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The process of standardising practice: developing a gynaecology trial of void guideline
Chloe Adams, Katie Foxcroft, Karen Baker, Melissa Wright and Belinda Baker

A multidisciplinary approach to incontinence-associated dermatitis in a rural setting: a case study
Catherine Leahy, Suud Nahdi, Michelle Lai, Fiona Coyere, Michelle Barakat-Johnson and Members of the IMBED Project Steering Committee



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Autumn 2023
Volume 29 Number 1
ISSN 2208-5750

THE OFFICIAL JOURNAL OF THE
CONTINENCE FOUNDATION OF
AUSTRALIA + THE NEW ZEALAND
CONTINENCE ASSOCIATION

Published four times a year by



10 Walters Drive
Osborne Park, WA 6017
www.cambridgemedia.com.au

Publisher Greg Paul
Copy editor Ceridwen Clocherty
Design and layout Gordon McDade

Advertising enquiries to
Simon Henriques
Cambridge Media
Tel (08) 6154 3912
Email simonh@cambridgemedia.com.au

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

To discuss topics or for assistance in the preparation of papers and articles, please email journal@continence.org.au

EDITORIAL

For referencing Moro C. Editorial. Australian and New Zealand Continence Journal 2023; 29(1):3.

DOI <https://doi.org/10.33235/anzcj.29.1.3>

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Welcome to our first edition of the *Australian and New Zealand Continence Journal* for 2023. This is the first publication I have worked on as the Editor in Chief and Chair, and it's been an absolute delight to progress these fantastic submissions. I am continually impressed at the quality of publications we receive, and the growing impact that our journal demonstrates as an independent and high quality outlet for research. The recent move to an online journal has occurred without any hiccups, and we are looking forward to a positive future as the journal expands in both publications and an international readership.

This edition features two articles. Adams and colleagues submitted a recommendation for a gynaecology trial of void (TOV) protocol. This work presents insights from this protocol's use in a large tertiary hospital, and aims to assist with the standardising of practice. Leahy and colleagues have provided insights and learning from their multidisciplinary prevention and management intervention to assist with a case of incontinence-associated dermatitis (IAD). This study, undertaken in a rural health setting, provides guidance, information and best practice recommendations for this type of presentation.

The journal continually encourages submissions of quality research and, if you are a first-time author, our reviewing and editorial teams offer feedback and support to assist. Conducting research not only helps our community with increased knowledge and insights, but also advances the vision and purpose of both the Continence Foundation of Australia and the New Zealand Continence Association to promote bladder and bowel health, and to eliminate the stigma and restrictions of all aspects of incontinence. We work hard to ensure visibility of published works in the journal and, to facilitate this, all publications are available online, as full open access, with no cost to readers. Each article is also allocated an individual doi number which assists with referencing and tracking. It's these types of features that help our journal stand out, and present it as an excellent outlet for the submission and eventual publication of quality works.

Lastly, we thank Jacinta Miller for her incredible service to the journal. Jacinta retired as the Managing Editor, after 18 years in the role. It has been an absolute pleasure to have worked with Jacinta on the editorial committee since 2018. While in transition to a new managing editor, Jacinta continues to offer her support, and has gone the extra mile to assist us with this current issue. On behalf of the journal, I would like to express our incredible gratitude to Jacinta for her management, leadership and guidance for both our teams and the many researchers she has helped and supported over this time.

I hope you have a fantastic start to 2023 and enjoy reading the articles in this Autumn edition of the journal.



Christian Moro
Editor *Australian and New Zealand
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The process of standardising practice: developing a gynaecology trial of void guideline

For referencing Adams C et al. The process of standardising practice: developing a gynaecology trial of void guideline. Australian and New Zealand Continence Journal 2023; 29(1):5-9.

DOI <https://doi.org/10.33235/anzcj.29.1.5-9>

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Submitted 30 March 2022, Accepted 16 January 2023

ABSTRACT

This study presents the introduction of a comprehensive trial of void (TOV) guideline in the gynaecology department of a large tertiary hospital in Queensland, Australia. The aim was to standardise care and increase both nursing and medical staff compliance and satisfaction of processes in the department while improving quality of care. This was measured by a two-phased (pre- and post-implementation) survey of gynaecology department staff. The survey evaluated knowledge, confidence, compliance and satisfaction when comparing the previous TOV local protocol to a new standardised guideline introduced during the study. As follow-up, an audit of medical records was also conducted to reflect clinical practice. The TOV guideline was adopted following consultation and benchmarking with other Australian tertiary hospitals and implemented with a 3-month education program. Pre-implementation survey responses (n=51) from medical and nursing staff with wide range of gynaecology experience (35% 0-2 years, 65% >3 years) were compared with post-implementation survey responses (n=45). Staff knowledge of TOV process increased from the pre-implementation survey (71%) to post-implementation (84%). The overall improvement in satisfaction of the new guideline increased from 37% to 82%. Compliance in using the new guideline was 80% compared to 73% for the previous local protocol. Over a 4-month period for both audits, the pre-implementation audit (n=48) resulted in 33% compliance compared to the post-implementation audit (n=36), 86% compliance. The study determined that the introduction of a standardised TOV guideline improved knowledge, compliance and satisfaction when performing a TOV within the gynaecology department.

Keywords trial of void, gynaecology, voiding trial, postoperative voiding dysfunction, continence

INTRODUCTION

Women undergoing gynaecological surgery, especially surgical interventions to address the cause of urinary incontinence or pelvic organ prolapse, are at risk of developing postoperative voiding dysfunction. Assessment of normal bladder function prior to hospital discharge is an important step to identify this postoperative complication. Normal bladder function is defined as both successful storage and emptying; both aspects have potential to be affected by gynaecological surgery^{1,2}.

Trial of void (TOV) is defined as the assessment of voiding function and should be commenced immediately post-removal of an indwelling urinary catheter (IDC)¹. TOV is not routinely performed following all types of gynaecological procedures, for example, a laparoscopic hysterectomy, as the complication of urinary retention for this common procedure ranges from 7-14%³. The current gold standard for assessing voiding function is by measuring micturition (urination) as well as the post-void residual

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Conflict of interest

The authors declare no conflicts of interest.

Funding

The authors received no funding for this study.

(PVR), which is defined as the volume of urine left in the bladder at the completion of micturition¹⁴. This can be assessed by a bedside ultrasound (bladder scanner) or re-catheterisation, (intermittent catheter/Nelaton) to drain and measure the PVR volume.

Hakvoort and colleagues claimed “As abnormal PVR is a complication that necessitates additional treatment, the absence of consensus implies that part of the patients receive either undertreatment or overtreatment”⁵. As such, when a TOV is deemed unsuccessful within our gynaecology department, the patient requires their bladder to be emptied via an intermittent catheter or clean intermittent self-catheterisation (CISC), education to be commenced, and the treating team to be notified for further management⁶. If clinically appropriate and practical for the patient, CISC is the preferred intervention rather than insertion of an IDC for postoperative voiding difficulties following gynaecological surgery⁷.

Prior to this study, an out-of-date TOV local protocol was used by medical and nursing staff within the gynaecology department. Anecdotally, junior nursing and medical staff within the organisation had expressed confusion around the process of a TOV. This was due to varying individual approaches by medical treating teams which created confusion among staff in regards to which patients required a TOV and the correct TOV procedure.

A review of the literature revealed variable physician definition and practices on the process of a TOV in the field of gynaecology and the management of PVR and urinary retention^{15,8,9}. A study completed in Western Australia by Bosco and colleagues⁹ explored research priorities for nurses working in the gynaecology setting which identified the highest ranking priority for research was the postoperative management of TOV¹⁰. Similarly, to mitigate clinical variation, Buchko and Robinson⁹ developed and implemented an algorithm which included standard definitions and a consistent protocol for TOV to minimise variation among practitioners.

The purpose of this study was to promote standardised care through the introduction of a clear and comprehensive TOV guideline. The aim was to increase medical and nursing staff compliance to the guideline and best practice, improve satisfaction of the TOV process, and increase quality of care within the unit.

METHODS

Ethics

Ethics approval was granted for this study by The Royal Brisbane and Women’s Hospital Human Research Ethics Committee (HREC) for review, approval number LNR/2019/QRBW/5863, in accordance with the National Statement on Ethical Conduct in Human Research¹¹.

Introducing a new guideline

A benchmarking review of local guidelines from five hospitals in Australia was undertaken. From this review a draft guideline was developed and circulated for

critical, expert review, including stakeholders such as gynaecologists and specialised nursing staff to ensure best and evidence-based practice was implemented¹². Benchmarking was chosen to guide the standardisation of care as it is well supported in the literature to evolve practice and assess current performance against best practice¹³. The biggest difference between the study site hospital and other facilities that were benchmarked was the type of protocol implemented. All of the benchmarked hospitals had gynaecology TOV protocols or guidelines in place, rather than a local work instruction^{6,14-18}. Key stakeholders such as medical officers, the continence advisory service and senior nursing staff, including the safety and quality unit, were consulted by the distribution of the standardised TOV guideline for review and comment, prior to approval and publishing.

Education program

The rollout of a new guideline required gynaecology service-wide notification and education that was completed via an education bundle. Email dissemination of the TOV guideline was distributed to all current in-patient gynaecology staff (medical and nursing). Out of the 40 current active in-patient gynaecology nursing staff, 34 acknowledged that they had reviewed the guideline and received in-service education. These in-service sessions were presented by research nurses allocated as ward clinical champions. In addition to training, they provided support and were an educational resource for all gynaecology staff surrounding TOV practice. The in-service PowerPoint slides were also printed and placed within the nurses’ station as a reference tool for all staff.

The guideline was discussed at various leadership meetings within the organisation including the Gynaecology Management Advisory Group meeting, which captures both medical and nursing leaders within gynaecology. Research nurses presented at a routine registrar training session capturing junior and senior registrars. The new guideline contained a TOV flowsheet which was printed and placed in every patient bedside chart to allow for easy reference for all clinicians¹².

Survey

To assess staff knowledge, confidence, compliance and satisfaction of the TOV process within gynaecology, a two-phase web-based survey of standardised practice was conducted. The survey excluded all students working in gynaecology as well as enrolled and assistant nurses and staff not actively working in the in-patient department within gynaecology. All eligible in-patient ward gynaecology medical and nursing staff within the department were invited to participate in the voluntary pre- and post-implementation surveys. At the time of the study, approximately 40 registered nurses and 55 doctors were actively rostered in the gynaecology in-patient department, with staff in each discipline having varied levels of experience in gynaecology. Participants were informed, and consent was implied by the submission of the completed survey.

The surveys were conducted over a 3-week period in February and December 2020. The collection of the surveys was completed by nurses from the research team, inviting participation from eligible medical and nursing staff in gynaecology using an iPad and multiple email disseminations. All participant privacy and confidentiality was maintained throughout the quality improvement activity and all results were de-identified. A mixed method approach was utilised throughout the survey, giving the participants the ability to respond to questions by free-text and Likert scales, prompting elicited opinions, ideas, issues or questions of relevance to the TOV process within the department. In both the pre-implementation and post-implementation surveys, answers were mandatory and skip logic was used to keep the questions relevant to the selected profession. The post-implementation survey started with the question “Did you complete the pre-education survey?” to capture audience data and assess changes in practice and knowledge post the standardisation of care.

Audit

A retrospective audit of patient medical records identified those patients who required a TOV prior to discharge. Each audit included all patients booked for surgical procedures requiring a TOV over a 4-month period (pre-TOV standardisation 2 September 2019 to 3 January 2020 and post-TOV standardisation 1 January to 1 May 2021). All data were collected on a secure Excel spreadsheet and analysed by research nurses, capturing appropriate patient medical records using ORMIS ICD-10 codes to isolate specific gynaecology and urogynaecology surgical procedures that would routinely require a TOV. The same ORMIS ICD-10 codes were used for both pre- and post-implementation audits to ensure the same patient group was identified. In order to assess compliance of TOV processes, both audits were conducted by comparing the “Bladder chart for trial of void” documentation (voided versus PVR volumes and interventions/comments) against

the current protocol and guideline at the time of the audit. Additionally, further medical records such as progress notes were reviewed to determine whether any deviation from the protocol parameters had occurred such as deviations in time of removal or acceptable residual volumes.

RESULTS

Survey

The web-based survey host Citizen Space managed all survey data and analysis. In both surveys, broad gynaecology experience was captured, with staff with less than 1 year’s experience to staff with over 8 years’ experience completing both surveys (pre-implementation survey 35% 0–2 years, 65% >3 years, and post-implementation survey 40% 0–2 years, 60% >3 years). The pre-implementation survey completion rates resulted in 41% (n=21) medical professionals and 59% (n=30) nursing professionals; the post-implementation survey completion rates resulted in 31% (n=14) medical professionals and 69% (n=31) nursing.

Staff knowledge of the current TOV process increased from 71% pre-implementation survey to 84% post-implementation survey (Figure 1). Staff reported 80% compliance of use of the new guideline compared to 73% use of the initial work instruction. The overall improvement in satisfaction of the new guideline increased from 37% to 82%. The 5-point Likert survey question “I am satisfied with the current TOV for gynaecology” included a compulsory free-text component.

The pre-implementation survey evoked reoccurring answers such as “confusing, inconsistent, sometimes confusion between doctors and nurses, amounts changing weekly between consultants, no consistency across teams, different consultants request different TOV, outdated, difficult to follow, not everyone is on the same page and not clear”. In contrast, the post-implementation survey was found to have considerable

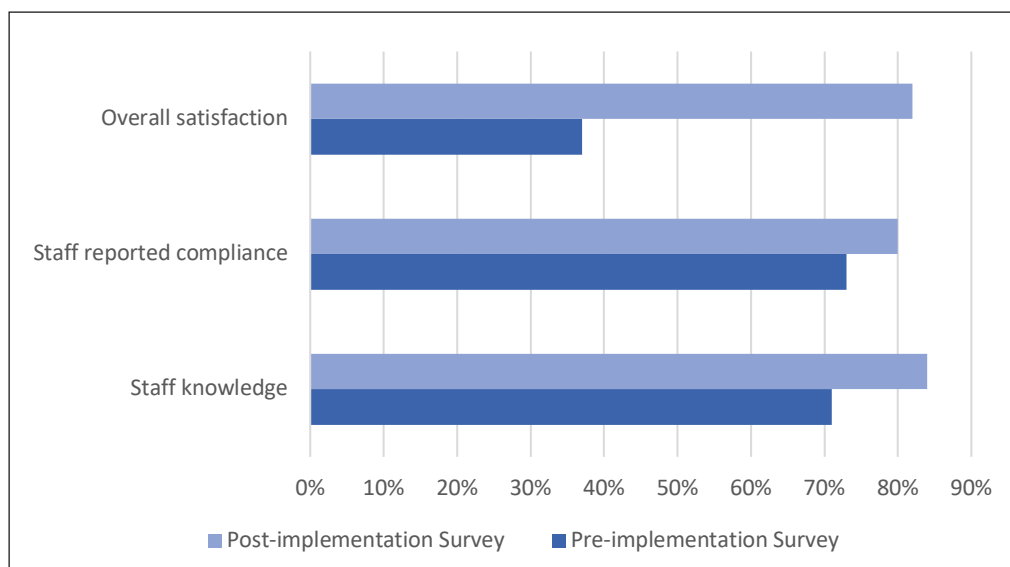


Figure 1. Gynaecology department pre- and post-implementation survey results

differences in the reoccurring answers such as “easy to follow, easy to understand, clear and concise, clear guide, policy is clear, clearly documented, straight forward, clear instructions”.

Survey results show that satisfaction was increased (odds ratio (OR)=7.79, 95% confidence interval (CI)=3.01-20.18), as well as knowledge of the TOV process (OR=2.26, 95% CI=0.83-6.19). The overall pre- and post-implementation survey results showed significant change in practice and staff awareness of TOV within the department (Z=4.51, p<0.1) (Table 1).

Audit

The number of patient medical records audited varied between both the pre- and post-implementation audit (n=48, n=36, respectively). Although the time period

of auditing remained the same between the two, 4 months, the post-implementation audit resulted in a smaller patient group due to a decreased cohort of TOV patients. The pre-standardisation of care audit reflected a high number of ‘other’ results. This was due to inconsistencies in the time of removal of the IDC post-procedure due to the original work instruction not being utilised correctly (Figure 2). These patient TOVs were classified as ‘other’ in both audits to highlight the varying TOV practices of treating teams within the gynaecology department. Three additional classifications of ‘other’ included unrelated patient complications, lost documentation and partial follows. Overall compliance of the TOV procedure in gynaecology at the time of audit improved from 33% to 86%.

Table 1. Further analysis of pre- and post-implementation survey results

1 Trial of void procedure						
1.1 New Outcome						
Study or Subgroup	Post-survey		Pre-survey		Weight	Odds Ratio M-H, Fixed, 95% CI
	Events	Total	Events	Total		
Compliance	36	45	37	51	35.2%	1.51 [0.58, 3.93]
Confidence initiating TOV	39	45	35	51	22.2%	2.97 [1.05, 8.44]
Knowledge of TOV	38	45	36	51	26.6%	2.26 [0.83, 6.19]
Satisfaction of TOV	37	45	19	51	16.1%	7.79 [3.01, 20.18]
Standardised TOV as beneficial	43	45	0	0		Not estimable
Total (95% CI)		225		204	100.0%	3.04 [1.88, 4.93]
Total events	193		127			
Heterogeneity: Chi ² = 6.14, df = 3 (P = 0.11); I ² = 51%						
Test for overall effect: Z = 4.51 (P < 0.00001)						

Risk of bias legend	
(A)	Random sequence generation (selection bias)
(B)	Allocation concealment (selection bias)
(C)	Blinding of participants and personnel (performance bias)
(D)	Blinding of outcome assessment (detection bias)
(E)	Incomplete outcome data (attrition bias)
(F)	Selective reporting (reporting bias)
(G)	Other bias

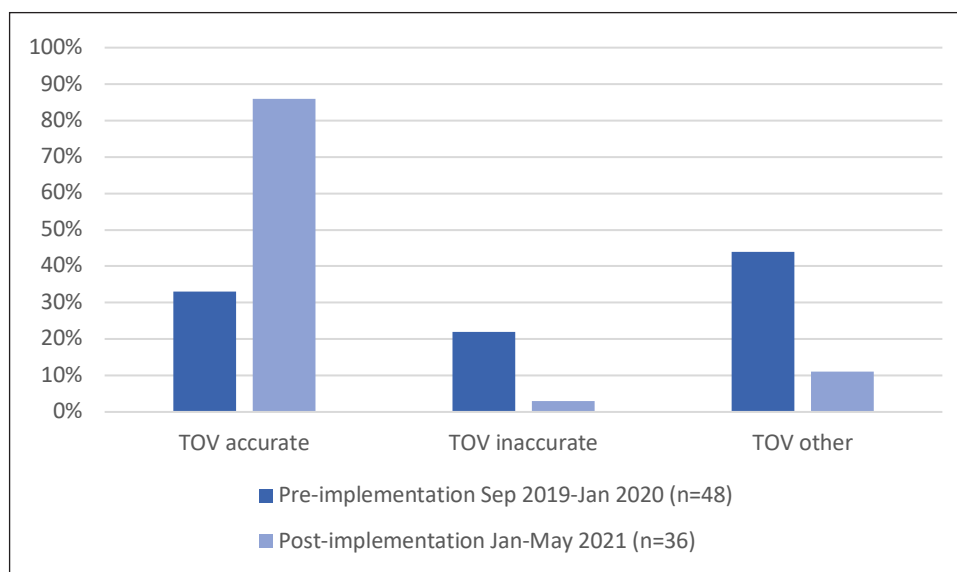


Figure 2. Retrospective patient chart TOV results pre- and post-implementation audits

DISCUSSION

The study team determined that, following the introduction of a standardised TOV guideline, the medical and nursing staff satisfaction of the TOV process significantly increased in the gynaecology unit. It is important to note that, overall, both surveys represented lower completion rates by medical professionals than nursing, even with a higher number of staff in their cohort. However, the results remain relevant to both cohorts working in a gynaecology in-patient setting. While the timeframes of the pre- and post-implementation audit remained identical, it is believed the cancellation of surgical procedures at the tertiary hospital during the COVID-19 pandemic contributed to this decrease in surgical cases, resulting in a decreased number of post-implementation audited patients⁹.

There remains a lack of current cohesive literature surrounding TOV practice within gynaecology, with varied reported practices. Although compliance of the current guideline has improved, there is risk of both medical and nursing staff being unable to justify their practice. Without clear contemporary evidence and, although regarded important, recommendations may not always be implemented in routine practice if perceived not to be feasible⁹. This is shown in the study by Bosco and colleagues¹⁰; although clinical guidelines existed in their organisation, the management of TOV remained the number one research priority for nurses working in gynaecology.

CONCLUSION

This study aimed to determine if the introduction of a standardised procedure on TOV in gynaecological patients improves staff compliance and satisfaction. The major findings in our study have revealed that, within the gynaecology department, compliance, satisfaction and awareness has dramatically improved since the introduction of standardised TOV practice. Although there remains a current need for further contemporary TOV literature, this study has highlighted the importance of standardised care within a surgical unit to prevent confusion and dissatisfaction of TOV practice.

ACKNOWLEDGEMENTS

Our appreciation to Emma Dowling and Catherine Nicholas for your contribution and comments. We would also like to thank all survey participants and key stakeholders.

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A multidisciplinary approach to incontinence-associated dermatitis in a rural setting: a case study

For referencing Leahy C et al. A multidisciplinary approach to incontinence-associated dermatitis in a rural setting: a case study. Australian and New Zealand Continence Journal 2023; 29(1):10-15.

DOI <https://doi.org/10.33235/anzcj.29.1.10-15>

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Submitted 19 June 2022, Accepted 23 January 2023

ABSTRACT

Incontinence-associated dermatitis (IAD) is a common complication often unrecognised and mistreated in individuals with incontinence. It is the erosion of the skin from prolonged exposure to urine and/or faeces from incontinence and is often mistaken for a pressure injury. People experience considerable discomfort such as pain, burning and itching in the affected areas (buttocks, perineum and gluteal clefts). The prevention and management of IAD involves assessing and managing incontinence and implementing a skin care regimen to protect and maintain the integrity of the person's skin. We report a case study of a 71-year-old female to illustrate the benefits of an interdisciplinary plan of care for IAD to prevent further complications. The woman at the centre of our case study had multiple co-morbidities and severe urinary stress incontinence prior to her admission. A multidisciplinary team – continence nurse practitioner (NP), wound clinical nurse consultant (CNC), occupational therapist (OT) – were engaged to devise a management plan to manage her incontinence, treat the IAD and improve skin integrity. The purpose of this case study is to present their treatment journey through a regional health service, the issues encountered, and the prevention and management plans implemented in order to highlight best practices and the benefits of an interdisciplinary plan of care.

Keywords Incontinence, incontinence-associated dermatitis, case study, plan of care

INTRODUCTION

Incontinence-associated dermatitis (IAD) is skin erosion/damage that occurs when exposed to urine, faeces or both for prolonged periods¹. Symptoms of IAD may include significant pain, discomfort and itching in the affected areas such as the buttocks, perineum and gluteal clefts^{2,3} which may result in reduced quality of life, including loss of independence, depression and sleep disturbance⁴⁻⁷.

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Conflict of interest

The authors declare no conflicts of interest.

Funding

The IMBED study is supported by the New South Wales Ministry of Health Translational Research Grant Scheme, Round 4 [TRGS Application: H19/53776]. The funding source had no role in the study design, writing of this paper, or in the decision to submit this paper for publication.

The prevalence of IAD is reported to be 8%⁸ among residents of residential aged care facilities and, in the acute setting, prevalence is reported to be 19%⁸, 29%⁹ and even as high as 45.7% among adult patients who have urinary or faecal incontinence in acute care facilities³. In accordance with the best practice guidelines, prevention and management of IAD should consist of appropriate assessment and management of incontinence, and the implementation of a structured skin care regimen¹.

The aim of this case study is to present the journey of a woman with incontinence and IAD through a regional health service, the issues encountered, and the prevention and management plans implemented in order to highlight best practices in the prevention and management of IAD. This regional health service offers a nurse-led virtual consultancy service to support rural and remote clinicians within the local health district, including for wound prevention and management and continence management. Clinical reviews and assessments are conducted via telehealth.

Ethical approval for this case study was provided by the Royal Prince Alfred Hospital Human Research Ethics Committee (2019/ETH08742). Written informed consent was provided for the case details to be reported. Written consent was provided for the organisation's clinical archive of images to be published.

CASE PRESENTATION

Margaret (pseudonym), a 71-year-old female living in a small remote town in New South Wales, Australia, was admitted to a regional hospital and diagnosed with intertriginous dermatitis and bacterial cellulitis on her abdominal pannus. Margaret had experienced heavy urinary incontinence for over 30 years for which she had sought treatment for in the past. On admission to hospital, Margaret was enrolled as a participant in a multi-site funded implementation science study that focused on implementing the best practice guidelines on the prevention and management of IAD across NSW¹⁰.

Medical history

Margaret's medical history and comorbidities included urinary stress incontinence, high body mass index (BMI) of 42, poorly controlled insulin dependent diabetes mellitus, bilateral knee osteoarthritis, hypertension,

gastroesophageal reflux disorder, previous pulmonary embolism and gout. Table 1 lists the multiple medications Margaret was taking to manage these conditions. Margaret was ambulant and independent using her four-wheel walker, but her activities of daily living (ADLs) were restricted due to her body habitus and bilateral knee osteoarthritis.

Environment

She lived alone in social housing, in a single storey home where she had access to a toilet in the home. Due to the severity of the incontinence, the floors and her mattress were soaked with urine. The only person she regularly encountered was her professional carer who assisted her with ADLs such as personal care, including hygiene and shopping. At the time of her admission to hospital, Margaret was in the process of finding alternative accommodation.

Incontinence profile

Margaret's urinary stress incontinence began when she was aged in her twenties, post-childbirth. She raised her incontinence issues with a number of her general practitioners (GPs) over the years but said her concerns were dismissed, and she did not pursue this further due to embarrassment and a belief that it was normal and that she could not seek help beyond her GP. Margaret described it as if the "flood gates" would open each time she stood up and then leakage occurred when she sat down, coughed or sneezed. The heavy urinary incontinence led to urine soaking her mattress and carpet in the house. She had tried many continence aids such as pull up padded pants, wrap around pads and pad liners. Her BMI and body habitus made it challenging to find a correct fitting continence aid. She therefore relied on liners. As a result of this, she was fearful of leaving the house and was socially isolated, she did not go out to shop or get a haircut and did not attend family gatherings due to fear of others smelling her body odour from her urinary incontinence. She did not have any formal diagnosis of depression.

When asked about incontinence management at home, Margaret and her carer said the liners used in the pads were ineffective as urine still trickled down her legs. Margaret accessed the continence assistance payment scheme (CAPS), an Australian government financial support scheme for patients with severe incontinence.

Table 1. Medications prescribed to manage comorbidities

Medication	Dose	Frequency	Reason for medication
Allopurinol	300mg	Daily	Gout
Atorvastatin	20mg	Nocte	Hypertension
Coloxyl with Senna	2 tablets	Nocte	Constipation
Hydrocortisone-clotrimazole topical		TDS	Excoriation under breast, underarms and pannus
NovoRapid®	Sliding scale	TDS, prior to meals	Poorly controlled insulin-dependent diabetes mellitus
Magnesium aspartate	500mg	BD	Not specified
Metformin	1000mg	BD	Poorly controlled insulin-dependent diabetes mellitus
Pantoprazole™	40mg	Daily	Gastroesophageal reflux disorder

Upon further review by the continence nurse practitioner (NP), Margaret was found to be constipated. She reported episodes of faecal incontinence, once or twice per month, in the past. A mid-stream urine (MSU) collection and culture were analysed and revealed a *Candida albicans* urinary tract infection, which is one of the most common causes of nosocomial fungal urinary tract infections¹¹.

Skin integrity profile

Margaret's skin was assessed on admission and revealed:

- Moisture-associated skin damage (MASD) under her breasts, abdominal pannus and underarms.
- A stage two pressure injury (PI¹²) on her sacrum.
- A stage one PI on each buttock.

A stage two PI involves partial-thickness skin loss into but no deeper than the dermis; stage one PIs are characterised by non-blanchable erythema and the skin is intact¹³.

Bacterial cellulitis, which was confirmed via culture, was found in the skin fold of her abdominal pannus with satellite erythema. In the area her skin was hot to touch, oedema was present, and micro lesions were noted with weeping serous fluid. Margaret complained of pain, tenderness and an itch in the area.

Margaret was referred to the wound clinical nurse consultant (CNC) for virtual review while she was in hospital. This service is a nurse-led consultancy service that provides wound prevention and management outreach and support to rural and remote health facilities within the local health district.

The wound CNC determined that Margaret did not have PIs but instead had IAD on each buttock and the sacral region. The IAD on the buttocks extended down her thighs to her knees and was diagnosed as a category 1A (redness without infection)¹⁴. On the sacrococcygeal region, IAD was diagnosed as a category 2A (broken skin and without signs of infection)¹⁴ with linear lesions noted. Figures 1 and 2 show examples of the two IAD categories from the clinic archives. Margaret was



Figure 1. Example of IAD category 1A on bilateral buttocks

confirmed to have intertriginous dermatitis underneath her breasts, underarms and abdominal pannus. An example of intertriginous dermatitis under the abdominal pannus from the clinic archives is presented in Figure 3.

MANAGEMENT

Physical and functional assessment was undertaken by a multidisciplinary team comprising of a wound CNC and continence NP, occupational therapist (OT) and Margaret's GP. The wound CNC, continence NP and OT provided consultation via telehealth. The multidisciplinary team developed a care plan to treat infection, manage incontinence and address mobility and self-care issues.

Incontinence management

The continence NP found that the extra large wrap around incontinence pads supplied did not fit and layers were used on the chair and bed to 'catch' the overflowing urine. The CAPS support package level was deemed insufficient to cover all her incontinence product needs and further financial support was sourced from other agencies. The extra funding allowed her to acquire bariatric wrap around pads that fitted correctly to provide social continence and improve her skin condition, and which had a positive effect on her quality of life, including feeling comfortable when leaving the house.



Figure 2. Example of IAD category 2A on sacrum



Figure 3. Example of intertriginous dermatitis under abdominal pannus

There was a structured toileting regimen implemented as an intervention to manage her urinary incontinence. This involved going to the toilet every 2 hours to empty her bladder. To address the issue of constipation and episodes of faecal incontinence, the continence NP and the wound CNC recommended implementing an individualised bowel toileting regimen, twice daily. The *C. albicans* urinary tract infection was managed with oral antifungal medication.

An OT review via telehealth occurred 6 days after admission to assess her mobility, including gait and use of mobility equipment and aids. The focus of that review was on her mobilising to the toilet and pelvic muscle assessment and exercises to address the stress urinary incontinence. The OT also recommended using a pressure relieving cushion and air mattress for PI prevention during her inpatient stay.

Skin integrity management

The wound CNC's treatment plan involved:

- A daily nursing assessment involving visual and tactile inspection of her skin.
- Twice daily cleansing and protecting of the areas using barrier cream cloths to protect and restore her skin (the barrier cream cloths used were impregnated with 3% dimethicone to provide all-in-one skin cleansing, moisturising, deodorising treatment and barrier protection).
- Application of thin, absorbent sheets designed to absorb skinfold moisture, minimise friction, and keep moisture away from the skin; these were placed between the abdominal pannus skin folds and were changed daily or when required.
- Additionally, the intertriginous dermatitis under Margaret's breasts, underarms and pannus were managed with the application of hydrocortisone 1% and clotrimazole 1% cream three times daily.
- During her in-patient stay, Margaret was initially administered intravenous antibiotics (Ceftriaxone), and then, after 4 days, transitioned to oral antibiotics (Cephalexin) to manage the bacterial cellulitis. The misdiagnosed PIs were managed with the application of hydrocolloid dressings on the sacrum and both buttocks. A hydrocolloid dressing is a dressing that provides a moist and insulated healing environment.

This plan of care is in line with the best practice guidelines for the management of IAD^{1,10}, and included recommending super absorbent polymer (SAP) pads be placed underneath Margaret as needed but not daily. For further prevention and management of Margaret's intertriginous dermatitis and IAD, barrier cream cloths were used during personal care in the pelvic region and skin folds and continued post-discharge to prevent IAD recurring.

Discharge planning and ongoing care

Margaret was in hospital for 5 days by the time her care plan was in place. The care plan was in place for 10 days until she was discharged. Overall, Margaret's length of stay in hospital was 15 days.

The multidisciplinary team commenced discharge planning at the beginning of Margaret's admission. Nursing staff referred Margaret to the local community nursing service and made other referrals to link her into non-government organisation carer support. The continence NP liaised with Margaret and her carer to ensure that appropriate continence funding and supply and product selection for aids and skin hygiene were in place. The wound CNC provided consumer and carer skin integrity education to ensure continuity of care upon discharge. The OT conducted a virtual home assessment and worked with social services to arrange alternative, stable, independent and long-term accommodation. Margaret's GP provided ongoing support and care upon discharge to arrange specialist urology and plastic surgeon reviews into the future.

Upon discharge, Margaret's intertriginous dermatitis and IAD were resolved, and she did not develop any PIs. The IAD resolved within 3 days following the initiation of her management plan. Margaret described significant improvement of her stress urinary incontinence, skin condition and quality of life and was successful in finding a new housing option to move into.

A few months after the resolution of Margaret's abdominal cellulitis, she was referred to a urology service in a larger regional centre and plastic surgeon in Sydney for further assessment of the cause of her urinary incontinence. Margaret required plastic surgeon consultation to address her weight and volume of excess skin prior to undergoing corrective uterine prolapse surgery. Subsequently, she was diagnosed with a urinary prolapse and urinary retention. The recommendation was for Margaret to lose weight and undergo an abdominoplasty and apronectomy before correction of the prolapse.

DISCUSSION

Incontinence and IAD management can be problematic for clinicians and patients alike; Margaret's case is an exemplar of this. Many people are severely affected by incontinence for years and, because of stigma, embarrassment and fear of odour associated with the condition, can suffer social isolation and lack of access to healthcare¹⁵⁻¹⁷. In Margaret's case, psychosocial factors such as lack of independence and unstable housing impacted on the management of her incontinence and hospital discharge planning. These psychosocial factors (not specifically addressed in our case study) must be addressed by a multidisciplinary team that includes a social worker and other community services to assess social conditions that can affect the management and prevention of IAD and then develop an appropriate management plan.

Margaret's case highlights the benefit of multidisciplinary expert clinical assessment and management of incontinence to prevent the severe complications of IAD and PI. The initial misdiagnosis of the IAD as a PI highlights a need for further clinician education on the differences between the two conditions as misdiagnosis is common^{4,18-20} and can

lead to incorrect or delayed management, prolonging pain and discomfort^{3,18}. A recent study reported major gaps in current practice, including clinician knowledge of IAD²¹, its identification, prevention and management.

Prevention of IAD requires the correct assessment and management of incontinence; this involves identifying and addressing any reversible causes of incontinence such as urinary tract infection, constipation or medications¹. To manage incontinence, measures such as individualised toileting plans or use of continence containment pads, which in Margaret's case was in place, could be implemented to reduce or avoid episodes of incontinence¹. Toileting plans can establish when and how frequently patients should be toileted and can be tailored to a patient's abilities and needs such as their mobility and nutritional status²². Margaret's access to the toilet was further enhanced by engaging with mobility exercises under the guidance of the OT.

Other steps which contributed to maintaining Margaret's skin integrity included minimising the bed protection layers and using an SAP bed pad, when necessary, as well as the use of correct sized continence aids which prevented urine leakage. These measures improved the microclimate of the skin²³. Skin surface microclimate includes temperature and moisture. Exposure to moisture, such as urine and faeces, can lead to MASD due to inflammation of the epidermis and dermis⁴. Exposure to urine and faeces results in hyperhydration of the skin and increased skin pH, lowering tissue tolerance². Faeces contain enzymes, intestinal flora and moisture which are harmful to the skin². The regular use of barrier cream cloths improved healing of Margaret's existing IAD compared with the zinc oxide cream and dressings that were previously applied to Margaret's skin.

CONCLUSION

This case study reports an interdisciplinary best practice plan of care for the prevention and management of IAD. It demonstrates how coordinated efforts can improve outcomes by tackling multiple factors affecting the treatment of incontinence, mobility and skin integrity. This case study highlights the benefit of using best practice evidence in the assessment, prevention and management of IAD and the steps to be integrated into clinical practice to improve outcomes for patients with IAD.

ACKNOWLEDGEMENTS

We acknowledge Ivanka Komusanac, Executive Director of Nursing and Midwifery Services, Sydney Local Health District, executive sponsor of the IMBED study. We also acknowledge all members of the IMBED Project Steering Committee, IMBED Clinical Expert Group and IMBED Post-Research Implementation Advisory Committee.

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NEWS

AUSTRALIAN NEWS

We have started the new year with a host of exciting events and projects for members to look forward to engaging with. We anticipate a busy first half of 2023 at the Continence Foundation of Australia, including commencing a new strategic planning process and implementation of important projects such as the model of continence care in residential aged care and the commissioning of a new prevalence report replacing the Deloitte Access Economics report: The Economic Impact of Incontinence in Australia 2011, in order to obtain more recent data on the overall impact of living with and caring for someone with incontinence.

Journal news

The journal is currently being managed by our Senior Policy and Research Officer, Debra Parnell and Associate Professor Christian Moro, who accepted the role of Chair and Editor. Assoc Prof. Moro has been a member of the journal's Editorial Committee and we thank him for his ongoing support.

Joint NCOI and FUS Conference 2023

The Continence Foundation of Australia and the Urological Society of Australia and New Zealand (USANZ) are holding a joint conference of the 31st National Conference on Incontinence (NCOI) and the 4th Functional Urology Symposium (FUS) at the Adelaide Convention Centre from 14th - 17th June 2023.

This scientific program is overseen by scientific co-chairs Dr Ashani Couchman and Julie Westaway (Continence Foundation of Australia), and Professor Vincent Tse and Professor Eric Chung (Functional Urology Symposium).

This is Australia's leading multidisciplinary meeting for healthcare professionals working in bladder, bowel and pelvic health and functional urology. It also presents an excellent professional development opportunity for nurses, physiotherapists, doctors, pharmacists, medical specialists, researchers and other allied health professionals to hear the latest research from international and Australian experts, and the most current evidence-based best practice.

The conference program will commence with a full first day of workshops, followed by three days of plenary and abstract presentations, with concurrent breakout sessions. The program includes a welcome reception, conference dinner and exhibition space, providing numerous opportunities to connect and access information and support. The full NCOI program and further information regarding speakers, workshops, awards and sponsorship opportunities is now available at continence.org.au/NCOI

The Great Dunny Hunt

In April 2023, we will be running the Great Dunny Hunt

again, which takes place virtually at the National Public Toilet Map (NPTM) free website (toiletmap.gov.au) and on the App. The NPTM lists over 22,000 toilets around Australia, giving people the confidence to go out and about knowing where the closest toilets are. It has recently been updated to include two new features which are:

- Specialty maps: a feature which allows organisations and individuals to create and share maps based on their preferences. Specialty maps can be shared as a URL or QR Code, allowing them to be emailed, printed or shared on social media.
- Distance by route: a feature which allows individuals to calculate the quickest route to a facility, on foot or by car, and considers one-way streets and access to buildings.

The Great Dunny Hunt campaign serves to highlight discussions on incontinence, raising awareness of the prevalence and stigma, and where to seek help. This campaign always attracts a lot of enthusiasm and participation and we would like to thank all our campaign supporters. I anticipate the 2023 campaign will be as successful as in previous years.

BINS4Blokes

An advertising campaign commenced in December 2022, with 500 posters asking people to pledge their support for the installation of incontinence product disposal bins in male public toilets in shopping centres nationally. The campaign runs until 30th June 2023 and, so far, we have received more than 1,200 pledges of support. Adding disposal bins for incontinence products to male public toilets will support men in the community live and work with confidence and our aim is to make all Australians aware of how common incontinence is in men of all ages, and have bins installed in male public toilets Australia-wide.

Health promotion community grants

Between \$5,000 and \$20,000 is available for eligible organisations who offer activities which focus on primary and secondary prevention of incontinence aligning with the Foundation's new Health Promotion Framework. The activities will contribute to the evidence-base to improve our understanding of what works to prevent people from becoming incontinent and/or prevent other negative health consequences due to incontinence. This may include:

- Using principles of community development, bringing communities together and taking a strengths-based approach to empower and enable communities to achieve better bladder and bowel control health outcomes.
- Building individual skills, and supporting personal and social development of people in communities by providing information, education and life skills in bladder and bowel control health.

Any organisations or groups that may be interested in these grants are encouraged to contact Sharon Porteous, Health Promotion Manager at s.porteous@continence.org.au. Expressions of interest should include a short description of the project/activity, target group, aim, organisation name and contact details.

Values-based messaging

Foundation staff recently completed training on values-based messaging guided by Common Cause Australia, with the feedback that it was both perceptive and beneficial. The aim of the training was to focus on the power of values to motivate people to change in our messaging, rather than focussing on the problems and the barriers. Staff are keen to incorporate these concepts into future communications and campaigns.

Rowan Cockerell

CEO, Continence Foundation of Australia

NEW ZEALAND NEWS

Continence NZ Conference 2023

Continence NZ is pleased to be hosting a two day conference in Auckland on 14th – 15th September 2023. The conference will cover a range of topics for both adults and children. Further details and information on speakers, content and registration will be shared soon. We look forward to seeing you there!

Pelvic floor focus workshops

Continence NZ, in conjunction with Exercise NZ and REPs, is hosting pelvic floor focus workshops across the North Island in the first quarter of 2023. The workshops help exercise professionals gain a better understanding of basic anatomy and the function of the pelvic floor and core, recognise dysfunction of the pelvic floor and core, and reduce the risk of pelvic floor injury when developing an exercise programme. More details on how to register are available at https://www.continence.org.nz/p/Pelvic-Floor-Focus-Workshop-2023/2348/?fbclid=IwAR0phwX2VUpqRaKTncB5fyEgTnlCAvANyvi33xiSOGd4B_4DAzYJwuSr70g

Community and online education

Our nurses Lisa Smith and Louise Mills are offering free webinars and education sessions to both health professionals and our wider community on a range of topics, including bowel and bladder health, toilet training, constipation, bedwetting, daytime wetting, stool withholding, supporting continence in aged care settings, pelvic health across the lifespan, catheter management and more. Please contact info@continence.org.nz for a list of upcoming webinars or to discuss your specific requirements.

With support from the IHC Foundation, Continence NZ has recently developed two new online training modules – Key Continence Training for Schools and Key Continence Training for Disability Support Services. These are free and may be accessed anytime at <https://www.continence.org.nz/pages/Free-Online-Training/295/>

Research update

Continence NZ is progressing with a significant piece of research funded by the New Zealand Lottery Grants Board. The purpose of this project is to make recommendations as to how Continence NZ can most effectively serve those living with incontinence in New Zealand. Focus groups have been running through December and January and will continue in February, discussing the experiences of our community living with incontinence, the barriers to accessing care, and what support is needed for those living with incontinence. The research is expected to be completed in March.

Team update

Late last year we farewelled Lucy Keedle from our Executive Committee. We would like to thank Lucy for an exceptional ten years of service on our Executive. We also have the pleasure of welcoming two new

Executive Committee members, Jacinta Townsend and Helen Peek.

Jacinta Townsend is a nurse practitioner with over 25 years of experience in urology. She qualified as a nurse practitioner in 2015 with Distinction. Her training includes male and female voiding dysfunction, bladder cancer diagnosis and surveillance, and prostate cancer assessment and surveillance, in addition to other common benign urological conditions. Jacinta runs independent flexible cystoscopy and urodynamics clinics. She established her own consulting company four years ago and now works across both the public and private sectors. Her passion is providing evidence-based nursing practice and she has published several research articles.

Helen Peek is a continence nurse specialist at Southland DHB. She completed her nursing training at Timaru Hospital New Zealand before moving south. All of her nursing career has been in Invercargill, so she very proudly calls herself a Southlander. Helen worked in paediatrics and aged care before becoming a continence nurse specialist, a role she truly enjoys. She completed her Master's degree with a dissertation exploring women's perceptions and understanding of the pelvic floor.

Helen now works alongside other health professionals creating education packages for primary healthcare providers, focusing on recognising and managing those affected by surgical mesh, and preventing and managing urinary incontinence and pelvic organ prolapse.

Laura Fear
CEO, Continence NZ