Strategic Directions for Continence Services in Gippsland

October 2008
In developing this report, we would like to acknowledge the assistance and support of Gippsland Continence Nurse Advisors - and the members of the Continence Services Steering Committee:

Margaret Wilson  Bairnsdale Regional Health Service
Saskia Turra  DHS Gippsland
Maree Scanlon  Latrobe Community Health Service
Lesley Murray  Orbost Regional Health
Fiona McLennon  West Gippsland Healthcare Group
Dianne Jones  Gippsland Southern Health Service
Bronwyn Hughes  Bass Coast Regional Health
Christina Rush  DHS Gippsland
Mary Hartwig  Central Gippsland Health Service
Will Hanrahan  DHS Gippsland
Liz Brown  Bairnsdale Regional Health Service
Katherine Breen  DHS Gippsland

We would also like to acknowledge the consultancy work undertaken by Flynn Health Consulting and Inside Health Management.

Disclaimer:
Please note that, in accordance with Company policy, Flynn Health Consulting is obliged to advise that neither the Company, employee or sub-contractor undertakes responsibility in any way whatsoever to any person or organisation (other than the Client) in respect of information in this report, including any errors or omissions therein, arising through negligence or otherwise however caused.

Published by the Victorian Government Department of Human Services
© Copyright State of Victoria 2008

This publication is copyright, no part may be reproduced by any process except in accordance with the provisions of the Copyright Act 1968.

This document may also be downloaded from the Department of Human Services website at:

Authorised by the State Government of Victoria, 64 Church Street, Traralgon, Victoria
# Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Executive Summary</td>
<td>2</td>
</tr>
<tr>
<td>2 Background</td>
<td>4</td>
</tr>
<tr>
<td>2.1 Methodology</td>
<td>5</td>
</tr>
<tr>
<td>2.2 Policy context</td>
<td>5</td>
</tr>
<tr>
<td>3 Population growth and change</td>
<td>8</td>
</tr>
<tr>
<td>3.1 Regional Victoria: population growth and change</td>
<td>8</td>
</tr>
<tr>
<td>3.2 Gippsland region: population growth and change</td>
<td>8</td>
</tr>
<tr>
<td>4 Health status for Gippsland region</td>
<td>10</td>
</tr>
<tr>
<td>4.1 Burden of disease</td>
<td>10</td>
</tr>
<tr>
<td>5 Incontinence</td>
<td>11</td>
</tr>
<tr>
<td>5.1 Risk factors</td>
<td>11</td>
</tr>
<tr>
<td>5.2 Prevalence</td>
<td>11</td>
</tr>
<tr>
<td>5.3 Impact</td>
<td>12</td>
</tr>
<tr>
<td>6 Continence service provision</td>
<td>13</td>
</tr>
<tr>
<td>6.1 Funding sources</td>
<td>13</td>
</tr>
<tr>
<td>6.1.1 National Continence Management Strategy (NCMS)</td>
<td>13</td>
</tr>
<tr>
<td>6.1.2 State funding</td>
<td>13</td>
</tr>
<tr>
<td>6.1.3 Continence Aids &amp; Assistance Scheme (CAAS)</td>
<td>15</td>
</tr>
<tr>
<td>6.1.4 Department of Veterans Affairs (DVA)</td>
<td>16</td>
</tr>
<tr>
<td>6.1.5 Victorian Aids &amp; Equipment Program (VA&amp;EP)</td>
<td>16</td>
</tr>
<tr>
<td>6.1.6 Transport Accident Commission (TAC)</td>
<td>16</td>
</tr>
<tr>
<td>6.1.7 Australian Government funded packages</td>
<td>16</td>
</tr>
<tr>
<td>6.1.8 Children’s therapy</td>
<td>16</td>
</tr>
<tr>
<td>6.2 Workforce</td>
<td>16</td>
</tr>
<tr>
<td>6.2.1 Professions</td>
<td>16</td>
</tr>
<tr>
<td>6.2.2 Qualifications</td>
<td>17</td>
</tr>
<tr>
<td>6.2.3 Training</td>
<td>18</td>
</tr>
<tr>
<td>6.2.4 Recruitment and retention issues</td>
<td>18</td>
</tr>
<tr>
<td>6.3 Continence services in Gippsland</td>
<td>18</td>
</tr>
<tr>
<td>6.3.1 Local service mapping tool - summary results</td>
<td>18</td>
</tr>
<tr>
<td>6.3.2 HACC continence survey - summary results</td>
<td>19</td>
</tr>
<tr>
<td>7 Service utilisation and projected need</td>
<td>21</td>
</tr>
<tr>
<td>7.1 Separations and attendances</td>
<td>21</td>
</tr>
<tr>
<td>7.2 Future demand</td>
<td>21</td>
</tr>
<tr>
<td>8 Issues</td>
<td>22</td>
</tr>
<tr>
<td>8.1 Equitable access for Gippsland residents</td>
<td>22</td>
</tr>
<tr>
<td>8.1.1 Service system structure &amp; access</td>
<td>22</td>
</tr>
<tr>
<td>8.1.2 Unmet need</td>
<td>23</td>
</tr>
<tr>
<td>8.1.3 Referrals</td>
<td>23</td>
</tr>
<tr>
<td>8.1.4 Acute interface</td>
<td>24</td>
</tr>
<tr>
<td>8.2 Workforce</td>
<td>24</td>
</tr>
<tr>
<td>8.3 Responding to high needs groups</td>
<td>26</td>
</tr>
<tr>
<td>8.4 Funded continence products</td>
<td>27</td>
</tr>
<tr>
<td>8.5 Data collection</td>
<td>27</td>
</tr>
<tr>
<td>8.5.1 Service utilisation</td>
<td>27</td>
</tr>
<tr>
<td>8.5.2 Assessment tools</td>
<td>28</td>
</tr>
<tr>
<td>8.6 Continence health promotion</td>
<td>29</td>
</tr>
<tr>
<td>9 Future development of continence services in Gippsland</td>
<td>30</td>
</tr>
<tr>
<td>9.1 Recommendations</td>
<td>30</td>
</tr>
<tr>
<td>9.1.1 Develop a “Consortium” approach for continence in Gippsland - short term</td>
<td>30</td>
</tr>
<tr>
<td>9.1.2 Models of service delivery &amp; equitable access - short to medium term</td>
<td>31</td>
</tr>
<tr>
<td>9.1.2 Recruitment &amp; retention - medium to long term</td>
<td>32</td>
</tr>
<tr>
<td>9.1.3 Systematic intake, assessment &amp; referral processes - medium to long term</td>
<td>32</td>
</tr>
<tr>
<td>9.1.5 Health promotion - medium to long term</td>
<td>33</td>
</tr>
<tr>
<td>10 Planning principles</td>
<td>34</td>
</tr>
<tr>
<td>10.1 State-wide service planning principles</td>
<td>34</td>
</tr>
<tr>
<td>10.2 Gippsland service planning principles</td>
<td>34</td>
</tr>
<tr>
<td>11 Appendices</td>
<td>35</td>
</tr>
<tr>
<td>Appendix 1 – Membership of Gippsland Continence Project Steering Committee</td>
<td>35</td>
</tr>
<tr>
<td>Appendix 2 – Consultations &amp; Workshop Attendees</td>
<td>36</td>
</tr>
<tr>
<td>Appendix 3 – Glossary of Terms and Acronyms</td>
<td>37</td>
</tr>
<tr>
<td>Appendix 4 – Policy frameworks</td>
<td>38</td>
</tr>
<tr>
<td>Appendix 5 – Survey Results Parts 1 and 2</td>
<td>39</td>
</tr>
<tr>
<td>Appendix 6</td>
<td>43</td>
</tr>
</tbody>
</table>
1 Executive Summary

Incontinence is a significant health issue which has physical, social and serious quality of life implications for individuals of all ages and backgrounds.

Incontinence is a complex and widespread health issue. The major at risk groups include people with disabilities and/or chronic illness; people with post-operative complications; ante and post natal women and; the elderly.

The impact of incontinence is far reaching, as demonstrated by the following statistics from the Continence Foundation of Australia:

- Urinary incontinence affects up to 13% of Australian men and up to 37% of Australian women at some stage in their life - one in two Australians
- Faecal incontinence affects up to 20% of Australian men and up to 12% of Australian women at some stage in their life

At the Home and Community Care annual planning consultations in 2007, continence was identified as an area of high need and prioritised to be the focus of the 2008 Service Development Project. The aim of the project was to map the continence service provision in Gippsland and to consider the current models of services delivery in light of current national best practice.

Like the condition itself, the continence service system is complex. In Gippsland the system has developed over a number of years, utilising funding and resources from a variety of sources, including Australian Government and State Government funded programs and schemes, along with private providers such as pharmacies.

The Gippsland Continence Project focused primarily on the services and resources provided through the Department of Human Services (DHS) Gippsland Region and relates specifically to the provision of continence services in the area.

The Gippsland Continence Project “Strategic Directions for Continence Services in Gippsland” outlines recommendations for improvement to the service system in the region and in turn, to the health and wellbeing of Gippsland residents.

The following recommendations are in order of priority, however it is not essential to implement them in this sequence:

1. That Gippsland region adopt a “Consortium” or partnership approach to the development of new directions for Continence Services within the region:
   - that providers of continence services and DHS Gippsland region work together to implement best practice approaches to continence service provision in accordance with the planning principles (described in Section 10)
   - that DHS and the sector give due consideration to the most appropriate structure to undertake this role and seek any resources that may be required to support such development

2. That models of service delivery be implemented to ensure equitable access to best practice continence services across the region, including those people living in outlying areas:
   - that priority be given to establishing multidisciplinary continence teams where possible and that protocols be developed which clarify roles of the various professionals involved including Continence Nurse Advisors, district nurses, allied health staff, general practitioners and other medical specialists
   - that the role of the Continence Nurse Advisor be promoted to utilise this expertise more as mentors and educators for other professionals and the community
   - to document in local protocols how linkages between continence services and other health care providers can be strengthened and supported
   - that innovative outreach and video-conferencing models be adopted to overcome geographic barriers within the region

3. That service providers work together to improve the recruitment and retention of the multidisciplinary professionals required for the provision of best practice continence services:
   - that the use of scholarships or other incentives be used to enhance the potential of recruitment and training of staff
   - that the role of the various Continence practitioners be actively promoted across the sector

---

1 DHS funds Continence services and resources through the following programs: Acute, Sub-acute Ambulatory Care Services (SACS), Home and Community Care (HACC), Disability Services, and Community Health.
4. That continence service providers implement systematic intake, assessment and referral processes, in line with DHS guidelines such as Health Independence Programs and HACC, and the capture and reporting of appropriate continence service provision data be utilised to inform future planning:
- that data collection and management across all continence services is improved and standardised
- that new assessment tools and procedures be adopted and implemented as they become available

5. That the region advocate for appropriate incontinence prevention approaches to be included in the health promotion strategies across Gippsland:
- that further research to identify the most effective interventions for the prevention of incontinence be undertaken and as these become available, are included in health promotion strategies across the region

---

2 Continence providers currently collect a variety of data, however the methodology is inconsistent and it was not possible to undertake comparative data analysis on a regional basis. Consequently the project steering committee was unable to set any benchmarks for the level of service provision at this time. The providers recognise that this is important and expressed a willingness to address this issue in the future.
2 Background

Continence is defined as the ability to control bowel and bladder function. People can lose this ability for various reasons and consequently need help to either regain continence or manage incontinence. As indicated above incontinence is a significant health issue which has physical, social, economic and serious quality of life implications for individuals, carers and the community. Furthermore, continence management can be complex and requires a diverse range of responses by all levels of the aged care, disability and health services systems.

Gippsland’s ageing population is projected to increase, with a consequent increase in demand for a range of health services including, acute, community and home-based services. By undertaking this project, the Gippsland region of the Department of Human Services is seeking to prepare for the expected increase in demand, by developing a coordinated approach to continence service provision in Gippsland which ensures maximum benefit to consumers.

The project utilised a consultation process which involved a combination of surveys and individual and group consultation sessions with a variety of organisations across the region.

The project focused on the Gippsland region and this document relates specifically to the provision of regional continence services. The map of Gippsland Local Government Areas (LGA) below shows the geographical area encompassing the Primary Care Partnerships in the region.

Primary Care Partnerships (PCP) are a major health sector service planning and service co-ordination platform in Gippsland. PCPs have four priorities: partnership development; integrated health promotion; service co-ordination and; integrated chronic disease management.

The South Coast Health Service Consortium PCP covers the Bass Coast Shire and South Gippsland Shire LGAs. The Central West PCP covers Baw Baw Shire and Latrobe City LGAs. The Wellington PCP covers the Wellington Shire LGA - and the East Gippsland PCP covers the Shire of East Gippsland LGA.

Map of Gippsland Local Government Areas
2.1 Methodology
A working party comprising Gippsland DHS program staff and the project consultants developed project responsibilities and timelines - and identified key stakeholders. Stakeholder ‘buy-in’ was seen to be imperative to the development of a Gippsland wide continence plan.

The preparation phase provided entailed reviewing and summarising relevant research, demographic data and policy documents. A local service mapping tool was developed and sent to relevant continence service providers in Gippsland. In addition, a HACC continence survey tool was distributed, to ensure services potentially involved with provision of continence services were consulted.

The consultation included a regional workshop, focus groups, individual consultation and/or surveys. Participants included:
- relevant clinicians and managers from Gippsland continence service providers
- representatives of both the CALD and Aboriginal communities
- representatives from non-continence health service providers
- consumer representatives
- Department of Human Services personnel

The information gathered through this process has been used to develop strategic directions for continence services in Gippsland.

2.2 Policy context
The National Continence Management Strategy (NCMS)\(^3\), an Australian Government initiative, supports research, public awareness activities, education and resource development, aimed at improving continence awareness, management and treatment. The Strategy was established in 1998 to provide funding for research and service development initiatives aimed at prevention and treatment of this significant problem. Information pertaining to the work undertaken through the National Continence Management Strategy is available at Appendix 6.

Care in your community: a planning framework for integrated ambulatory health care\(^4\) (DHS, 2005) is a planning framework for integrated and ambulatory health care. It invests in a mix of inpatient and community-based integrated care services, to better meet future needs and expectations of communities and individuals. The policy encourages a person centred rather than an agency centred approach to health care delivery, and focuses on delivery of care in community rather than organisational settings. Integrated health care focuses on individual need, rather than on service type; professional boundaries; organisational structure; program funding; or reporting requirements. The policy has a strong focus on health promotion, prevention, early intervention and self-management.

Rural Directions for a Better State of Health (DHS, 2007)\(^5\) provides a framework for rural health services to orientate themselves towards the changing needs of the community and make the best use of available resources. It identifies an integrated direction for service planning, mapping the shape and direction of Victoria’s rural health system and working constructively with the Care in your community policy.

The Gippsland Sub-Acute Services Plan (DHS, 2006)\(^6\) identified significant shortages in the provision of sub-acute services in Gippsland. This included the provision of specialist clinics such as continence clinics. The Integrated Area-based Service model postulated in this plan assumes provision of core services, such as continence clinics, at regional and district level agencies.

---

\(^3\) National Continence Management Strategy, Department of Health & Ageing, 2003
\(^4\) Care in your community, DHS, 2005
\(^5\) Rural Directions for a Better State of Health
\(^6\) Gippsland Sub-Acute Services Plan
Included in the key challenges identified for Gippsland region under the *Gippsland Regional Action Plan 2007-08 (DHS 2007)* are points of particular relevance to continence:

- a skilled and flexible workforce
- progress in technology and knowledge
- increased demand for services
- increased complexity of client need
- avoidable use of tertiary services
- focus on preventive and early intervention
- service delivery around the person and place
- chronic disease prevention and care
- assistance to disadvantaged groups

The Home and Community Care Program (HACC) is jointly funded by the Australian Government and the Victorian State Government, along with significant contributions from local government authorities. HACC is the state’s largest source of practical assistance for the frail aged and people with disabilities living in their own homes. *The HACC Program - Gippsland Region Triennial Plan 2006-09*, through the introduction of the “Active Service Model”, challenges the system to move from a ‘dependency’ model of service delivery to a restorative care and capacity building approach, to meet clients’ basic maintenance and support needs.

The *Victorian HACC Program Manual (DHS 2003)* allows HACC activity service system resourcing to fund continence nurses - whose main role is to provide advice and education to consumers, carers and service providers. It also allows for funding of nurses and allied health professionals, who play a resourcing role in continence service provision. The majority of continence services in Gippsland are funded under this mechanism.

The Council of Australian Governments’ *Long Stay Older Patients Initiative* (COAG, 2006) (LSOP) commenced in February 2006. This four year initiative aims to improve care for older people in acute and sub-acute settings. It further aims to reduce or prevent avoidable or premature admission of older people to hospitals. The Initiative builds on the *Improving Care for Older People* (ICOP) and the *Hospital Admission Risk Program - Chronic Disease Management* (HARP-CDM) programs.

ICOP aims to minimise functional decline and to expand the HARP-CDM program to additional rural health services. Functional decline is a decrease in physical and/or cognitive functioning. It is a leading complication of hospitalisation in older people and can occur as early as the second day of admission. Functional decline can manifest as malnutrition, decreased mobility, loss of skin integrity, incontinence, falls, delirium, problems with medication, poor self-care and depression. Ten functional domains, including continence, are being addressed. This project identifies that continence is not promoted and that incontinence is poorly managed.

The Department, in consultation with the health sector, has developed a set of guidelines, to provide health and community services with direction for closer alignment of identified Health Independence Programs. Health independence programs include:

- Post Acute Care (PAC)
- Sub-acute Ambulatory Care Services (SACS), including centre-based, home-based and specialist clinics
- Hospital Admission Risk Program - Chronic Disease Management (HARP-CDM)
- Hospital Admission Risk Program - Better Care for Older People (HARP-BCOP)

---

7 *Gippsland Regional Action Plan 2007-08*
8 *HACC Program - Gippsland Region Triennial Plan 2006-09*
9 *Victorian HACC Program Manual (DHS 2003)*
10 *Long Stay Older Persons Initiative, COAG, 2006*
11 *Improving Care for Older People, DHS, 2006*
12 *Hospital Admission Risk Program - Chronic Disease Management, DHS, 2006*
Alignment of these services is underpinned by the following objectives:

- simplify the service system
- provide efficiencies in service delivery
- minimise duplication
- improve equity
- enhance coordination
- reduce fragmentation of existing silos
- embed innovations and lessons learnt in mainstream programs
- enhance flexibility in service delivery

A copy of the draft guidelines can be located at: www.dhs.vic.gov.au/ahs/concare

In addition to the development of the HIP guidelines, the development of a state-wide sub-acute planning framework aims to integrate and take a common approach to all sub-acute services. This brings together what otherwise might be viewed as a set of separate programs. The sub-acute programs include:

- rehabilitation (inpatient and ambulatory services)
- Geriatric Evaluation and Management (GEM)
- specialist services provided in sub-acute ambulatory settings, such as:
  - continence
  - dementia
  - falls
  - pain management

During the second year of the ICOP initiative (2007-08), the focus includes the development of an implementation resource tool kit that aims to minimise functional decline, and expanding the HARP-CDM program to additional rural health services. The tool kit is being trialled in regional and metropolitan health agencies.

As part of the COAG LSOP Initiative, a trial of the Functional Decline Implementation Toolkit at Southern Health, identified that continence problems were poorly recognised in the continuing care (sub-acute) setting, as substantiated by a lack of documented evidence in patient medical histories. Recommendations from the COAG LSOP Initiative include development of a continence assessment tool which incorporates assessment, diagnosis and management for an identified continence issue. This toolkit is intended to guide those with less knowledge and experience rather than targeting Continence Nurse Advisors.

The five health services in Gippsland participating in the LSOP initiative are Latrobe Regional Hospital, West Gippsland Healthcare Group, Bass Coast Regional Health Service, Central Gippsland Health Service and Bairnsdale Regional Health Service. It is expected that Gippsland Region will maintain close links with this initiative in order to take advantage of any new developments that arise.
3 Population Growth and Change

The population projections in this Section are sourced from *Victoria in future*, (Department of Sustainability and Environment (DSE)) and are based on 2001 census data. At the time of this project, the 2006 census data has not been released.

3.1 Regional Victoria: population growth and change

The age profile for regional Victoria shows a consistent and marked increase in individuals in the five-year age cohorts from 55 to 85+. There is also a drop in the numbers of individuals in the age cohorts from 0 to 19 years. Figure 1 shows the forecast composition of Victoria’s regional population, at 2006, 2011 and 2016.

*Figure 1: Change in regional Victorian age profile 2006 to 2016*

3.2 Gippsland region: population growth and change

Gippsland’s population is unevenly spread between the six Local Government Areas (LGAs). The largest population concentration is in Latrobe City, but strongest population growth is forecast in the Bass Coast and Baw Baw Shires. Table 1 below shows five-year and ten-year projected growth outcomes for each of the six LGAs. By comparison, the Victorian population is expected to grow by 9.8 per cent over that period, while the Victorian rural population is expected to grow by 8.5 per cent. The Gippsland population is expected to grow by 6.4% between 2006 and 2016 with the highest LGA growth expected to be in Bass Coast 16.9%.

*Table 1: Population growth in Gippsland*

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Bass Coast (S)</td>
<td>25,631</td>
<td>29,408</td>
<td>32,380</td>
<td>35,374</td>
<td>16.9</td>
</tr>
<tr>
<td>Baw Baw (S)</td>
<td>36,404</td>
<td>38,416</td>
<td>40,292</td>
<td>42,110</td>
<td>8.8</td>
</tr>
<tr>
<td>East Gippsland (S)</td>
<td>39,439</td>
<td>41,046</td>
<td>42,487</td>
<td>43,790</td>
<td>6.3</td>
</tr>
<tr>
<td>Latrobe (C)</td>
<td>70,643</td>
<td>70,454</td>
<td>70,537</td>
<td>70,468</td>
<td>0.0</td>
</tr>
<tr>
<td>South Gippsland (S)</td>
<td>26,159</td>
<td>27,243</td>
<td>28,162</td>
<td>29,016</td>
<td>6.1</td>
</tr>
<tr>
<td>Wellington (S)</td>
<td>41,462</td>
<td>41,361</td>
<td>41,519</td>
<td>41,511</td>
<td>0.4</td>
</tr>
<tr>
<td>Total</td>
<td>239,738</td>
<td>247,929</td>
<td>255,377</td>
<td>262,270</td>
<td>6.4</td>
</tr>
</tbody>
</table>

*Source: Victoria in Future, DSE, 2004*
During this period, the population structure of the region is forecast to change, with decreases in infant population and increases in post-retirement population. Figure 2 demonstrates forecast changes in population age cohorts to 2011 and 2016, looking at the region as a whole. This data demonstrates the likely continued emigration of the working age population (20 to 55 years) and forecasts a large increase in the post-retirement population. The forecast growth in the over-85 population is notable. Figure 2 demonstrates that Gippsland’s forecast demographic structure is similar to other Victorian regions, with a substantial and ongoing increase in the numbers of people in Gippsland over 55 years of age.

**Figure 2: Forecast Gippsland demographic change 2006 to 2016**

*Source: Victoria in Future, DSE, 2004*
4 Health Status for Gippsland Region

4.1 Burden of disease

The Public Health Branch of DHS publishes data on the burden of disease in the Victorian community. The main measure used is the disability-adjusted life year (DALY). One DALY can be thought of as one lost year of healthy life and is calculated as a combination of years of life lost as a result of premature mortality and equivalent healthy years of life lost as a result of disability. The burden of disease therefore measures the gap between current health status and an ideal situation in which everyone lives into old age free of disease and disability. As such it indicates the unfinished health agenda, identifying areas in which additional health gains could be made.

The Burden of Disease and Injury in Australia 2003 document, assumes that a number of diseases and injuries are associated with the condition of incontinence; most of which are more prevalent at older ages – and that the underlying causes are multi-factorial and interrelated. The document also notes that much disability resulting from incontinence may also be hidden under other nomenclature such as benign prostate hypertrophy or stroke. This adds to the under-recognised nature of incontinence as a major disabling factor in the lives of many people.
5 Incontinence

Incontinence is a common health problem that afflicts over two million Australians at any point in time and of all ages and backgrounds. Continence is defined as the ability to control bowel and bladder function. For various reasons, people can lose this ability and need help to either regain continence or manage their incontinence.

The problem is of particular concern to people that are bed bound, elderly, and disabled. It can also cause major issues for young and otherwise fit and active individuals.

5.1 Risk factors

For the purposes of this report, incontinence risk factors is the term given to a range of health related behaviours that can impact on the continence of an individual. The high risk factors for bladder and bowel control problems are:

- peri-natal and post-natal women
- younger women who have had children
- people who are overweight & obese
- urinary tract infections
- presentation of dementia type behaviours
- people with a range of chronic diseases such as diabetes, stroke, heart conditions, neurological disorders, respiratory conditions
- recent surgery
- prostate problems

Incontinence risk factors appear to be cumulative, with the risk of incontinence increasing as these risk factors advance in severity and/or duration.

Correlation between continence, chronic disease and falls

There appears to be some correlation between incontinence, chronic disease and falls. Within the incontinence high risk groups, it is common that these individuals also experience chronic disease. Many of these cohorts are also at high risk of falls. Therefore it is reasonable to expect considerable overlap in the approaches utilised for chronic disease management, falls prevention, and continence management.

Incontinence needs to be assessed and treated as part of the raft of services provided for chronic disease management. A component of effective chronic disease care is the management of the disease conditions; and their interplay with overall health status, functional status and quality of life issues. It is this interplay of elements with chronic disease conditions, that requires health care professionals to engage with Continence Nurse Advisors and other practitioners, to develop collaborative service pathways and management plans.

Several Australian research studies have shown a link between falls and incontinence. In general, the findings of research suggest that urinary incontinence is a powerful measure that can be used to identify people with the greatest risk of falls.

The impact of incontinence and its correlation to other significant health issues goes without sufficient recognition. More work needs to be undertaken to ensure incontinence has appropriate recognition across the health sector and the community.

5.2 Prevalence

In 1998 the overall prevalence of incontinence in Australia was estimated affect 26% of the population (11% of males, 40% of females). Incontinence is eleven times more likely to be reported by women and Australian evidence indicates, while increasing for both genders, the prevalence for women increases more markedly across the lifespan.

The Women’s Health Australia project (1999)\(^\text{15}\) reported that the prevalence of urinary incontinence increased from 13% for women aged 18-23 years, to 36% for those aged 45-50 years and reduces slightly to 35%, for those aged 70-75 years. A possible reason for the slightly lower prevalence among older women is that incontinence is a major consideration for admission to residential care amongst older adults. (Approximately 70% to 80% of nursing home residents are female and the rate of incontinence (both urinary and faecal) is estimated at between 44% and 50%).

\(^{15}\) Women’s Health Australia, 1999
The 1997 NSW Health Survey reported that for men aged 40+ years, 15% were classified with urinary incontinence. Consistent with data on females, incontinence symptoms for males increase over the lifespan. For males aged 15-39 years, the prevalence of incontinence was 2%; for those aged 40-59 years it was 2%, and for those aged 60+ years it was 18%.

There are no specific figures on the prevalence of incontinence for the Gippsland region. Given that the region’s population is ageing at approximately the same rate as the general Victorian and Australian populations, it can be assumed incontinence prevalence is of similar proportion.

5.3 Impact

The detrimental effects of a continence issue cannot be understated. The problem is often a sequela of an underlying medical disorder but can in itself be a major health issue. This is particularly the case for individuals where there is a potential danger of loss of skin integrity or risk of infection, such as residential care residents or elderly or disabled people living in the community.

Incontinence can affect an individual’s capacity to function in their home and community. It can affect a person’s capacity to be employed, to participate in any form of exercise, to have normal sexual relationships and to deal with the everyday matters of normal family life. Incontinence can also be an extremely expensive issue for people, especially if they do not fall within the ambit of those who can be compensated through a recognised program such as the Victorian Aids & Equipment Program.

Perhaps the most overwhelmingly negative factor relating to continence issues is the stigma attached to the condition. Many people take years to be able to discuss the issue with their local general practitioner - some never do. This is an enormous problem within the greater community, but even more so when other cultural factors are taken into account. All of these factors limit the likelihood that an individual will attend for treatment and management of the condition.

Incontinence appears to be a condition where it is common for many to suffer in silence. Many Continence Nurse Advisors report that it is common for consumers to wait for many years before reporting it to a General Practitioner or other health professional.

Intervention by Continence Nurse Advisors can frequently result in rapid improvement in an individual’s scenario. Continence Nurse Advisors attest to the number of people who present with a continence issue which they have endured for a long period, only to discover that the matter can be managed and improved with minimal adjustment to normal practices.

In many cases, however, the process is much longer and more complicated, but nevertheless contact with a professional and freedom from the stigma associated with discussing such intimate issues can mean a considerable improvement in lifestyle. Such life changing benefits cannot be downplayed; people can go on to maximise their social and physical capacity to interact in their community with massive improvements to their capacity to live and enjoy a healthy and happier life.

One continence advisor wrote: “I believe that continence issues can have an imposing and negative impact on people’s lives if they are not provided with aids, education and opportunities to discuss appropriate options with appropriate health professionals.” Another wrote: “People remain unaware of what continence services can offer and generally only present once there is an acute issue. People on the whole are extremely embarrassed about continence issues so tend to keep it hidden until it must be attended to.”

The negative response to the condition also affects the ability of the health system to attract people into this specialised workforce. It has been common for staff who work in the profession to have commenced almost incidentally – having taken on a position for a finite period of time or to cover another worker on leave and then discovering it to be a challenging and rewarding area of work.

16 Measuring Incontinence in Australia: A National Continence Strategy Project, University of Melbourne, 2006
6 Continence Service Provision

6.1 Funding sources

6.1.1 National Continence Management Strategy

The extent of the continence issue is to some degree, represented by the level of funding provided by the Australian Government ($31 million of funding over seven years) to resource the National Continence Management Strategy (NCMS). Through this strategy, the Australian Government aims to improve continence treatment and management to enable Australians to live and participate in their communities with dignity and confidence. A listing of activities, along with the web address of the National Continence Management Strategy is attached at Appendix 6.

6.1.2 State funding

The Victorian Government through the Department of Human Services provides funding for continence services from a number of program streams: Disability Services Division (DHS), Community Health, Home and Community Care service (HACC) - and through the Sub-Acute Ambulatory Care Service model (SACS). Under the SACS model, identified health services provide specialist clinics, including Continence Clinics. There is one SACS funded continence clinic in Gippsland, provided by West Gippsland Healthcare Group at its Drouin centre.

Figure 3 shows DHS funding for continence in Gippsland (2007-08) as defined by each program. The total program funding is $724,000. It should be noted that additional resources (Aids and Equipment and Community Health Nursing) are used in providing continence services, but are not specifically defined by DHS.

Figure 4 shows the Gippsland HACC program continence per capita funding by LGA. Baw Baw Shire does not receive any HACC funding for continence because it has a Sub-Acute Ambulatory Care Services (SACS) funded service.

The Gippsland column is effectively the total of regional per capita funds - in other words, the average $ funded per capita. Per capita funding (PCF) is calculated by dividing the funding by the HACC Target Population for a Region or LGA. The HACC Target Population is derived using the ABS census data and the Regional Resource Equity Formula (RREF). PCF is utilised for planning and equity purposes only and is not an indication of the level of funding applied per actual HACC consumer.

This is not a perfect form of analysis but is a reasonable approach to establishing some comparative analysis across LGAs. It should also be noted that whilst the SACS clinic based in Baw Baw is a regional service, most of the service is provided to Baw Baw residents and residents from the neighbouring LGAs. This is due to the significant distances between dispersed population centres in Gippsland, (refer to Table 2).

Figure 3: Total Funds per DHS program 2007-08

Figure 4: Gippsland HACC Continence Funding $ per capita by LGA 2007-08
6.1.2.1 Home & Community Care Service (HACC)

With funding of over $410 million in 2005, HACC is Victoria's largest source of practical assistance for older people and people with disabilities living in their own homes. In 2003-04, the HACC data collection recorded over 216,000 Victorians of all ages having received one or more services from the program. These services include home care (home help), personal care, nursing, social support and delivered meals. A broad cross-section of Victorians receives these services. About two thirds are aged 70 or older, but the program assists Victorians in all age groups.

HACC is an extremely popular program. Because of people's preference for services to help them maintain their independence in their own homes, demand for community care is steadily rising.

HACC activity service system resourcing, funds continence nurses, whose main role is providing advice and education to consumers, carers and service providers. It also allows the funding of nurses and allied health professionals, who play a resourcing role in continence service provision. The majority of continence services in Gippsland are funded in this manner.

The program is moving from what has often been seen as a ‘dependency’ model of service delivery, to a restorative care and capacity building approach, to meet clients’ basic maintenance and support needs. Instead of assuming constant decline, the aim is to retain or improve clients’ independence and self-efficacy, thereby minimising the impact of functional decline on the person’s capacity to live at home and to participate in everyday social interactions. The provision of continence services is integral to increasing the independence of HACC clients.

6.1.2.2 Sub-Acute Ambulatory Care Service (SACS)

A continence clinic is defined as being:

“an accessible multidisciplinary clinical service specialising in incontinence and other bladder and/or bowel function difficulties (and) providing assessment, diagnosis, management, education and support to improve continence for clients. The service will also provide consultancy, education and support to carers, relatives and professional service providers”.

(Program Guidelines and Performance Indicators, Acute Health Division, DHS, 2000)

Continence clinics are SACS funded and provide specialist continence services for each region in Victoria. The Gippsland regional SACS continence clinic is situated in Drouin near the western boundary of the region and is staffed by 2 EFT Continence Nurse Advisors - and a Urologist 1 day per week.

Clients can and do access the service from across Gippsland, but there are often accessibility issues, particularly for those clients living in the outlying areas of the region (for instance those areas more than 100kms from Drouin). Refer to Table 2 and the accompanying map, which show the distance and approximate travel time between Drouin and some Gippsland townships.

Little would be gained by moving the clinic to another single site, but consideration needs to be given to alternate models of service delivery such as out-reach services or the use of video-conferencing.
6.1.3 Continence Aids & Assistance Scheme (CAAS)

The Continence Aids Assistance Scheme (CAAS) is an Australian Government program that assists eligible people who have permanent and severe incontinence, to meet some of the costs of continence products. CAAS is administered on behalf of the Australian Government by Intouch, the commercial arm of the Spinal Injuries Association Incorporated.

CAAS clients receive a subsidy of up to $470 per year on continence products ordered through Intouch. Clients aged five years or older are eligible for funding, subject to meeting assessment criteria. Applicants are required to obtain an assessment from an appropriate health professional such as a Continence Nurse Advisor, general practitioner, medical specialist, community nurse, physiotherapist or occupational therapist, to support their application.

Recent changes to the eligibility criteria for CAAS have resulted in a considerable increase in the number of assessments being undertaken by Continence Nurse Advisors. Funding has not been increased to match this work load increase.
6.1.4 Department of Veterans Affairs (DVA)

The Australian Government Department of Veterans Affairs provides funding to assist “Gold card” holders and confirmed eligibility “White” card holders, who have a continence issue. DVA funding for continence assistance is accessed through application to ‘Independence Solutions’ in Collingwood, Victoria. Products may be prescribed by Continence Nurse Advisors and other health professionals following client assessment. A prescription is valid for two years, providing the client’s condition remains unchanged. Clients are issued with three months supply of consumables at a time. There are 25 categories of items, each with a specified ordering limit, which can be exceeded in exceptional circumstances.

6.1.5 Victorian Aids & Equipment Program (VA&EP)

The Victorian Aids & Equipment Program (VA&EP) is a DHS Victorian Government administered scheme providing funding for disabled clients living in the community. The funding is administered by regional coordinators and products are accessed from ‘Independence Solutions’. Gippsland’s regional coordinators are situated at Bairnsdale Regional Health Service (deals with applications from East Gippsland, Latrobe, Wellington and West Gippsland - Gippsland Southern Health Service (deals with applications from South Gippsland) - and Bass Coast Regional Health Service (deals with applications from Bass Coast).

Funding is a maximum of $300 per individual per three month period, for specified products. Signed confirmation of diagnosis from the client’s general practitioner is required.

Current CAAS recipients are eligible to apply for VA&EP funding, when CAAS funding is exhausted for the financial year and where there is demonstrated need.

6.1.6 Transport Accident Commission (TAC)

Transport Accident Commission Australian Government funding for continence clients is administered in Victoria at a state level from TAC offices. Case managers support clients with continence issues as a sequela to their acquired injuries. A comprehensive assessment is required, in order to assess continence service needs; current management; recommended management - and recommended continence products which TAC fund. A new assessment is required every two years. Funding is per client according to a schedule of fees for service.

6.1.7 Australian Government funded packages

Extended Aged Care at Home (EACH), EACH Dementia, Community Aged Care Packages (CACPs), Linkages, Intensive Support Packages (ISP), Making a Difference and; Early Start funded packages for clients with complex conditions and multiple needs, often have provision for continence aids funding. A Continence Nurse Advisor will assess a client and make recommendations to a case manager, on continence management and products needed. Clients on all packages except EACH can access continence aids through VA&EP and CAAS.

6.1.8 Disability services - children

DHS Disability Services provide funding to children aged between 5 years and 15 years who have identified disabilities and are in receipt of a disability pension. $470 in funding is available for therapy and up to $501 for funded continence products per financial year. This is a regional service and in Gippsland is split between West Gippsland Healthcare Group (64 packages) covering Baw Baw, South Gippsland, Bass Coast and Latrobe LGAs, and Bairnsdale Regional Health Service (50 packages) covering Wellington and East Gippsland Shires.

6.2 Workforce

6.2.1 Professions

Continence Services can be provided by a range of health care professionals. In Gippsland, continence services are predominantly delivered by registered nurses. This is especially the case with HACC funded service delivery. The sub-acute care continence clinic managed by West Gippsland Healthcare Group is also run by registered nurses, but there is a formal affiliation with a urologist who attends the clinic on a weekly basis, to manage complex clients.
Continence Nurse Advisors
There is no formal accepted definition of a Continence Nurse Advisor but for the purposes of this document, the term is defined as follows:
A Continence Nurse Advisor (CNA) (also known as Continence Nurse Consultant or Clinical Nurse Consultant) is a registered nurse (Division 1) who has extensive background experience and knowledge in continence management; has generally completed further study in this area either at graduate certificate, diploma or masters level and; is recognised by contemporaries as a leader who is able to provide them with advice and assistance with a range of complex patient issues. A CNA works with significant autonomy (and organizational expectations of role initiative) and has the capacity to work at advanced nursing practice level.

Continence Nurse Advisors provide comprehensive assessment and management plans regarding continence issues. They provide a tertiary referral and therapy service and implement therapeutic regimes.

District Nursing Service & Bush Nursing Centres
District nurses have considerable involvement in the provision of continence services to clients, as do nurses working in more remote areas such as Bush Nursing Centres. In most cases, these nurses manage their clients with the help of expert advice from Continence Nurse Advisors. Time limitations and the tyranny of distance places severe limitations on the CNA input to these services.

Nurses comprise the single largest group in the Health Service System workforce. Nursing activity accounts for 25% of the HACC program resources in Gippsland. It is likely that nurses have the capacity to undertake a greater role in relation to provision of continence services to the community. The role of general nursing needs to be clarified in relation to Continence Nurse Advisors.

General Practitioners
General practitioners provide medical assessment and treatment options, review and prescribe medications, order clinical tests and/or refer clients to a medical specialist or a Continence Nurse Advisor or continence therapist. Most general practitioners seem to prefer to refer to a continence service but continue to manage the patient within their own service.

Continence Physiotherapists
Continence physiotherapists specialise in the treatment of incontinence. They are often located in public outpatient clinics for women; in public hospitals or; in private physiotherapy practice. They provide professional assessments and give advice and treatment, include pelvic floor muscle exercises and muscle rehabilitation.

There are physiotherapists across Gippsland who have an interest and training in continence, but do not appear to be involved due to time or practice constraints. With the encouragement of a multi-disciplinary team approach to the provision of continence services, these professionals would be a valuable addition to the continence workforce. This expertise could be employed at a regional level to work with other professionals or at a local level to provide direct services to individual patients or groups.

Pharmacists
Pharmacists advise on medications and sell continence products. They may provide information leaflets on incontinence. Their input is vital, given that continence issues can frequently arise as a consequence of certain medications. Pharmacy assistants are also trained in the effects of medication on continence and provide a ready avenue of access for individuals.

Medical Specialists
Medical specialists including urologists, geriatricians, gynaecologists and bowel specialists are frequently involved in the treatment and management of continence issues. Geriatricians are specially noted as an invaluable assistance in the care of older clients with continence issues. Access to these specialists is limited to a lack of geriatricians practicing in Gippsland.

6.2.2 Qualifications
Generally, a Registered Nurse Division 1 with continence education or experience is accepted as the appropriately qualification to provide continence service delivery. The degree of qualification is currently being reviewed by the relevant nursing bodies.
A range of qualifications is available for nursing staff and others who are interested in this area of work. The Mayfield Clinic in Melbourne provides a 3 day course delivering the basics required to practice in this area. This course is available to all comers; there is no requirement to hold an underlying health related qualification. This is seen as a useful starting point, and many Division 2 nurses and Personal Care Workers (PCWs) from residential care facilities utilise the course to develop their skills. From there, qualifications can extend to a Masters level qualification in this discipline. There are no strict definitions of the qualification required to work in this field, but all the continence nurses in Gippsland have a qualification of some sort.

6.2.3 Training
Ongoing training for Continence Nurse Advisors is an area of concern. In Gippsland, Continence Nurse Advisors have formed their own group, as a means of providing peer support. Many undertake ongoing training or attendance at seminars and conferences run by the National Continence Foundation. In some cases, costs are covered by their home health agency, whilst others fund their own professional development. Improving the level of training available for Continence Practitioners and other professionals is a high priority.

Examples of available training for Continence Nurse Advisors include:
- Certificate in Health - Continence (Flinders University)
- pelvic floor workshop (Newcastle)
- Prostate Care Nurse (La Trobe University)
- various distance education programs

6.2.4 Recruitment and retention issues
All staff consulted during the project and employed in the area of continence service delivery, indicated that it is difficult to attract new practitioners. Nonetheless, all report they consider continence management a fascinating, stimulating and rewarding vocation in which to work – and are keen to encourage more health practitioners to participate.

Unfortunately, the vocation is not seen as attractive by many members of either the health work force or the general public. Descriptive terms bandied about by non-practitioners are often derogatory. As such, stigma associated with being part of the service system increases the difficulty of attracting more people to practice. Negative branding in the community may also have had a discouraging effect upon peoples’ willingness to actually attend for service.

Raising the profile of continence practitioners as positive and rewarding roles, is an essential step in addressing the recruitment issue. In addition, some benefit may be gained from partnering with other organisations already addressing workforce issues - such as Monash University School of Rural Health (Gippsland) and local Divisions of General Practice.

6.3 Continence services in Gippsland
Providers of Continence Services were surveyed using a local service mapping tool. HACC funded agencies which refer such services, were surveyed using the HACC Continence Survey. (Refer to Appendix 5 for further details)

In a number of cases, continence service providers were unable to provide precise information because the data are not routinely collected. Comments from continence providers and from HACC services (as stated on survey forms) are provided at Appendix 5.

Continence providers currently collect a variety of data, however the methodology is inconsistent and it was not possible to undertake comparative data analysis on a regional basis. Consequently the project steering committee was unable to set any benchmarks for the level of service provision at this time. However, providers recognise this is important and expressed a willingness to address this issue in the future.

6.3.1 Local service mapping tool - summary results
Bairnsdale Regional Health Service
Bairnsdale Regional Health Service (BRHS) employs 2 Continence Nurse Advisors (.8 EFT and .6 EFT) who provide services to the Shire of East Gippsland. They cover the local Bairnsdale area and also provide a clinic at Central Gippsland Health Service Sale. This responsibility is being transferred to Central Gippsland Health Service at the end of June 2008. BRHS also deliver out-reach and telephone services to Buchan Bush Nursing Centre and Orbost Regional Health, in addition to providing services to Gippsland and East Gippsland Aboriginal Cooperative (GEGAC) in Bairnsdale and Ramahyuck Aboriginal Corporation in Sale. Funding is received predominantly from HACC (74%) and DHS Disability program (24%) with a small amount from PAC (1%) and from fees collected (1%). A range of specialist treatment and services are delivered from BRHS’s Ross Street facility in Bairnsdale.

Latrobe Community Health Service
Latrobe Community Health Service has resources for 2.4 EFT Continence Nurse Advisors who service the City of Latrobe. Most of the funding for the continence program is provided by HACC and the remainder through community health. Most clients are seen at the Centre. No further information was recorded. Details are at Appendix 5.

Bass Coast Regional Health
Bass Coast Regional Health employs one continence advisor (.76 EFT). The service is totally HACC funded and services the Shire of Bass Coast. A range of predominantly centre-based treatment is provided. Occasions of Service are recorded using ‘PJB’ software.
Details are at Appendix 5.

West Gippsland Healthcare Group
West Gippsland Healthcare Group is a SACS funded specialist clinic and reports on the SACS system. As the Gippsland regional SACS continence clinic, services are provided to residents from across the region, at the Drouin based centre. However, as Table 2 demonstrates geographic barriers exist for those who reside outside Baw Baw Shire and most clients who access the Drouin centre live in Baw Baw shire. Three Continence Nurse Advisors are employed (total of 1.8 EFT), along with a physiotherapist (.2 EFT). A urologist provides a urodynamic clinic one day per week. Details are at Appendix 5.

Gippsland Southern Health Service
Gippsland Southern Health Service employs two Continence Nurse Advisors (total of .4 EFT) The service is totally HACC funded and services the Shire of South Gippsland and the Yarram district of Wellington Shire. There may be alterations to the service provision to Yarram if Central Gippsland Health Service is funded to provide additional continence services. A range of treatment types are provided at the clinic and through a home-based service.
Details are at Appendix 5.

6.3.2 HACC continence survey - summary results

Orbost Regional Health
Orbost Regional Health services parts of East Gippsland Shire. Continence services for the Orbost area are provided at the Orbost Medical Clinic through the auspice of Bairnsdale Regional Health Service. Information to ascertain the adequacy of service provision is not available. Education is an identified need for the community health nurse and allied health providers. Details are at Appendix 5.

Swifts Creek Bush Nursing Centre
Swifts Creek Bush Nursing Centre services the Swifts Creek area for a 20 km radius from the centre of town. Continence services are provided by Bairnsdale Regional Health Service, either by direct referral or through telephone consultation. The population is small and the Bush Nursing Centre Manager believes they are adequately serviced due to good communication and assistance from Bairnsdale Regional Health Service. Education and training are noted as an area to be addressed. Details are at Appendix 5.

Yarram & District Health Service
Yarram & District Health Service receives a continence service through the auspice of Gippsland Southern Health Service one day per month. The service is seen as meeting the needs of the area. Details are at Appendix 5.
- **Central Gippsland Health Service**
  Central Gippsland Health Service receives continence services through the auspice of Bairnsdale Regional Health Service for one day per week. This service will be transferred to Central Gippsland Health Service in the near future. CGHS has 0.2 EFT which is about to be increased to 1 EFT for a Clinical Nurse Consultant - Continence. This person will assume management and promotion of the continence program in Wellington Shire and will provide education for district nursing staff, who will provide direct care where this is deemed appropriate. Details are at Appendix 5.

- **Buchan Bush Nursing Association Inc.**
  Buchan Bush Nursing Association Inc. services the LGA of East Gippsland for a 25 kilometre radius around the town of Buchan. Continence services are provided by Bairnsdale Regional Health Service, either by direct referral or through telephone consultation. The service is adequate to the needs of the township. Details are at Appendix 5.

- **Gippsland Lakes Community Health**
  Gippsland Lakes Community Health services Lakes Entrance and surrounding districts in the Shire of East Gippsland. Continence services are provided by Bairnsdale Regional Health Service, either by direct referral or through telephone consultation. The Continence Nurse Advisor has been training individual community nurses on an ‘as needs’ basis so that ongoing care can be provided. This is seen by the community health service as a sensible use of resources. The current system is seen as meeting their needs. Details are at Appendix 5.

- **Gippsland Multicultural Services**
  Gippsland Multicultural Services is a Region wide service providing: settlement services, respite services, social support services, friendly visiting program, equity and access program, community partnerships program – and English language classes. Continence clients (small in number) are referred to Latrobe Community Health Service for assessment and treatment. More training is required for CALD staff, and information literature in different languages is also needed.
7 Service Utilisation and Projected Need

7.1 Separations and attendances
Data provided on the continence survey forms (see Appendix 5) was insufficient to undertake comparative data analysis on a regional basis. Consequently, the project steering committee was unable to set any benchmarks for the level of service provision at this time. However, the providers recognise that this is important and indicated a willingness to address this issue in the future.

Data reporting on utilisation of continence services in Gippsland is currently inconsistent. A number of agencies utilise “PJB” as a data collection tool. Others use excel spreadsheets - and some keep very limited data. Some Continence Nurse Advisors keep their own data, but these are not reported in any formal sense.

Given that continence services are funded from a number of sources (HACC, SACS, Disability) there is no one data collection method. HACC funded agencies report against the HACC Minimum Data Set which does not record continence service utilisation details. HACC Continence Nurse Advisors are ‘block funded’ under the activity Service System Resourcing (SSR). This activity funds the education role. All SSR funded programs are required to provide an annual written report on activities and services provided, however, limited data is recorded/reported.

Most of the Continence Nurse Advisors reported they had difficulty providing the data requested by the continence survey. This is a concern and shows that work needs to be carried out to develop and implement an accurate data reporting system for continence services.

7.2 Future demand
There is a general belief among Gippsland continence service providers that there is significant unmet need in the community but there is no data currently available to support this belief. It is anticipated the population of Gippsland will increase by 6.4% by 2016. This will mean much greater increases in the aged cohorts of people over 60 years of age - which may be 30% or more according to the DSE population projections. (See Table 1). There is also likely to be a notable increase in the number of people in the over 85 years of age population. This will mean a substantial increase in the number of people in the community with dementia and disabilities, which can be expected to have a significant impact on the demand for continence services.
8 Issues

8.1 Equitable access for Gippsland residents

8.1.1 Service system structure and access

There are six providers responsible for the delivery of continence services in Gippsland, one in each LGA. This appears to be a reasonable structure from a local area based perspective, however the location of Gippsland regional SACS Continence in Drouin appears to be an issue in regard to equitable access for consumers residing outside Baw Baw shire.

New models of service must be developed from an across program perspective to establish a structure that will support improved access for consumers in all Gippsland communities.

Further analysis to define the use of Community Health resources for continence service provision is needed. The HACC program resource should be increased over time on an equitable basis. Figure 4 on page 13 outlines the current HACC continence funding. The highest initial priorities for growth funding are Wellington and East Gippsland LGAs due to the current funding levels and geographic barriers to residents from these LGAs accessing services through the SACS Clinic. For the same reasons, South Gippsland and Bass Coast LGAs are considered to be at the next level of priority. Baw Baw should be prioritised for HACC funding when there is established provision of a SACS outreach service to the outlying LGAs of the region. As the highest resourced LGA, funding for Latrobe LGA should be increased over time on an equitable basis.

At the present time, there appears to be limited involvement of managers in the development and coordination of continence service across the region. Some differences appear to exist in governance, staffing mix, service access and service standards for clients across the region.

There appears to be an insufficient number of continence specialists practitioners such as Continence Nurse Advisors and allied health professionals, to provide the services required. Continence Nurse Advisors appear to deliver a majority of direct service provision and therefore have limited opportunities to increase interaction and education of other professionals and the community. The role of nurses and other health practitioners needs to be clarified and increased in relation to continence service provision.

<table>
<thead>
<tr>
<th>Continence service</th>
<th>Good practice/policy direction</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service System &amp; Access:</td>
<td>▪ Gippsland residents will have equitable access to information, aides and professional incontinence management advice regardless of where they live.</td>
</tr>
<tr>
<td>▪ barriers to accessing continence services</td>
<td>▪ need to establish models of service that ensure adequate service provision coverage across the region</td>
</tr>
<tr>
<td>▪ specialist service coverage is limited especially for outlying areas</td>
<td>▪ improve equitable distribution of resources across LGAs over time.</td>
</tr>
<tr>
<td>▪ insufficient resources &amp; isolation</td>
<td>▪ A multidisciplinary or team approach can provide improved service outcomes but role clarification is essential</td>
</tr>
</tbody>
</table>
8.1.2 Unmet need

The general anecdotal consensus (unable to be authenticated by current data) is that there is significant unmet need in the community. The current service delivery model would be overstretched if endeavouring to accommodate any further influx of numbers such as could be caused by any increase in promotion or marketing of the continence service. Conversely, this promotion is exactly what is required to ensure appropriate and equitable service provision to clients.

Continence issues are a social taboo area. As a consequence, it is a hidden part of everyday life for many people who may see it as a normal process of ageing and never seek services.

<table>
<thead>
<tr>
<th>Continence service</th>
<th>Good practice/policy direction</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unmet need:</td>
<td>• establish a measurement of the ‘unmet need’ for service planning</td>
</tr>
<tr>
<td></td>
<td>• improved data collection and reporting</td>
</tr>
<tr>
<td></td>
<td>• address system structure: models and resourcing before major promotions work is undertaken</td>
</tr>
<tr>
<td></td>
<td>• incontinence prevention approaches included in health promotion strategies</td>
</tr>
</tbody>
</table>

8.1.3 Referrals

Referrals are received from a variety of sources. People are able to self refer - and referrals also come from general practitioners, specialists, acute health facilities, community health services, friends and family. Referrals are not always appropriate, resulting in loss of consultancy time. The Continence Foundation of Australia (CFA) is currently undertaking a project to improve the quality of self referrals. Gippsland health service providers should work in conjunction with the CFA to improve the level of community knowledge of incontinence and to improve the quality of self referrals. Continence providers should work with the sector to clarify referral pathways and improve the quality of referrals.

Many clients actually require a case management service rather than specific continence services. General practitioners are cited in DHS literature as a source of case management services, but this is often not the case. Work is required with the Divisions of General Practice and the health sector to identify suitable case managers where appropriate.

<table>
<thead>
<tr>
<th>Continence service</th>
<th>Good practice/policy direction</th>
</tr>
</thead>
<tbody>
<tr>
<td>Referrals:</td>
<td>• establish a single point of access in line with the HIP Guidelines and HACC Assessment Framework</td>
</tr>
<tr>
<td></td>
<td>• establish formal referral criteria, and baseline assessments prior to referral</td>
</tr>
<tr>
<td></td>
<td>• provision of appropriate information to community for individuals to self refer</td>
</tr>
<tr>
<td></td>
<td>• work with the Divisions of General Practice and the health sector to identify suitable case managers</td>
</tr>
</tbody>
</table>
8.1.4 Acute interface

Acute hospitals settings appear to have limited knowledge of continence related issues and a limited understand of the role and services provided by Continence Nurse Advisors. Continence Nurse Advisors need to work more closely with acute staff to establish or strengthen this important relationship and to improve referral processes.

<table>
<thead>
<tr>
<th>Continence service</th>
<th>Good practice/policy direction</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute interface:</td>
<td>■ regular meetings between acute services and continence services to provide information exchange, education and improve discharge planning and linkages with SACS programs such as HARP &amp; CRC</td>
</tr>
<tr>
<td>■ poor knowledge of continence issues and continence services</td>
<td>■ acute environment has little understanding of how clients function in the community after discharge</td>
</tr>
</tbody>
</table>

8.2 Workforce

Availability of an appropriate workforce is one of the main factors that determines whether individuals gain access to the appropriate type of service and within an appropriate time frame. Continence services need to be supported by a team of appropriately qualified and trained staff that may include nurses, physiotherapists, urologists, general practitioners and administrative support. A valuable addition to the team would be a geriatrician - to appropriately case manage older clients - however there is a shortage of available geriatricians to fill this need.

Specialist urodynamics work needs to continue to be available. Currently this service is only available through the Sub-Acute Specialist Clinic located in Drouin. There is an overlay of the responsibilities of urology and continence services in rural health settings. There are no dedicated urology units in rural hospitals and therefore no urology nurses, which means the role of the Continence Nurse Advisor increases to cover the shortfall.

Opportunity exists to utilise the skills of Continence Nurse Advisors (an expert resource) to train other professionals such as district nurses to provide initial continence assessments and some ongoing care in line with the care plan documented by the CNA. There is some resistance to this concept because experience suggests it is a time consuming and an ongoing process which limits the capacity of the Continence Nurse Advisor to provide direct client care.

There is a need to increase the EFT of Continence Nurse Advisors to cater for the current service demand, as well as provide the education and support to other professionals such as district nurses. This will mean that nurses can carry out continence assessments and provide some support to community based patients which will increase the availability of Continence Nurse Advisors to undertake other duties.

Some providers have had difficulties recruiting additional Continence Nurse Advisors. There is a need to be creative - to consider other workforce strategies and provide additional support such as scholarships, for upskilling existing or new nursing staff to undertake this role.
<table>
<thead>
<tr>
<th>Continence service</th>
<th>Good practice/policy direction</th>
</tr>
</thead>
</table>
| **Recruitment/retention:**  
  ■ profile of continence advisor is seen to be somewhat negative and a major barrier to attracting staff  
  ■ Division 1 nurses receive far fewer hours on continence issues during training than Division 2 nurses  
  ■ workload is a major retention issue  |  ■ utilise innovative approaches to attract and upskill staff, clarify and promote role of nurse advisors as an educator and specialist  
  ■ advocate for training bodies to rectify this situation  
  ■ provide continence training to nurses across the region  
  ■ develop ways to distribute workload appropriately to maximise CNA expertise (eg: increased role for general nurses) |
| **Qualifications/ongoing training:**  
  ■ qualifications vary from 3 day Mayfield course to masters degree  
  ■ no formal agreed qualification requirement for Continence Advisor  
  ■ ongoing education and training is largely dependent on the individual practitioner to seek own peer support  |  ■ Explore considerations regarding acceptable qualifications with relevant bodies such as the Nurses Board of Victoria (work has already begun through ANF - professional issues committee)  
  ■ improve recognition and retention of continence practitioners through provision of appropriate training, educational and support opportunities |
| **Administrative support:**  
  ■ little or no administrative support is available for Continence Nurse Advisors  
  ■ improved use of continence expert resources (CNA's) to provide continence service  |  ■ some work components could be undertaken by admin staff to maximise CNA expertise (data collection, administration, initial phone enquiries)  
  ■ work with management of continence services to provide a level of administrative support |
| **Expert resource:**  
  ■ CNA's at the moment largely “do it all” in terms of continence service provision which is not sustainable given current work loads  
  ■ training for district nurses, acute, residential care staff and other practitioners  
  ■ reluctance of some Continence Nurse Advisors to reduce client contact  |  ■ engage CNA’s, general nurses and other practitioners in a process of clarifying the various roles and responsibilities of each and document in local protocols  
  ■ provide training to District Nursing services and residential care staff that ensures appropriate use of staff trained in initial continence assessment and appropriate practice in line with the care plan  
  ■ regular client contact helps to maintain skill levels and ensure current best practice |
| **Sick leave/recreational leave:**  
  ■ HACC funded services currently do not backfill for sick leave or recreational leave thereby adding additional pressure on CNA’s in terms of workload and waiting periods for clients  |  ■ continence services management to consider the issue and means of providing backfill for CNA’s. |
8.3 Responding to high needs groups

High needs groups such as Gippsland residents who are culturally and linguistically diverse (CALD), or Aboriginal and Torres Strait Islanders (ATSI), or people in residential care, are frequently unable to or struggle to access continence services. The limited workforce available to service the general population accentuates the difficulties of accessing services for high needs groups such as those who reside in more remote areas. Training of Koori health workers in continence service provision should be considered, to ensure the local indigenous population considers the service to be culturally sensitive.

The Bairnsdale Regional Health Service is working with GEGAC (Gippsland and East Gippsland Aboriginal Cooperative) to improve access to continence services. Cultural issues are seen as a barrier for Aboriginal clients to access the service, which needs to be provided in combination with GEGAC staff and in an appropriate setting. A close relationship should be established between the HACC Aboriginal Liaison Officer and the CNA’s.

Gippsland Migrant Resource Service in Morwell indicates that access to continence services can be problematic for many of their clients due to cultural and language issues. There is a general reluctance to speak about such an intimate subject and this is further complicated by the need for a third party to interpret such messages. Usually the subject is totally avoided by clients to save embarrassment. Work needs to be undertaken to improve the quality and availability of interpreting services and to educate the community about continence services.

Workload constraints also impinge on the capacity of Continence Nurse Advisors to provide a service to residential care facilities, even though it is acknowledged that this is one of the areas of greatest need. Incontinence is a substantial issue for both aged and disabled residents. In addition, it appears there may be funding constraints around service provision to private residential care facilities who are required to pay for external services to their residents. Education of workers in residential care facilities is one way to address this issue.

<table>
<thead>
<tr>
<th>Continence service</th>
<th>Good practice/policy direction</th>
</tr>
</thead>
<tbody>
<tr>
<td>High need groups:</td>
<td></td>
</tr>
<tr>
<td>- Aboriginal &amp; Torres Strait Islanders</td>
<td>consideration of cultural issues is essential when providing continence services to both aboriginal and CALD communities. All CNA’s should undertake cultural respect or awareness training</td>
</tr>
<tr>
<td>- CALD communities</td>
<td>consideration should be given to training staff in CALD and ATSI communities</td>
</tr>
<tr>
<td>- residential care (aged and disabled)</td>
<td>residential care funding should be clarified prior to continence service provision. Continence should form part of the resident’s management plan</td>
</tr>
<tr>
<td>- remote communities</td>
<td>consideration should be given to continence training for staff in residential care facilities and nurses in remote communities</td>
</tr>
</tbody>
</table>
### 8.4 Funded continence products

There is a need to improve and increase the ‘Continence Aids Assistance Scheme’ (CAAS). The program guidelines and cost appears to restrict access for some consumers. The provision of continence products is very expensive and further complicated by the requirement to see a Continence Nurse Advisor to be eligible under the scheme. Often a client will have a considerable waiting period before they can see an Advisor and consequently have to endure considerable expense in the mean time. This can be a problem for more disadvantaged parts of the population such people on aged or disabled pensions. When people live in more remote areas, the problem of actually accessing any aids or equipment can be considerable.

<table>
<thead>
<tr>
<th>Continence service</th>
<th>Good practice/policy direction</th>
</tr>
</thead>
<tbody>
<tr>
<td>funded continence products:</td>
<td>aids and equipment should be available to all Gippsland residents on an equitable basis</td>
</tr>
<tr>
<td>- multiple funding schemes and eligibility guidelines present some barriers to access</td>
<td>further research is required to quantify and analyse the extent of these barriers</td>
</tr>
<tr>
<td>- multiple funding schemes are time consuming, costly and confusing for clients and care providers alike</td>
<td>work with CAAS to explore possibilities of improving eligibility process, to streamline and expedite access and overcome barriers associated with CAAS scheme including costs associated with delays</td>
</tr>
<tr>
<td>- accessing aids &amp; equipment can be costly</td>
<td>consider options such as video conferencing for remote areas</td>
</tr>
</tbody>
</table>

### 8.5 Data collection

#### 8.5.1 Service utilisation

There is no consistent method for data collection of service utilisation across Gippsland continence services. This is a consequence of both the various funding sources and the isolation and diversity of the service providers. Services that are HACC funded, report against the HACC Minimum Data Set (MDS), but this has no separate reporting for continence services. Given that HACC funded services sometimes see people who are not within the HACC criteria, the problem becomes even more complicated.

There are different approaches regarding the reporting requirements for HACC. Some services demand that their Continence Nurse Advisors spend 6.5 hours per day in face to face contact and report these hours on MDS – others do not. All HACC providers submit an annual report as is required by block funding business rules.

The SACS service reports on the SACS data base using VINAH criteria. Unfortunately VINAH records episodes of service while HACC records hours of service, thereby making meaningful analysis of regional continence data very difficult or impossible to achieve. In addition, Disability Services Division provides funding to some services, but there is limited reporting of service utilisation data. Community health centre service provision is generally not specified at agency level and therefore is not reported at this level of detail to DHS.

There is no appropriate waiting list data and consequently it is not possible to accurately determine how many people are waiting to be provided with a service, let alone how many people would fall into the ‘unmet need’ category.
## Continence service

### Service utilisation:
- No consistent reporting of continence service data across SACS, HACC, Disability & community health programs
- HACC MDS does not specify continence services
- Different approaches to HACC continence service contact hours per day
- Some clients are not eligible under the HACC criteria and the data is not collected

### Good practice/policy direction
- Develop and implement a mechanism for consistent and accurate reporting in conjunction with the continence service providers; the funded programs and the regional office
- Continence service data needs to be collected through HealthSmart and HACC MDS
- Clarify HACC service contact hours requirements
- Service providers to identify a suitable funding source for these consumers, such as community health, etc

### Assessment tools:
- Limited intake structure and varying admission criteria across the region
- No common assessment tool is used. Some Continence Nurse Advisors are keen to maintain their own assessment methods rather than using a common approach
- No accurate picture regarding discharge numbers as some services never discharge their clients. No throughput figures

### Good practice/policy direction
- That all continence service providers with a direct intake model review their structure and consider further development and a standardise admission criteria across the region
- The ICOP, LSOP & HIP initiatives include the development of consistent assessment tools and approaches to service coordination, the region will adopt these tools and approaches as they become available or known – see further details on page 10
- Develop a standard discharge process for continence services across the region

### 8.5.2 Assessment tools

There is no standard intake structure for entry into a continence service. Each service has developed its own model, which is often predicated on the standard intake model for their general service. Overall the structure is limited with intake consisting of direct contact from the consumer to the CNA, thereby taking up valuable time with inappropriate referrals and basic information gathering that could be undertaken by other staff. Some services use the Service Coordination Tool Templates as part of their admission process. Some are fortunate to have an intake worker. There is no standard assessment tool once the client is part of the service and no standard discharge model or summary.
8.6 Continence health promotion

Much work has been undertaken to increase public awareness of the issue of continence and to increase community understanding. At the forefront is the National Continence Management Strategy which funds a variety of projects to increase community understanding of incontinence, reduce the taboo associated with the condition, and improve reporting and treatment of bowel and bladder problems.

Many continence issues are almost totally preventable hence there is a substantial need to focus on population health and prevention strategies. There is well-documented evidence tying continence to obesity, Type 2 diabetes and the prevalence of falls. Nevertheless, there is still significant stigma relating to any incontinence condition and in many ways this issue seems to be one of the last bastions of denial for both sufferers and the general population. This impacts negatively not only on the sufferers, but also on the possibility of encouraging health professionals to work in this area.

Gippsland continence service providers have indicated considerable interest in being involved in the provision of health promotion to the community but consider themselves severely restricted by the lack of resources - both in time and funding.

<table>
<thead>
<tr>
<th>Continence service</th>
<th>Good practice/policy direction</th>
</tr>
</thead>
<tbody>
<tr>
<td>Continence health promotion:</td>
<td>• work with the continence foundation of Australia to provide community education regarding continence issues and services available, to increase awareness and reduce stigma</td>
</tr>
<tr>
<td>• lack of awareness in the general community and health workforce of continence issues and the services available</td>
<td></td>
</tr>
<tr>
<td>• stigma associated with incontinence conditions</td>
<td>• advocate for appropriate incontinence prevention approaches to be included in the health promotion strategies across Gippsland</td>
</tr>
</tbody>
</table>


9 Future Development of Continence Services in Gippsland

The Gippsland Continence Project “Strategic Directions for Continence Services in Gippsland” has identified recommendations for improvement to the regional service system and in turn, to the health and wellbeing of Gippsland residents.

The following recommendations are in order of priority however, it is not essential to implement them in this sequence. Each recommendation is given a timeframe priority rating based on the following designation:

- **short term up to 6 months**
- **medium term 6 to 18 months**
- **long term 18 to 36 months**

Recommendations in this report have been developed using the following key assumptions and are based on known policy and funding guidelines:

- there is no guarantee of new funding
- primary sources of funding will continue to exist
- there is no current planning ratio for the provision of continence services
- the requirements of the ATSI and CALD populations in Victoria will be taken into consideration and addressed appropriately

9.1 Recommendations

9.1.1 Develop a “consortium” approach for continence in Gippsland - short term

- that DHS Gippsland adopt a “consortium” or partnership approach to the development of new directions for Continence Services within the region
- DHS Gippsland will establish a consortium of service providers from across the region to develop a regional continence implementation plan
- providers of continence services and DHS Gippsland agree to enter a decision-making process in accordance with planning principles (described in Section 10) to resolve the issues currently surrounding continence service provision
- this plan will adopt a holistic approach and achieve best practice models of service delivery, education and advice within the region
- new developments to include a review of existing protocols and procedures in relation to, but need not be restricted to: intake, service coordination, service provision and discharge planning

Discussion:

DHS Gippsland should establish a consortium approach to the management of continence services in the region. The consortium ought to consist of senior management and clinical staff, including Continence Nurse Advisors from each agency involved in continence service delivery. The consortium will guide the strategic planning for continence services in Gippsland.

The presence of all relevant players will be a key to success with such a model, including participation of DHS representatives from the various funding and policy areas.

A strength of this approach is that all relevant agencies will be able to contribute to strategic planning. The Consortium model lends itself to collaboration and enables a regional approach to activities such as clinical practice, standards, credentialing and professional development. Under such an approach, knowledge and expertise can be shared and best practice promoted.

It is proposed that the consortium comprises:

- representatives of continence service providers from all 6 LGAs
- a representative of each profession undertaking continence related service provision
- senior management representatives from agencies providing continence services
- representatives of outlying services including bush nursing centres
- DHS regional representation from HACC, Acute, Primary Health and Disability programs

It is further suggested that the consortium be chaired by a chief executive officer or director with experience in continence provision and policy development, who currently manages an agency which provides or receives continence services.
The amount of time, travel and work associated with participation in such a consortium should not be underestimated. Therefore consideration should be given to becoming an adjunct to an existing consortium or another suitable group if one exists. One such option may be the Gippsland Palliative Care Consortia, however there may be others. This could prove to be more efficient and effective for a number of areas including continence, dental, renal etc.

9.1.2 Models of service delivery & equitable access - short to medium term

New models of service delivery to be implemented, to ensure equitable access to best practice continence services across the region, for ATSI and CALD Communities – and to those people living in rurally isolated or outlying areas:

- that a priority be given to establishing multidisciplinary continence teams where possible and that protocols be developed which clarify roles of the various professionals involved including Continence Nurse Advisors, district nurses, allied health staff, general practitioners - and other medical specialists
- that the role of the Continence Nurse Advisor be promoted, in order to utilise expertise more as mentors and educators for other professionals and the community
- to document in local protocols how linkages between continence services and other health care providers can be strengthened and supported
- that innovative outreach and video-conferencing models be adopted to overcome geographic barriers within the region

Discussion:

A service delivery model is a framework to provide services. The aim of the framework is to deliver client centred services consistently, efficiently and in accordance with best practice principles.

In redeveloping the model/s of service delivery, the consortium should consider: the existing structures, processes, geographic barriers; linkages with other providers; availability of professional expertise; continence specialty equipment and; technology such as video conferencing. Consideration also needs to be given to state-wide or national developments, with a view to incorporating these into local approaches.

When reviewing and redeveloping the model of continence service delivery across Gippsland, special consideration should be given to access for those who are from ATSI and CALD backgrounds or who reside in remote areas. Particular emphasis should be given to involvement of Aboriginal Liaison Officers, interpreters and to the use of video conferencing.

As has been documented in section 6.1.2.2, many Gippsland residents’ live substantial distances from specialist continence services. Some have to travel hundreds of kilometres and this is problematic for individuals with severe continence conditions. The provision of more outreach clinics is one option to address this issue, although workforce issues will have an impact on how readily this can be achieved.

The issues of equity of resourcing – and ease of access to continence services, overlays any proposed continence service development. An essential task for Gippsland continence service providers to undertake, will be a detailed examination of whether the level of agency funding currently directed to providing continence services is commensurate with the number of clients/client hours being provided.

DHS programs that fund continence services will need to undertake a similar task - and examine whether the present level of funding in each program stream is commensurate with the numbers of clients eligible for/accessing continence services in their respective programs - and for current and forecast future service demand. Anecdotal information suggests that clients who meet eligibility criteria for one particular program stream may be accessing a continence service funded by a different funding stream - because the level of program funding is not commensurate with the demand from clients who meet eligibility criteria. By way of example, eligibility to services for those in residential aged care facilities is complex and the funding stream must be determined on a case by case basis by intake practitioners.

DHS will also need to examine whether clients who would otherwise meet eligibility criteria for and access a SACS funded service, are accessing a HACC funded service because of geographic or other impediments. Given that some agencies resource continence services from an aggregated internal pool of funds, DHS may need to take a lead role in assisting funded agencies to determine the allocation of appropriate levels of funding to continence services.
As indicated in section 6.1.2 funding for continence services across Gippsland is currently inequitable, with the vast majority of funding going to Baw Baw Shire (for a regional sub-acute service) and the least to Wellington Shire. To some extent, this inequity is a result of the different funding streams under which the services are funded. Consumers of continence services should not be disadvantaged by eligibility to the various streams. Ideally, equity should be established across all funding streams over time.

The dedication, expertise and enthusiasm of the Continence Nurse Advisors is central to the existing model and undoubtedly will continue to be in future models. However, given current and future demand the existing model based around the Continence Nurse Advisor being all things to most consumers, does not appear to be sustainable.

Continence Nurse Advisors already undertake an important role in the provision of mentoring and education services to other health care professionals, particularly nursing staff. The CNA role as expert advisor, mentors and educator is clearly an area for further expansion. However there is a need to clearly define the roles of general nurses, CNAs, allied health and other professionals when redeveloping the model of continence service delivery.

Furthermore, this does not mean that the CNAs will be responsible for all education of other professionals. Nursing and allied health services should take advantage of the various formal courses and training opportunities currently available.

9.1.3 Recruitment & retention - medium to long term

That service providers work together to improve the recruitment and retention of the multidisciplinary professionals required for the provision of best practice continence services:

- that the use of scholarships or other methods be used to enhance the potential of recruitment and training of staff
- that the role of the various continence practitioners be actively promoted across the sector

Discussion:

Workforce recruitment and retention is a widespread issue in Australia today and requires an innovative and determined approach to achieve success. The benefits of a multi-disciplinary team approach to continence service delivery are obvious to most professionals however, the possible solutions to achieve such a team are not so apparent.

Health providers should consider utilising scholarships, traineeships, flexible employment and a range of other inducements to overcome the recruitment and retention difficulties prevalent today. Whilst it is often difficult for organisations to recruit staff when and where and when required, a strategic, planned and flexible approach can bear results over time.

Positively promoting the role of continence practitioners throughout the sector in order to improve the current image of the work should be a high priority.

9.1.4 Systematic intake, assessment & referral processes - medium to long term

That continence service providers implement systematic intake, assessment and referral processes in line with DHS guidelines such as Health Independence Programs and HACC, ensuring the collection and reporting of appropriate continence service provision data which can be utilised to inform future planning:

- that data collection and management across all continence services is improved and standardised
- that new assessment tools and procedures be adopted and implemented as they become available

Discussion:

Some continence services are small and have relatively unsophisticated intake, referral and data collection systems. It is therefore necessary to review and update these systems in line with DHS guidelines such as Health Independence Programs, service coordination and data collection.

A review of intake processes should also seek to increase the role of Continence Nurse Advisors in relation to what might be considered core continence business – and where appropriate, rely upon other staff to undertake administrative intake duties.
Lack of administration support is reported as a general problem for continence services. Most CNAs work part time and find that up to half their day can be taken up with activities that could be effectively delegated to administrative staff. There is currently no dedicated, skilled, administrative support to help with appointments, placing product orders, entering statistical data or maintaining resources. Administrative support workers may need relatively high levels of skill, including the capacity to problem solve, ability to deal with clients, capacity to undertake medical audio typing and to undertake general reception tasks.

As indicated, continence providers currently collect a variety of data, however the methodology is inconsistent and it was not possible to undertake comparative data analysis on a regional basis. Consequently, the project steering committee was unable to set any benchmarks for the level of service provision at this time. However the providers recognise that this is important and expressed a willingness to address this issue in the future.

9.1.5 Health promotion - medium to long term

That the region advocate for appropriate incontinence prevention approaches to be included in the health promotion strategies across Gippsland:

- further research is required to identify the most effective interventions for the prevention of incontinence, and as these become available they should be included in the health promotion strategies across the region

Discussion:

There appears to be very little health promotion activity other than that provided by Continence Foundation of Australia - and special events such as Continence Awareness Week. Health promotion programs in Gippsland should work with the Continence Foundation of Australia to maximise the benefits of existing approaches and seek to develop new strategies.

All existing and new health promotion strategies should be tailored for the ATSI and CALD communities and be modified where necessary, for example, involving Aboriginal Liaison Officers - and translating literature into different languages.

There appears to be potential service delivery and health promotion synergies between continence and chronic diseases such as Type 2 diabetes and obesity. It seems that some preventative approaches may have health benefits across a range of conditions.

Considerable work is required to increase awareness of and reduce the stigma surrounding incontinence, both across the health sector and across the general community.

Further research is required to identify the most effective interventions for the prevention of incontinence. As any such developments become available, they should be included in the health promotion strategies across Gippsland.
10 Planning principles

This Section addresses the overarching principles that should guide the service configuration for continence services in Gippsland region. It will be considered firstly under the state-wide principles and secondly under the agreed Gippsland principles.

10.1 State-wide service planning principles

- planning will be based on the catchments described in Care in your Community with the view of achieving a level of self-sufficiency for continence services within each catchment
- there is no current planning ratio for the delivery of continence services
- services will be planned to enable cost efficiencies and facilitate recruitment of specialized staff
- resources will be directed to ensure the provision of services to areas of greatest population whilst ensuring that services are also equitably available to more isolated and remote areas
- planning will identify services that can be safely and effectively delivered in a community setting and any which should be delivered in more structured hospital settings
- services, where appropriate, will be provided close to where people live and access regularly
- planning will deliver collaborative outcomes based on partnerships

10.2 Gippsland service planning principles

The following principles are proposed to guide the development of a service system for continence service delivery in the Gippsland region. These statements are not listed in order of priority:

- no diminution in overall service levels: while service configurations and service types may change, it is not intended to reduce the overall quality, capacity or resources of continence services in the Gippsland region
- best models of care: options should be based on best models of care to achieve the goals of provision of continence services-specialist assessment, care, treatment and prevention in the appropriate service setting for the individual consumer
- best access: consumers should have prompt access to appropriate services as close as practicable to their usual place of residence.
- no service faces sustainability risks: a new service model should improve the sustainability of individual services and the system as a whole
- planning will develop partnerships and service configurations that improve workforce capacity in all catchments
- equity of resource per capita, equity of service provision and equity of skill provision will be considered by the consortium
## Appendix 1 - Membership of Gippsland Continence Project Steering Committee

<table>
<thead>
<tr>
<th>Name</th>
<th>Position/Organisation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Margaret Wilson</td>
<td>Continence Advisor, Bairnsdale Regional Health Service</td>
</tr>
<tr>
<td>Julie Parker</td>
<td>Continence Advisor, Latrobe Community Health Service</td>
</tr>
<tr>
<td>Mary Hartwig</td>
<td>Nurse Manager, Central Gippsland Health Service</td>
</tr>
<tr>
<td>Maree Scanlon</td>
<td>Continence Advisor, Latrobe Community Health Service</td>
</tr>
<tr>
<td>Fiona McLennan</td>
<td>Continence Advisor, West Gippsland Healthcare Group</td>
</tr>
<tr>
<td>Kaye Brews-Bundle</td>
<td>Continence Advisor, West Gippsland Healthcare Group</td>
</tr>
<tr>
<td>Bronwyn Hughes</td>
<td>Continence Advisor, Bass Coast Regional Health</td>
</tr>
<tr>
<td>Dianne Jones</td>
<td>Continence Advisor, Bass Coast Regional Health</td>
</tr>
<tr>
<td>Lesley Murray</td>
<td>HACC Manager, Orbost Regional Health</td>
</tr>
<tr>
<td>Liz Brown</td>
<td>Manager Community Health, Bairnsdale Regional Health Service</td>
</tr>
<tr>
<td>Will Hanrahan (Chair)</td>
<td>Aged Care, DHS Gippsland Region</td>
</tr>
<tr>
<td>Saskia Turra</td>
<td>Aged Care, DHS Gippsland Region</td>
</tr>
<tr>
<td>Katherine Breen</td>
<td>Disability Services, DHS Gippsland</td>
</tr>
<tr>
<td>Christina Rush</td>
<td>Acute Health, DHS Gippsland Region</td>
</tr>
</tbody>
</table>
### Appendix 2 - Consultations & Workshop Attendees

<table>
<thead>
<tr>
<th>Name</th>
<th>Position/Organisation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lisa Sinha</td>
<td>Director, Gippsland Migrant Resource Centre</td>
</tr>
<tr>
<td>Nikki Lowe</td>
<td>Manager HACC, Gippsland Migrant Resource Centre</td>
</tr>
<tr>
<td>Claire Kent</td>
<td>LRH</td>
</tr>
<tr>
<td>Kay Brews-Bundle</td>
<td>Continence Advisor, West Gippsland Healthcare Group</td>
</tr>
<tr>
<td>Fiona McLennan</td>
<td>Continence Manager, West Gippsland Healthcare Group</td>
</tr>
<tr>
<td>Clare Fyfield</td>
<td>Continence Advisor, Latrobe Community Health Service</td>
</tr>
<tr>
<td>Julie Parker</td>
<td>Continence Advisor, Latrobe Community Health Service</td>
</tr>
<tr>
<td>Maree Scanlon</td>
<td>Continence Advisor, Latrobe Community Health Service</td>
</tr>
<tr>
<td>Dianne Jones</td>
<td>Continence Advisor, Gippsland Southern Health Service</td>
</tr>
<tr>
<td>Margaret Wilson</td>
<td>Continence Advisor, Bairnsdale Regional Health Service</td>
</tr>
<tr>
<td>Susan Denny</td>
<td>Central West Gippsland Division of General Practitioners</td>
</tr>
<tr>
<td>Bronwyn Hughes</td>
<td>Continence Advisor, Bass Coast Regional Health (telephone)</td>
</tr>
<tr>
<td>Terese Tierney</td>
<td>CEO, Orbost Regional Health (videoconference)</td>
</tr>
<tr>
<td>Leslie Maurray</td>
<td>Continence Advisor, Orbost Regional Health (videoconference)</td>
</tr>
<tr>
<td>Anne Brewer</td>
<td>Bush Nurse Manager, Buchan Bush Nursing Centre (telephone)</td>
</tr>
<tr>
<td>Robyn Redenbach</td>
<td>Practice Nurse, Gippsland &amp; East Gippsland Aboriginal Cooperative</td>
</tr>
<tr>
<td>Michele</td>
<td>LRH</td>
</tr>
<tr>
<td></td>
<td>LRH</td>
</tr>
<tr>
<td>Geraldine Atkins</td>
<td>CACP Manager, Gippsland &amp; East Gippsland Aboriginal Cooperative</td>
</tr>
<tr>
<td>Sandra Kelly</td>
<td>Aboriginal HACC, Regional Development Officer, DHS Gippsland (telephone)</td>
</tr>
<tr>
<td>Ann Fitts</td>
<td>Gippsland Region, DHS</td>
</tr>
<tr>
<td>Jacqui Hickey</td>
<td>Gippsland Region, DHS</td>
</tr>
<tr>
<td>Christine Rush</td>
<td>Gippsland Region, DHS</td>
</tr>
<tr>
<td>Jennifer Doultree</td>
<td>Gippsland Region, DHS</td>
</tr>
<tr>
<td>Will Hanrahan</td>
<td>Gippsland Region, DHS</td>
</tr>
<tr>
<td>Saskia Turra</td>
<td>Gippsland Region, DHS</td>
</tr>
<tr>
<td>Laurice Ryan</td>
<td>Gippsland Region, DHS</td>
</tr>
<tr>
<td>Greg Blakeley</td>
<td>Gippsland Region, DHS</td>
</tr>
<tr>
<td>Katherine Breen</td>
<td>Gippsland Region, DHS</td>
</tr>
</tbody>
</table>
# Appendix 3 - Glossary of Terms and Acronyms

<table>
<thead>
<tr>
<th>Term</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>ATSI</td>
<td>Aboriginal &amp; Torres Strait Islanders</td>
</tr>
<tr>
<td>CAAS</td>
<td>Continence Aids Assistance Scheme</td>
</tr>
<tr>
<td>CALD</td>
<td>Culturally &amp; Linguistically Diverse</td>
</tr>
<tr>
<td>COAG</td>
<td>Council of Australian Governments</td>
</tr>
<tr>
<td>DHS</td>
<td>Department of Human Services</td>
</tr>
<tr>
<td>DSE</td>
<td>Department of Sustainability &amp; Environment</td>
</tr>
<tr>
<td>EFT</td>
<td>Effective Full Time</td>
</tr>
<tr>
<td>GEGAC</td>
<td>Gippsland &amp; East Gippsland Aboriginal Cooperative</td>
</tr>
<tr>
<td>HACC</td>
<td>Home and Community Care</td>
</tr>
<tr>
<td>LGA</td>
<td>Local Government Area</td>
</tr>
<tr>
<td>LSOP</td>
<td>Long Stay Older Persons</td>
</tr>
<tr>
<td>MDS</td>
<td>Minimum Data Set</td>
</tr>
<tr>
<td>MoC</td>
<td>Model of Care</td>
</tr>
<tr>
<td>NCMS</td>
<td>National Continence Management Strategy</td>
</tr>
<tr>
<td>PAC</td>
<td>Post Acute Care</td>
</tr>
<tr>
<td>PCF</td>
<td>Per Capita Funding</td>
</tr>
<tr>
<td>PCP</td>
<td>Primary Care Partnership</td>
</tr>
<tr>
<td>PCW</td>
<td>Personal Care Worker</td>
</tr>
<tr>
<td>RREF</td>
<td>Regional Resource Equity Formula</td>
</tr>
<tr>
<td>SACS</td>
<td>Sub-Acute Care Services</td>
</tr>
<tr>
<td>SSR</td>
<td>Service System Resourcing</td>
</tr>
</tbody>
</table>
Appendix 4 - Policy frameworks

Care in your community: a planning framework for integrated ambulatory health care, DHS, January 2005
Rural directions for a better state of health, DHS, 2007
Continence Clinics: Program Guidelines and Performance Indicators, DHS, 2000
Gippsland Sub-Acute Services Plan, DHS, Gippsland Region, 2006
Gippsland Regional Action Plan 2007-08, DHS, Gippsland Region, 2007
HACC Program - Gippsland Region Triennial Plan 2006-09, DHS, Gippsland Region, 2006
National Continence Management Strategy, DHA
Victoria in future, DSE, 2004,
Burden of Disease & Injury in Australia, 2003
Women’s Health Australia, 1999
Measuring Incontinence in Australia - A National Continence Strategy Project, University of Melbourne, 2006,
HACC Program Manual, DHS, 2003
Long Stay Older Patients Initiative, COAG, 2006
Improving Care for Older People, DHS, 2006
Hospital Admission Risk Program - Chronic Disease Management
Appendix 5 - Gippsland Region Continence Services
Local Service Mapping Tool: Part 1

The purpose of this tool is to assist the project team to identify the range and nature of continence services provided within the Gippsland Region. This will aid the consultants and Gippsland DHS to gain an understanding of local continence services. We are asking each provider of continence services to complete the tool. This will be of invaluable assistance in the production of the Gippsland Continence Services Plan that will follow.

You may already have much of the information at your fingertips, but in some cases we will be asking for your best “guesstimate”. (Part of this project is to identify what is and isn’t counted at this point in time.)

Thank you for your contribution.

<table>
<thead>
<tr>
<th>Agency Name</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of Person*</td>
<td></td>
</tr>
<tr>
<td>Role of Person*</td>
<td></td>
</tr>
<tr>
<td>Address</td>
<td></td>
</tr>
<tr>
<td>Telephone Number</td>
<td></td>
</tr>
<tr>
<td>Email Address</td>
<td></td>
</tr>
<tr>
<td>Auspice agency (if relevant)</td>
<td></td>
</tr>
<tr>
<td>Area serviced</td>
<td></td>
</tr>
<tr>
<td>Catchment &amp; LGA</td>
<td></td>
</tr>
</tbody>
</table>

*Person = person completing mapping tool

Who undertakes the initial screening of referrals and determines suitability to the continence service?

What are the major gaps at present in the continence services system in your catchment?

Describe the current model (structure/approach) of service delivery in your catchment?

What alternative model/s (structure/approach) could improve service delivery in your catchment?
What qualifications/training are required to provide continence service delivery?

Is there a formal orientation program relevant to this area of work?

What additional training needs do your staff or other staff, have in relation to continence, if any?

Partnerships & Linkages: Good working relationships with other services/programs is an essential element of a well functioning service system. What work is required to achieve this and with whom? (It could be educational, partnership development, other)

What are the 5 priority areas you would like to see addressed at the forthcoming continence workshop?

Appendix 5 - Gippsland Region Continence Services Local Service Mapping Tool: Part 2

The purpose of this tool is to assist us to identify the range and nature of continence services provided within the Gippsland Region. We are asking each provider of continence services to complete the tool.

You may already have much of the information at your fingertips, but in some cases we will be asking for your best “guesstimate”. (Part of this project is to identify what is and isn’t counted at this point in time.) We believe that most of the information we are asking for is currently not collected by the Department of Human Services.

The purpose of this Service Mapping Tool is to aid the consultants and Gippsland DHS to gain an understanding of local continence services. This will be of invaluable assistance in the production of the Gippsland Continence Services Plan that will follow.

Thank you for your contribution.
<table>
<thead>
<tr>
<th>Service Name</th>
<th>Address</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Telephone Number</th>
<th>Email Address</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Auspicing agency (if relevant)</th>
<th>Area serviced (Town/city/LGA)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## Service Provision

Please indicate the type/s of service you provide. (Add more where you feel it is relevant):

<table>
<thead>
<tr>
<th>Treatment</th>
<th>Equipment</th>
<th>Information</th>
<th>Health promotion</th>
<th>Y/N</th>
<th>Y/N</th>
<th>Y/N</th>
<th>Y/N</th>
<th>Y/N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Y/N</td>
<td>Y/N</td>
<td>Y/N</td>
<td>Y/N</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Y/N</td>
<td>Y/N</td>
<td>Y/N</td>
<td>Y/N</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Y/N</td>
<td>Y/N</td>
<td>Y/N</td>
<td>Y/N</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Please indicate where services are provided. (Add more where you feel it is relevant):

<table>
<thead>
<tr>
<th>Centre-based</th>
<th>Home-based</th>
<th>Schools</th>
<th>Residential Care facilities</th>
<th>HITH*</th>
<th>PAC</th>
<th>Y/N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Y/N</td>
<td>Y/N</td>
<td>Y/N</td>
<td>Y/N</td>
<td>Y/N</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Y/N</td>
<td>Y/N</td>
<td>Y/N</td>
<td>Y/N</td>
<td>Y/N</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Y/N</td>
<td>Y/N</td>
<td>Y/N</td>
<td>Y/N</td>
<td>Y/N</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*(HITH is Hospital In the Home, PAC is Post Acute Care, HARP is Hospital Admissions Risk Program)*

## Occasions of Service

Please indicate how you collect data on patient through-put

<table>
<thead>
<tr>
<th>SWITCH</th>
<th>AIMS</th>
<th>Occasions of service</th>
<th>Y/N</th>
<th>Y/N</th>
<th>Y/N</th>
<th>Y/N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Y/N</td>
<td>Y/N</td>
<td>Y/N</td>
<td>Y/N</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Y/N</td>
<td>Y/N</td>
<td>Y/N</td>
<td>Y/N</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Y/N</td>
<td>Y/N</td>
<td>Y/N</td>
<td>Y/N</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Please indicate the number of patients your service has seen (July - Dec 2007)

How is your time spent? (Please consider as a % of your total work time)

<table>
<thead>
<tr>
<th>Patient Care</th>
<th>Information</th>
<th>Administration</th>
<th>Travel</th>
<th>Meetings</th>
</tr>
</thead>
<tbody>
<tr>
<td>%</td>
<td>%</td>
<td>%</td>
<td>%</td>
<td>%</td>
</tr>
<tr>
<td>%</td>
<td>%</td>
<td>%</td>
<td>%</td>
<td>%</td>
</tr>
</tbody>
</table>
Staff Profile

<table>
<thead>
<tr>
<th>Nursing Staff</th>
<th>EFT</th>
<th>Total No. making EFT (eg 0.8 EFT. Total no 2)</th>
<th>Allied Health</th>
<th>EFT</th>
<th>Total No.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Div 1 (with continence quals/training)</td>
<td></td>
<td></td>
<td>Physiotherapists</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Div 1</td>
<td></td>
<td></td>
<td>Occupational Therapists</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Div 2 (with continence quals/training)</td>
<td></td>
<td></td>
<td>Other</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Div 2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Medical Staff</th>
<th>EFT</th>
<th>Total No.</th>
<th>Administrative</th>
<th>EFT</th>
<th>Total No.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Div 1 (with continence quals/training)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

What is your source of funding?

| HACC | Y/N | ACUTE | Y/N | SACS | Y/N | COMMUNITY | Y/N | OTHER | Y/N |

What qualifications/training are required for this work?

What are your links with other services?

Is there a formal orientation program relevant to your area of work?

Who do you receive your referrals from?

What are the priority issues you would like to see addressed at Continence Workshop? (I know there will be many but could I ask you to restrict it to the top 5 or 6 issues so we can try to structure the workshop around everyone’s needs)
Appendix 6

The *National Continence Management Strategy (NCMS)*, an Australian Government initiative, supports research, public awareness activities and education and resource development, aimed at improving continence awareness, management and treatment. The Strategy was established in 1998 to provide funding to research and service development initiatives aimed at prevention and treatment of this significant problem. Policy and assistance documents produced to date include:

- Continence Outcomes Measurement Suite, 2006
- Review of Patient Satisfaction Measures, 2006
- Measuring Incontinence in Australia, 2006

The Strategy is now in its third phase of activity. This phase has four major priorities:

- improving the information and evidence base;
- raising awareness of incontinence;
- supporting the continence workforce; and
- improving access to continence intervention and management.

Projects established under the *National Continence Management Strategy* include:

**Continence Awareness and Support Project**

The Continence Awareness and Support Project (CASP) is managed on behalf of the Department of Health and Ageing by the Continence Foundation of Australia. The project aims to raise awareness of continence promotion, management and treatment and to facilitate access to a range of information and support services through the *National Continence Helpline* which provides clinical advice to people at risk of and affected by incontinence, their carers, family, friends, health professionals and the general public; continence educational and training activities; health promotion and awareness raising activities such as Continence Awareness Week; and promoting cooperation between continence related groups and agencies and facilitating local support groups and activities (through State and Territory based organisations).

**Bladder and Bowel Health Website**

The Bladder and Bowel Website, [www.bladderbowel.gov.au](http://www.bladderbowel.gov.au) has information and advice on the prevention and management of bladder control and bowel problems for consumers, carers, health professionals, service providers and researchers. It also contains information about the Continence Aids Assistance Scheme.

**National Public Toilet Map Website**

The National Public Toilet Map website, [www.toiletmap.gov.au](http://www.toiletmap.gov.au) shows the location of more than 14,000 public and private public toilet facilities across Australia. Details of toilet facilities can be found along major travel routes and also for shorter journeys. Location information, opening hours, availability of baby change rooms, accessibility for people with disabilities and the details of other nearby toilets is provided.

**Continence Outcomes Measures (COMS) Dissemination Project**

The COMS Dissemination Project will develop and deliver a translation program of continence outcomes measures to national and international clinicians. Educational material will be developed to assist clinicians and health care workers to utilise and understand the continence instruments.

The University of Wollongong developed and presented papers and posters on the research findings of the continence outcome measures and patient satisfaction instrument to national and international clinicians and researchers. Further work is being proposed to conduct field trials to establish the validity, reliability and suitability of the continence outcome measures in Australian treatment settings and then to translate these for use by health professionals.

The reports are:

- *Measuring Incontinence in Australia 2006*
- *Continence Outcomes Measurement Suite together with Review of Patient Satisfaction Measures 2006*
- *Framework for Economic and Cost Evaluation for Continence Conditions 2006*
- *Measuring Patient Satisfaction with Incontinence Treatment 2006*
- *Refining Continence Measurement Tools 2006*
The Incontinence and Patient Satisfaction Tools and Instructions are:

- Revised Incontinence and Patient Satisfaction Tools and Instructions
- National Men’s Continence Awareness Project - aims to raise awareness among men of causes of poor bladder and bowel health. Information materials would be specifically targeted for men.
- Pharmacy Continence Care Project - The Pharmacy Guild of Australia is delivering a training package to educate Pharmacists and Pharmacy Assistants to enable them to better inform clients about continence care and management. The Guild developed the training to provide information and skills to raise community awareness of the issues of incontinence and to provide a better informed service to their customers.
- Daily Living Self Management Resources - offer strategies for people with incontinence to help with their work life, family life and social life. The resource for clients is: Live Better - for people with urinary incontinence. The resource for health professionals is: What now - a resource for health professionals.

The National Continence Management Strategy website is:
