre-test.

A pilot study was conducted to ensure that the revised questionnaire was easily comprehensible to the respondents. The pilot study took place in a community care area excluded from the main study.

The Public Health Nurses did not appear to have any problem with understanding and completing the questionnaire.

Main Study-Sample

The sample and total population consisted of all Area Registered Public Health Nurses working in a Health Board area. The sample was chosen because all the Public Health Nurses care for older people. A questionnaire was posted to each Area Registered Public Health Nurse.

5.2 The Respondents.

Demographic Characteristics.

Of the 44 Public Health Nurses who responded, 2 did not identify which age group they corresponded to, and 1 did not indicate her length of nursing experience since qualifying as a Registered Public Health Nurse. Therefore the statistical analysis here is confined to the remaining responses.

All the respondents were female whose ages ranged from 20's to 60's. 25 of them were over 45 years.

Vinsnes et al (2001) in their study of Health Personnel's attitudes towards patients with urinary incontinence found that the average age of the 71 registered nurses caring for the older person who returned their questionnaires was 41.9 years.

Their years of experience as a Public Health Nurse ranged from less than 1 year to 32 years. This result indicated that the majority of area Registered Public Health Nurses have gained high levels of experience working in the community. 18 of them have been in their current position for over 20 years.

Educational Preparation and Knowledge concerning Continence Promotion.

The results of educational preparation were analysed independently of the questions on knowledge.

5.3 Educational Preparation.

Overall, educational preparation was found to be that the majority of Public Health Nurses had received education on continence promotion.

Vinsnes et al (2001) could not decide whether education makes nurses less prepared for dealing with urinary incontinence or could their findings reflect the fact that higher education could lead to a more honest and confident expression of feelings and reactions.

Further interpretation of the data indicated that over half of the Public Health Nurses had completed a Continence Promotion Course. Almost all of them had attended lectures and/or seminars. Half of the respondents had received lectures relating to the subject of Continence/Incontinence during their Public Health Nurse course. 5 of the respondents indicated that they had completed a Post Graduate Course in Care of the Older Person. Only 1 nurse belonged to a continence group or association. Norton (1986) and Kennedy (1984) acknowledge that the restoration of continence is the responsibility of all nurses in spite of the development of the continence advisor role.

Feelings of the Public Health Nurses concerning preparatory knowledge indicated good levels of confidence in their own abilities. Urinary incontinence, particularly in the elderly, can be complex, with multifactorial symptoms, which can be the result of

pre-disposing, physical, environment, psychological and social factors and may result from several inter-related incidents (Norton, 1986).

Despite this complexity 40 of the respondents felt prepared about knowledge of causes of incontinence. 32 felt they had the ability to assess incontinence. 36 were aware of methods to promote continence. 32 felt confident in management of urinary incontinence. 37 were aware of aids to promote continence and 37 of them had preparatory knowledge of indwelling catheter management. Cheater (1992) found in her study of pre and post-registration nurses that education still focused predominantly upon palliative rather than therapeutic or rehabilitative nursing strategies in spite of considerable advances in the management of urinary incontinence.

Almost half of the Public Health Nurses who responded had received their professional knowledge relating to incontinence from in-service education.

In discussing the prevalence of urinary incontinence Thomas (1980) says that incidence is much higher in the elderly, particularly in the very elderly (80 years or more). Urinary incontinence, particularly in the elderly, can be complex, with multifactorial symptoms, which can be the result of pre-disposing, physical, environmental, psychological and social factors and may result from several inter-related incidents (Norton, 1986).

5.4 Knowledge.

The following discussion of analysis indicates knowledge.

All the Public Health Nurses who responded to the first question in this section, which asked if there are problems relating to clients who are incontinent, experience problems relating to caring for clients who are incontinent. There are 40 main problems listed in the frequency distribution (Appendix I). The problems ranged from client-centred needs, attitudes of clients and carers to incontinence and incontinence wear, difficulty recording frequency volume charts for accurate assessment, and there were references to lack of time to do proper assessments.

Almost half of the respondents stated that specialists e.g. Continence Advisors should be mainly responsible for promoting continence/management of incontinence in the community. 31.7% replied that nursing staff should be mainly responsible and 24.4 % thought that medical and nursing staff should be responsible. Opinions varied for responsibility of assessment of incontinence. 30.6% think Continence Advisors should assess patients and 69.4% thought assessment is of equal importance for a multidisciplinary approach.

It is interesting to note that there were no replies to either part of the question, stating that medical staff should be mainly responsible for assessment and management. This analysis agrees with what has been written in the literature. Morishita (1998) discussed the fact that nurses are in a prime position to make a positive impact on the care of elderly patients with urinary incontinence. Ouslander et al (1987) stated that

incontinent women may be more reluctant to admit incontinence to a man than to a woman. Therefore female nurses are more likely to be informed than male general practitioners.

Public Health Nurses included many factors, which they felt were important when assessing a patient in the community. The three most frequently mentioned factors were (i) type of incontinence (ii) fluid intake and output (iii) access to toilet. Overall there were 38 factors listed as being important for assessment (Appendix II). These varied from age profile, physical and mental condition, environmental and psychosocial factors and medical condition. Other factors mentioned were clients and carers attitudes and compliance with assessment of incontinence.

All respondents showed an interest in attending courses, study days, and conferences. When assessing and managing incontinence, 95% use guidelines for assessment and 75% use guidelines for management.

27.3% of the Public Health Nurses who responded expressed that the definition of incontinence was an involuntary loss of urine. Other terms used to define incontinence included inability to retain urine, leakage of urine or inappropriate passage of urine. Other terms used less frequently included loss of control of bladder, accidental wetting, unintended escape of urine. 13.6% did not attempt to define incontinence at all.

Public Health Nurses in this study had varying levels of knowledge in the promotion of continence in caring for the older person. In the community knowledge of

appropriate interventions that are available to restore continence or effectively manage the problem is required. Igon (1986) discusses that nurses and other Health Care Professionals need to be aware of the wide range of underlying causes of the problem so as to have a rehabilitative approach towards caring for an individual with incontinence.

The adequacy of the knowledge possessed by Nurses and other Health Professionals within this area has been questioned. (King's Fund, 1983; Royal College of Nursing, 1982).

In the past 20 years there has been a considerable expansion in knowledge about the assessment and treatment of urinary incontinence, together with innovations such as specialist assessment clinics and the development of the continence advisor role.

One would question whether nursing and medical practice has adapted sufficiently to meet satisfactorily the needs of incontinent people.

Reports of the King's Fund (1983) and Royal College of Nursing (1982) claimed that health professionals lacked sufficient knowledge about incontinence due to inadequate education at either basic or post basic levels.

Wells (1975), in her study of nursing problems encountered in caring for elderly people, conducted a small survey in which she aimed to assess nurses' knowledge about incontinence. Her response rate was low (35%) and respondents were limited to 14 in number, but her results indicated that nurses knew little about the causes of the problem. The authors' study risk a response rate of 67% indicated that 93% felt they were well informed about the causes of incontinence.

5.5 Attitudes

The following discussion of analysis indicates attitudes of the Public Health Nurses when caring for the Older Person with Incontinence in the Community.

Attitudes were measured by the means of a series of 19 five-point Likert- type statements.

The statements imply either a favourable or unfavourable attitude towards the issue under investigation.

In this study of the statements covered three broad dimensions: the nurse's perception of his or her role, the assessment and management of incontinence and popular misconceptions. Statements were phrased to reflect either rehabilitative/therapeutic (favourable) or palliative/non-therapeutic (unfavourable) attitudes towards continence management (Appendix III).

Favourable items (i.e. those considered to reflect a therapeutic/rehabilitate attitude) were scored from 1 (strongly disagree) to 5 (strongly agree); unfavourable items were scored in the reverse order. (i.e. 1 (strongly agree) to 5 (strongly disagree)).

The results of each individual statement are shown in Appendix III. It was encouraging to find that, overall, the results indicated that nurses tended to agree with statements which reflected rehabilitative/therapeutic attitudes and disagreed with items which implied less-positive, palliative attitudes towards continence management. It is important, to consider items to which there were a considerable number of less positive responses as these may represent areas requiring closer attention.

The Nurses Role.

The majority (three-quarters) of the respondents did not agree that their primary role in caring for patients with incontinence should be concerned with supplying incontinence aids, a substantial minority agreed with this statement.

The provision of appropriate incontinence aids is an important nursing function but it is only one of a wide variety of strategies, which nurses can employ to manage incontinence.

Over one quarter of nurses (n=12) considered continence management to be a specialised skill, which should be left to people such as continence advisers while 5 nurses answered that they were uncertain on this point. (item 15; Appendix III).

This is in direct contrast with professional opinion, which clearly identifies nurses in all areas of practise as having a key role in helping individuals achieve continence (Norton 1986, Kings Fund 1983, Royal College of Nursing 1982). Confusion surrounding the precise role of specialist such as continence advisors may have caused some nurses to be unclear about the nature of their own role. Alternatively, nurses may not have felt sufficiently well informed about methods of continence management, a factor inhibiting their active involvement.

Vinsnes et al (2001) when writing about attitudes of Norwegian staff towards patients with urinary incontinence stated that attitudes can influence the quality of care provided.

In their discussion of the results of their survey, Vinsnes et al (2001) reported that they had found that nurses report overall positive attitudes towards urinary

incontinence. They also questioned whether their attitudes had any impact on actual practise.

Aspects of Management.

Findings suggested that many nurses had only a limited awareness of the management options that are available to help incontinent people. Seventy percent (n =31) agreed that 'two hourly toileting and incontinence aids are the only realistic ways to promote continence in care of the older person.' (item 10: Appendix III)

This is in contrast to current research, which has demonstrated that bladder-training regimes, pelvic floor exercises and intermittent self-catheterisation, among other rehabilitative strategies, can be very successful in the management of incontinence in care of the older person. (Pengilly 1980, Castleden 1984, Bennet 1984).

In this study seventy nine percent (n = 35) of the respondents disagreed that bladder problems associated with the early phase of stroke rehabilitation were best dealt with by the use of a catheter (item 3 Appendix III). In some circumstances an indwelling catheter may be indicated as the only satisfactory means of controlling incontinence. Occasionally indwelling catheters may be prescribed prematurely without due consideration of their contradictions or before other less invasive methods of management are attempted. (Castleden 1984)

Misconceptions.

The older person is more susceptible to incontinence than younger people because of the additional pathological, physiological pharmacological and psychological factors from which they are at risk. (Resnick 1985). Contrary to popular belief, however, incontinence is not an inevitable consequence of ageing.

Indeed the majority of older people remain continent throughout life. In this study ninety- five percent (n= 42) disagreed that incontinence was an inevitable part of ageing.

Ninety seven percent agreed that incontinence is distressing for the older person.

These findings suggest that many nurses recognise the profound psychological and social impact incontinence may pose to the older person.

5.6 Conclusion

It is widely recognised that to fulfil the nurse's role of providing education in the prevention of incontinence and help restore continence, she/he require specific knowledge and skills.

Cheater (1991) discusses the fact that strong positive rehabilitative attitudes are considered to be essential. She goes on to refer to the real problem in dealing with urinary incontinence as one of attitude of the health providers.

The literature indicates that in general health professionals' attitudes contain many misconceptions about incontinence, which in turn may lead to their failure to take appropriate steps towards its prevention and effective management. (Wells-1981, Mitteness 1987, Issacs 1976).

According to Cheater (1991) nurses and other health professionals' attitudes towards this aspect of patient care has not been systematically examined by research.

The results for each of the individual statements on attitudes are shown in Appendix III. It was encouraging to find that, overall, the results indicated that nurses tended to agree with statements which reflected rehabilitative/therapeutic attitudes and disagreed with items which implied less-positive, palliative attitudes, towards continence management. It is important, however, to consider items to which there

were a considerable number of less positive responses as these may represent areas requiring closer attention.

While the majority of the respondents did not agree that their primary role in caring for patients with incontinence should be concerned with supplying incontinence aids a substantial minority of 8 Public Health Nurses (19%)(N=8) agreed with this statement. The provision of appropriate continence aids is an important nursing function, but it is only one of a wide variety of strategies which nurses can employ to manage incontinence. Lack of knowledge concerning alternative forms of therapy may have prevented some nurses from acknowledging the wider rehabilitative aspects of their role in this area. The proliferation of incontinence aids and appliances in recent years may have encouraged nurses to perceive their role as predominantly palliative rather than therapeutic or rehabilitative.

A small number of nurses (n =12) considered continence management to be a specialised skill, which should be left to people such as continence advisors while 5 nurses answered that they were uncertain on this point. This is in direct contrast with professional opinion, which clearly identifies nurses in all areas of practice as having a key role in helping individuals achieve continence (Kings Fund (1983), Royal College of Nursing (1982), Norton, (1986).

Confusion surrounds the precise role of specialists such as continence advisors and may have caused some nurses to be unclear about the nature of their role.

Alternatively, nurses may not have felt sufficiently well informed about methods of continence management, a factor inhibiting their active involvement.

Findings suggested a need for increased education concerning the nurse's role in preventive care and greater emphasis on the therapeutic, rehabilitative aspects of continence management. More attention needs to be given to ways in which misconceptions surrounding incontinence can be dispelled.

On a specific level, however, nursing staff who work with elderly patients who are incontinent describe feelings of hopelessness, frustration, and resignation. Vinsnes et al (2001) discovered similar negative feelings expressed by respondents when caring for people who are incontinent. Some feelings and negative reactions included frustration, discouraged, helpless, resignation. Thus, the prevailing belief may be that nothing more can be done. Staff may perceive their need as one of increased staffing to manage patients more efficiently, rather than one of learning new information that may decrease or eliminate incontinence in some patients.

More studies are needed that explore actual practise and knowledge about urinary incontinence, as well as feelings and behaviour towards patients who are incontinent.

Chapter 6

Limitations and Recommendations.

This research provides only a limited survey on Public Health Nurses knowledge and attitudes as it was confined to one Health Board area.

The findings could not be applied or be representative of other Health Board areas. The sample used in this study was a total population. Findings from other sampling methods e.g. random sampling may not be as confined.

The author used a questionnaire already designed but made some alterations to suit the sample selected. The style and presentation of the questionnaire may not have encouraged some potential respondents to reply. Open-ended questions often engender resentment among questionnaire respondents; who dislike having to compose and write out a reply. There is also a tendency for people to leave a question unanswered.

The sample selected was an all-female population. There was no opportunity in this research to examine knowledge and attitudes of male nurses to continence promotion. Thus future research could expand on the current findings by considering mixed population sample.

In spite of the limitations, the research has demonstrated that education in continence promotion needs to be maintained and improved.

Further research, using a qualitative design may uncover or expose other facets of knowledge or attitudes.

Ideally, all nursing students should receive basic information about the physical, social, psychological, and environmental factors that contribute to incontinence among older people.

The author strongly recommends that all Health Board areas should have continence services managers and continence advisors relative to each care group.

Continence Advisors where employed, may be involved in teaching nurses but the many other demands of their role may frequently prohibit more than a minimal input to pre and post registration nurse education.

The current level of education provision on continence promotion needs to be reviewed and evaluated.

The author recommends that nurse educators themselves should be sufficiently prepared to teach this important aspect of nursing care to nurses.

Ideally, all nursing students should receive basic information about the physical, social, psychological, and environmental factors that contribute to incontinence among older people.

Valuable opportunities should be provided to allow Public Health Nurses to update their professional knowledge about assessment and management of urinary incontinence and this should be equitable in all Health Board areas.

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APPENDIX I

Response to Question 10(B)

in questionnaire used.

Table 4:10.2 Can you explain what are the MAIN problems

	MAIN PROBLEMS	Frequency	Valid %	Cumulative %
Valid	0	4	9.1	9.1
	Alzheimer's - private i.e Proud Embarrassed(a few) Blocked male catheter Non Compliance of patients	1	2.3	11.4
	Client attitude. Carers frustration. Written work. Filling in intake output charts Client or carer demanding certain products e.g. diaper. Not willing to accept advice. Clients come when there is a crisis and want instant cures/aids/pads.	1	2.3	13.6
	Clients not admitting their problem when family look for help.	1	2.3	15.9
	Clients think when they come to PHN C/O incontinence that they should be given pads without assessment.	1	2.3	18.2
	Co-operation	1	2.3	20.5
	Collecting supplies. Inability of elderly to fill out intake and output charts.	1	2.3	22.7
	Embarrassment in disc Convenes not fitting and coming off. Catheters coming out-bulbs intact.	1	2.3	25.0
	Elderly women---Stress incontinence and urgency Extra stress for carer.	1	2.3	27.3
	Compliance in adhering to treatment regime and correct use of appliances	1	2.3	29.5
	Family requests.	1	2.3	31.8
	Frequency volume charts for elderly patients. Somebody to get patient to toilet.	1	2.3	34.1
	Functional Stress Urge compounded with some other problems e.g. Arthritis Post-- Op.	1	2.3	36.4
	Heavy workload. Time restraints-A lot of time for proper assessment.	1	2.3	38.6
	Incontinence of elderly female Carers find this difficult to cope with.	1	2.3	40.9
	Incontinence of urine in elderly women.	1	2.3	43.2
	Increasing number of people living alone with poor family	1	2.3	45.5
				47.7
				50.0
				52.3

support.			
Non-medical cardholders not entitled. Initial sorting out.	1	2.3	54.5
Patient compliance regarding charting fluid balance particularly with the	1	2.3	56.8
Lack of motivation or belief on other methods of treatment instead of using pads/nappies	1	2.3	59.1
Lack of proper assessment. Ignorance.	1	2.3	61.4
Lack of time. Lack of co-operation by the patient	1	2.3	63.6
Leakage from pads , allergic reaction to pads.			
Main problem is time. More nursing time to re-assess patient regularly. Reluctance to report incontinence.	1	2.3	65.9
No home care attendant for personal hygiene. Non-medical cardholders difficulty obtaining aids.	1	2.3	68.2
Non-compliance of client. Clients making demands for continence wear/not using according to guidelines.	1	2.3	70.5
Non-compliance with assessment and management.	1	2.3	72.7
Non -compliance with incontinence chart.	1	2.3	75.0
Non compliance with pads.	1	2.3	77.3
Patients just demanding PADS and unwilling to fill in baseline chart.	1	2.3	79.5
Patients always wanting the bigger pads.	1	2.3	81.8
Referrals from GPs and Hospitals for incontinence ware without previous assessment.	1	2.3	84.1
Reluctance to do urine frequency chart. People requesting nappy instead of pads.	1	2.3	86.4
Stress and urge incontinence.	1	2.3	88.6
Stress incontinence in the elderly. Post natal depression.	1	2.3	90.9
The Elderly alone getting to the toilet. Lack of family help towards continence management.	1	2.3	93.2
To get enough incontinence wear.	1	2.3	95.5
Wet and smelly. Relatives feel it is a very sensitive area.	1	2.3	97.7
Young people -under 65 years complaining of incontinence and in need of incontinence wear.	1	2.3	100.0
Total	44	100.0	

APPENDIX II

Response to question 12

In questionnaire used.

Table 4:12.1 Indicates what PHN's think are important factors when assessing a patient in the community.

Factors		Frequency	Valid %	Cumulative %
Valid	0	4	9.1	9.1
	24 Hour assessment chart	1	2.3	11.4
	Access to toilet	2	4.5	15.9
	Advise patient	1	2.3	18.2
	Age	1	2.3	20.5
	Age profile	1	2.3	22.7
	Back-up from GP's	1	2.3	25.0
	Co-operation from family member	1	2.3	27.3
	Co-operation from patient or carer	1	2.3	29.5
	Co-operation of family	1	2.3	31.8
	Common sense	1	2.3	34.1
	Condition of patient regarding mobility	1	2.3	36.4
	Confidentiality.	1	2.3	38.6
	Continence assessment chart	1	2.3	40.9
	Detailed history taking	1	2.3	43.2
	Eliminating UTI	1	2.3	45.5
	Fluid intake	1	2.3	47.7
	Fluid intake and output	2	2.3	52.3
	Help for patient	1	2.3	54.5
	Holistic approach	1	2.3	56.8
	Home setting	1	2.3	59.1
	How mentally alert is the patient.	1	2.3	61.4
	Language	1	2.3	63.6
	Medial background	1	2.3	65.9
	Nurse - good base knowledge	1	2.3	68.2
	Patients mental ability	1	2.3	70.5
	Physical	1	2.3	72.7
	Prior check by GP	1	2.3	75.0
	Privacy	1	2.3	77.3
	Privacy	1	2.3	79.5
	That the person understands	1	2.3	81.8
	That wear is suitable	1	2.3	84.1
	Time to assess	1	2.3	86.4
	Time to get thorough history	1	2.3	88.6
	Time with client-undisturbed	1	2.3	90.9
	Type of incontinence	3	6.8	97.7
	Urinary infection	1	2.3	100.0
	Total	44	100.0	

Table 4:12.2 Indicates what PHN's think are important factors when assessing a patient in the community.

Factors		Frequency	Valid %	Cumulative %
Valid	0	8	18.2	18.2
	Able to follow instructions	1	2.3	20.5
	Access to toilet or commode	2	2.3	22.7
	Accurate history	1	2.3	25.0
	Age and mobility of the patient	1	2.3	27.3
	Age gender and parity	1	2.3	29.5
	Assessing type of incontinence	1	2.3	31.8
	Assistance with fluid balance chart	1	2.3	34.1
	Attitude to incontinence	1	2.3	36.4
	Carer for patient	1	2.3	38.6
	Cause	1	2.3	40.9
	Communication skills	1	2.3	43.2
	Communication skills	1	2.3	45.5
	Equipment	1	2.3	47.7
	Honesty re history details	1	2.3	50.0
	Investigate cause	1	2.3	52.3
	Knowledge of family background	1	2.3	54.5
	Location	2	2.3	56.8
	Medical conditions and medication	1	2.3	59.1
	Medical history	1	2.3	61.4
	Patients physical ability	1	2.3	63.6
	Pattern of incontinence.	1	2.3	65.9
	Physical and mental ability	1	2.3	68.2
	Physical nd mental health	1	2.3	70.5
	Physical and mental state	1	2.3	72.7
	Privacy	1	2.3	75.0
	Psychosocial	1	2.3	77.3
	Social conditions	1	2.3	79.5
	Support with FVC.	1	2.3	81.8
	Surgery-----Bladder etc.	1	2.3	84.1
	That the family understands	1	2.3	86.4
	That wear is accessible	1	2.3	88.6
	Time to educate	1	2.3	90.9
	Time	1	2.3	93.2
	Type of incontinence	3	6.8	95.5
	Up to date information to give to clients	1	2.3	97.7
	Urine testing	1	2.3	100.0
	Total	44	100.0	

Table 4:12.3 Indicates what PHN's think are important factors when assessing a patient in the community.

Factors		Frequency	Valid %	Cumulative %
Valid	Home conditions	1	2.3	2.3
Valid	0	13	29.5	31.8
	Age	1	2.3	34.1
	Any underlying disease/Illness	1	2.3	36.4
	Be able to refer on if any difficulty	1	2.3	38.6
	Co-operation carrying out assessments	1	2.3	40.9
	Co-operation of carers	1	2.3	43.2
	Commitment and co-operation of carer	1	2.3	45.5
	Compliance	1	2.3	47.7
	Duration of problem	1	2.3	50.0
	Emotional health	1	2.3	52.3
	Environmental	1	2.3	54.5
	Family circumstances	1	2.3	56.8
	Lack of facilities	1	2.3	59.1
	Level of compliance	1	2.3	61.4
	Medical History	1	2.3	63.6
	No of Pregnancies/large babies	1	2.3	65.9
	Nurse sensitive to problems of the patient	1	2.3	68.2
	Patient compliance and understanding	1	2.3	70.5
	Presence or absence of infection	1	2.3	72.7
	Previous catheterisation	1	2.3	75.0
	Professional knowledge	1	2.3	77.3
	Proper assessment	1	2.3	79.5
	Recording baseline charts for 2-4 days	1	2.3	81.8
	Recording medical history	1	2.3	84.1
	Sensitivity -Care	1	2.3	86.4
	Severity of complaint	1	2.3	88.6
	Social environment	1	2.3	90.9
	That wear meets patients needs	1	2.3	93.2
	The specific problem	1	2.3	95.5
	Time to support	1	2.3	97.7
	Willing to co-operate with staff and family	1	2.3	100.0
	Total	44	100.0	

APPENDIX III

Question 14

**Attitudes to caring for the
Older person in the community**

Question 14 Attitudes to caring for the Older Person in the Community

Responses to Individual Statements:

All nurses' responses combined (n=44)

Statement		Strongly agree/agree		Strongly disagree/disagree		Uncertain	
Aids	1	8	(19%)	33	(78.7%)	1	(2.3%)
	2	1	(2.3%)	42	(95.4%)	1	(2.3%)
	3	3	(6.8%)	35	(79.6%)	6	(13.6%)
	4	34	(77.3%)	5	(11.4%)	5	(11.4%)
	5	28	(73.7%)	8	(21%)	2	(5.3%)
	6	1	(2.3%)	40	(91%)	3	(6.8%)
	7	4	(9.4%)	38	(88.4%)	1	(2.3%)
	8	6	(13.6%)	38	(86.3%)	0	(%)
	9	43	(97.7%)	1	(2.3%)	0	(%)
	10	6	(13.7%)	31	(70.5%)	7	(15.9%)
	11	11	(25%)	33	(75%)	0	(%)
	12	43	(97.7%)	1	(2.3%)	0	(%)
	13	2	(4.6%)	42	(95.4%)	0	(%)
	14	1	(2.3%)	42	(95.4%)	1	(2.3%)
	15	12	(29.3%)	24	(58.6%)	5	(12.2%)
	16	41	(93.2%)	1	(2.3%)	2	(4.5%)
	17	4	(9.1%)	38	(86.4%)	2	(4.5%)
	18	43	(97.7%)	1	(2.3%)	0	(%)
	19	37	(84.1%)	3	(6.8%)	3	(6.8%)

EXHIBIT 12

Appendix IV

The following information is provided for your information only. It is not intended to be used as a basis for any action.

Information is provided for your information only.

Information is provided for your information only.

APPENDIX IV

Questionnaire

CONFIDENTIAL

Registered Public Health Nurse Questionnaire

For many questions only a tick in the relevant box is needed. Other questions require you to give information. The first few questions relate to details about you and your nursing experience.

**For Official
Use Only**

1. Please tick the box which corresponds with your age group.

- 1) Less than 25 years
- 2) 25-30 years
- 3) 31-35 years
- 4) 36-45 years
- 5) Over 45 years

9
9

2. What is your total length of nursing experience since qualifying as a Registered Public Health Nurse?

.....months years

3. Have you completed a Continence Promotion Course?

- 1) Yes
- 2) No

4. Have your attended other Continence Management Lectures/ Seminars?

- 1) Yes
- 2) No

5. During your PHN Course , did you have any lectures relating to the subject of Continence/Incontinence?

- 1) Yes
- 2) No

6. Have your completed a Post graduate Course in Gerontological Nursing?

- 1) Yes
- 2) No

If 'Yes' please record which course and year taken

.....
.....

7. Do you belong to any group or association concerned with Problems of incontinence/continence e.g.(Irish Continence Interest Group)?

- 1) Yes
- 2) No

If 'Yes'

Please record which.

.....

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8. Looking at the teaching you have received , how prepared do you feel concerning the following areas?

	Well Prepared	Fairly Well Prepared	Not very Well Prepared	Not at all Prepared	
Causes of incontinence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ability to assess incontinence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Methods to promote Continence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Management of Urinary Incontinence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Aids to Continence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Indwelling catheter Management	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

9. Which one of the following do you feel has contributed MOST to Your knowledge relating to incontinence?
(PLEASE TICK ONE BOX ONLY)

- 1) Teaching during PHN training
- 2) Conference/study days
- 3) In-service education
- 4) Community experience
- 5) Post graduate course
- 6) Nursing books/journals
- 7) Other (please specify below)

.....
.....

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9

9

**10. In your community area are there problems relating to caring
For clients who are incontinent?**

- a) 1) Frequently
- 2) Sometimes
- 3) Occasionally
- 4) Rarely
- 5) Never

b) Can you explain what the MAIN problems are ?

.....
.....
.....

**11. a) Who do you think should be MAINLY responsible for the
Assessment of incontinence in the community?**

- 1) Medical staff
- 2) Nursing staff
- 3) Specialists (e.g. continence adviser)
- 4) Medical and nursing staff
- 5) Multidisciplinary Team

**b) Who do you think should be MAINLY responsible for
promoting continence/management of incontinence in
the community ?**

(PLEASE TICK ONE BOX ONLY)

- 1) Medical staff
- 2) Nursing staff
- 3) Specialists (e.g. continence adviser)
- 4) Medical and nursing staff

**12. What factors do you think are important when assessing a
patient in the community?**

.....
.....
.....

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

15. In the Community do nurses use any written guidelines for the :-

a) Assessment of incontinence?

1. Yes

2. No

b) Management of incontinence?

1. Yes

2. No

16. Finally I have not defined the term 'urinary incontinence' and would be interested to know what you mean by it.

.....

.....

.....

.....

.....

APPENDIX

Thank you very much for taking the time and effort to complete the questionnaire.

Your help is greatly appreciated.

APPENDIX V

Original Questionnaire



Dr. P. J. Hawthorn S.R.N. S.C.M.
Director

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CONFIDENTIAL

SISTER/CHARGE NURSE QUESTIONNAIRE

For many questions only a tick in the relevant box is needed. Other questions require you to give information. Please feel free to make any additional comments you may have on the back of the questionnaire. The first few questions relate to details about you and your nursing experience.

1. Please indicate whether you are: 1) Female
2) Male

2. Please tick the box which corresponds with your age group.

- 1) Less than 25 years
- 2) 25-30 years
- 3) 31-35 years
- 4) 36-45 years
- 5) Over 45 years

9
9

3. Please tick the box to show which of the following qualifications you hold.

- 1) Registered General Nurse (SRN)
- 2) Registered Mental Nurse (RMN)
- 3) Registered Midwife (SCM)
- 4) District Nurse (QN, NDN)

9

4. Please list below any other nursing qualifications you may have.

9

5. What is your total length of nursing experience since qualifying (please include any part-time nursing experience)?

..... year(s) month(s)

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9 9
9 9

6. Do you work:-

- 1) Days only
- 2) Nights only
- 3) Both (internal rotation)

9

7. How long have you been a Sister/Charge Nurse on your present ward?

- 1) Up to 6 months
- 2) More than 6 months up to 1 year
- 3) More than 1 year up to 3 years
- 4) More than 3 years up to 5 years
- 5) More than 5 years up to 7 years
- 6) More than 7 years

8. Apart from your present ward, have you worked on any of the following wards since you have trained? (Please tick which apply with length of time worked. If you have worked in any of these wards as a Sister/Charge Nurse, instead of a tick insert an 's' in the appropriate box.)

	Up to 6 mths	>6 mths up to 1 year	>1 yr up to 3 yrs	>3 yrs up to 5 yrs	>5 yrs up to 7 yrs	More than 7 yrs	
General Medical	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Health Care Elderly	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Psychogeriatric	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
General Surgical	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gynaecology	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Urology	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Orthopaedic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Neurosurgical	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other (please specify)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
.....							<input type="checkbox"/>
.....							<input type="checkbox"/>

NB > = more than

Please note that when the word 'incontinence' is used, it refers only to URINARY incontinence.

The next few questions relate to any teaching you may have had relating to continence/incontinence.

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9. a) During your basic nurse training, did you have any classroom teaching relating to the subject of incontinence?

- 1) Yes
- 2) No
- 3) Don't remember/unsure

If YES

b) Did this cover any of the following? (Please tick which apply. If you are not sure, put a ? in the appropriate box)

- 1) Anatomy of the urinary system
- 2) Physiology of micturition
- 3) Causes of incontinence
- 4) Assessment of incontinence

c) Briefly, what aspects of the management of incontinence, if any, did you cover?

10. a) Have you completed the following post-basic courses?

If YES (please tick which apply, giving the year in which it was taken)

- 1) ENB 298 course 'Nursing Elderly People' year
- 2) ENB 940/941 course 'Nursing Elderly People' year
- 3) ENB 978 course 'Promotion of Continence and Management of Incontinence' year
- 4) Other course(s) on continence/incontinence (EXCLUDE CONFERENCES/STUDY DAYS)? Please record which course and year taken

--	--

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--	--

..... year

--	--

..... year

--	--

b) Have you attended any conferences/study days relating to promoting continence and managing incontinence?

- 1) Yes
- 2) No

If YES

Please record which and year(s) when attended.

.....

.....

.....

11. Do you belong to any group or association concerned with problems of incontinence/continence (e.g. the Association of Continence Advisers)?

- 1) Yes
- 2) No

If YES

Please record which.

12. a) Have you had any in-service training relating to the management of incontinence?

- 1) Yes
- 2) No

If YES

b) Briefly, what area(s) did this cover?

c) Was this within the, last 12 months?

- 1) Yes
- 2) No

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13. Looking at the teaching you have received, how prepared do you feel concerning the following areas?

	Well prepared	Fairly well prepared	Not very well prepared	Not at all prepared	
Causes of incontinence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ability to assess incontinence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Methods to promote continence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Incontinence aids	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Indwelling catheter management	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

14. Which one of the following do you feel has contributed MOST to your knowledge relating to incontinence (PLEASE TICK ONE BOX ONLY)

- 1) Teaching during basic training
 - 2) Conference/study days
 - 3) In-service training
 - 4) Ward experience
 - 5) Post basic course (e.g. ENB 978)
 - 6) Nursing books/journals
 - 7) Other (please specify below)
-

The next few questions relate to specific aspects of incontinence.

15. a) On your ward, are there problems relating to caring for patients who are incontinent?

- 1) Frequently
- 2) Sometimes
- 3) Occasionally
- 4) Rarely
- 5) Never

b) Can you explain what the MAIN problems are?

--	--

9
9

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9 (x11)

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16. People have different ideas about the causes of incontinence. What do you think are the MAIN reasons why some people are incontinent?

17. a) Who do you think should be MAINLY responsible for the assessment of incontinence on the ward? (PLEASE TICK ONE BOX ONLY)

- 1) Medical staff
- 2) Nursing staff
- 3) Specialists (e.g. continence adviser)
- 4) Medical and nursing staff

b) Who do you think should be MAINLY responsible for promoting continence/management of incontinence on the ward? (PLEASE TICK ONE BOX ONLY)

- 1) Medical staff
- 2) Nursing staff
- 3) Specialists (e.g. continence adviser)
- 4) Medical and nursing staff

18. What factors do you think are important when assessing a patient on the ward who is incontinent?

19. How important do you think it is for nurses on your ward to have the opportunity to attend courses/study days/conferences, etc., relating to promoting continence/managing incontinence?

- 1) Very important
- 2) Important
- 3) Not very important
- 4) Unimportant

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20. Below are three short accounts describing some observations from patients who are incontinent of urine. If you are unsure about any of the answers to the questions below, then please put a ? in the space and go on to the next question.

A female patient loses small amounts of urine only when coughing, sneezing or during physical exercise.

a) What do you think might be the possible cause(s) of the above?

b) What might be done for a patient with this problem?

A patient with a distended bladder is frequently leaking small amounts of urine.

a) What do you think might be the possible cause(s) of the above?

b) What might be done for a patient with this problem?

A patient has a strong desire to void and needs the toilet frequently but is usually incontinent before reaching it.

a) What do you think might be the possible cause(s) of the above?

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	Strongly Agree	Agree	Uncertain	Disagree	Strongly Disagree	
Elderly people with longstanding incontinence problems do not usually require investigation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Incontinence is an inevitable part of the ageing process	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Continence promotion is a specialised skill and should therefore be left to people such as continence advisers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Continence is a realistic goal for many incontinent elderly people	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I find it demoralising looking after incontinent patients because there is little I can do to help	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Incontinence is usually more distressing for a young person than for someone who is elderly	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

22. On your ward, do nurses use any written guidelines for the:-

a) Assessment of incontinence?

- 1) Yes
- 2) No

If YES

What do these consist of?

b) Management of incontinence?

- 1) Yes
- 2) No

If YES

What do these consist of?

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Use Only

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23. Finally, I have not defined the term 'urinary incontinence' and I would be interested to know what you mean by it.

Thank you very much for taking the time and effort to complete the questionnaire. Your help is greatly appreciated.

I look forward to being able to give you a summary of the results of the questionnaire as well as results from other parts of the project in the future.

Please would you enclose the completed form in the addressed envelope provided and return it via your ward internal mailing system.

If you have mislaid the envelope, please would you send the completed questionnaire via the internal mailing system to:-

Francine Cheater
Research Assistant
Nursing Studies Unit
Floor E
Medical School
Queen's Medical Centre
Nottingham

Once again, thank you very much.

APPENDIX VI

Covering Letter

*Lynally,
Mucklagh,
Tullamore,
Co. Offaly.*

18th April, 2000.

Please find enclosed research proposal for continence promotion.

I am circulating a questionnaire to all area registered Public Health Nurses in the Board's region to identify nurses knowledge and attitudes of "continence promotion in care of the older person in the community".

I would be most grateful for financial support to facilitate my research project.

Thanking you in anticipation.

**Eileen Donovan,
Public Health Nurse
(Regional Continence Advisor)**

Midland Health Board.

APPENDIX VII

Reminder Letter

Lynally,
Mucklagh,
Tullamore,
Co. Offaly.

21st July, 2000.

Reminder

Dear Colleague,

I am writing to you with regard to a questionnaire I sent to you recently.

I am doing research in Continence Promotion as submission for my dissertation in MSc Course in Gerontological Nursing to the University of Dublin Trinity College.

If you have already posted back the completed questionnaire, I wish to thank you very much, if not I should be very grateful if you could find the time to complete it, as the closing date has been extended to 28th July, 2000.

Thanking you,

Yours sincerely,

Eileen Donovan.
(Public Health Nurse)

