

THE APPLICATION AND INTERPRETATION OF INTERNATIONAL STANDARDISATION REPORTS – THE BRIDGES AND BARRIERS TO ‘GOOD’ URODYNAMIC PRACTICE: A REGIONAL PERSPECTIVE

Hypothesis / aims of study

Evidenced-based healthcare is now one of the major policy themes on the National Health Service (NHS) modernisation agendas in the United Kingdom (UK). Recently it has been stated that the current provision of training and the assessment of competence in many areas of urology, especially within clinical investigations, is inadequate (1). The publication of this report has significant implications for urodynamic investigations, and their relationship with the core principles of evidence-based practice. Guidelines for urodynamic practice have been available for the last five years (2, 3). The aim of this study was to determine, five years on, whether these leading documents have been applied to everyday urodynamic practice, establish how healthcare professionals have interpreted the terminology, and explore the systems in place to support personal and professional development, so as to identify factors that can contribute to, or obstruct, ‘good’ urodynamic practice.

Study design, materials and methods

A descriptive exploratory research design was adopted using a mixed methodological approach. A purposive sample of doctors, nurses and technicians who currently undertake urodynamic investigations within one NHS region were selected. Postal questionnaires were sent out to sixty healthcare professionals, which were followed by eight semi-structured interviews. The questionnaire responses were entered into an Excel, which were analysed using simple descriptive statistics. Two statistical tests (Mann-Whitney, hypothesis test) were used to test for differences between professional groups. A manual/hand content analysis of the transcribed interview tapes was completed, which allowed the interview content, discussions during the interview, significant words, ideas and statements relating to urodynamic practice to emerge and be understood by the researcher.

Results

In total twenty-four participants (N = 24) completed and returned their questionnaires. Five participants were excluded from the study, as they did not perform urodynamics or they did not want to take part, which provided a questionnaire return rate of 44%. There was a 100% access rate to urodynamic training, with 92% attending a specific urodynamic. Equally, 92% of the participants were familiar with the ICS guidelines, with 63% using them in their current practice, along with 33% who had a department protocol. 92% of the participants had never had a formal assessment of their urodynamic practice, and 33% of participants did not keep a record of their training. This finding was highest amongst the doctors (statistically significant, $p < 0.01$). All participants completed incomplete definitions (Table I), which tested their knowledge and interpretation of commonly used urodynamic terminology. Although a trend was observed, there was no statistical difference between professional groups for incorrect responses to stress urinary incontinence, detrusor overactivity, or zero pressure.

Table I: Responses to incomplete urodynamic terminology /definitions

ICS Definition	Correct	Incorrect
Stress urinary incontinence is the complaint of...	54%	46%
Urgency is the complaint of...	92%	8%
Detrusor pressure is estimated by...	92%	8%
Detrusor overactivity is a urodynamic observation characterised by...	67%	33%
Bladder compliance describes the relationship between change...	92%	8%
Zero pressure can be defined as the surrounding...	79%	21%
Pressure recordings can be checked for accuracy and quality (during the test) by...	96%	4%

Interviews with 3 doctors, 3 nurses, and 2 technicians were completed. Their urodynamic experience ranged from 3 years – 18 years, with a mean of 9.8 years. Interviews lasted from 15 minutes to 50 minutes. There were strong themes which emerged, which were categorised under two main headings: (i) bridges to evidence-based urodynamic practice – access to supervision, MDT meetings, team working and networking, and (ii) barriers (Table II) to evidence-based practice – isolation, attitudes and time.

Table II: Barriers to Practice

Attitudes	Time	Isolation
The attitude was very much oh well you’ve done the course get on with it (Nurse)	There are lots on things that I would like to do with my own service and I just never have the time to do it (Doctor)	I just felt really quite isolated and really wondering whether I was doing OK (Nurse)
They’ve got no one to really help them – urodynamics can be a bit like that (Nurse)	If we had time to find out what other people are up to with their practice and the way they run their clinics I am sure we’ve got a lot of room for improvement (Nurse)	If I am working and feeling isolated then I will ring and ask other people (Doctor)
A sort of fighting match between various factions who differ about terminology was rather off putting and personally I just quietly get on with the job (Doctor)	There are things that I want to change in practice not just urodynamics but other areas and I just need that time (Nurse)	You become a bit of an island and you only can then do what you think is right with your knowledge and experience (Technician)

Interpretation of results

These findings confirm that standardisation reports/guidelines, in one NHS region, are reaching their target population. Essentially, the guidelines are often used in conjunction with department protocols and information from colleagues, which are naturally developed within a framework of personal experience. It would appear that there is some confusion around commonly used urodynamic terminology, which may have wider implications for practice and treatment outcomes. The importance of facilitating professional development should not be underestimated – the participants in this study felt this would be easier to achieve if there were greater resources to help develop, support, and evaluate their urodynamic practice. The bridges identified demonstrate the potential for developing practice and creating supportive practice frameworks, which are fundamental to 'good' urodynamic practice.

Concluding message

The translation of training and assessment into practice is a complex issue to address, as it requires skills in reflective practice, self-assessment, and critical analysis. Although guidelines/recommendations exist, a more robust framework may be required; incorporating structured mentoring and clinical assessment with experienced practitioners, in order to address the barriers that clearly exist.

References

1. Action on Urology Workforce Survey NHS Modernisation Agency (2005)
2. Neurourology and Urodynamics 21: 261 – 274
3. Neurourology and Urodynamics 21: 167 – 178

<i>Specify source of funding or grant</i>	The Florence Nightingale Foundation, Band Trust Research Scholarship 2006 - 2007
<i>Is this a clinical trial?</i>	No
<i>What were the subjects in the study?</i>	HUMAN
<i>Was this study approved by an ethics committee?</i>	Yes
<i>Specify Name of Ethics Committee</i>	North Bristol NHS Trust
<i>Was the Declaration of Helsinki followed?</i>	Yes
<i>Was informed consent obtained from the patients?</i>	Yes