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## 1. ABBREVIATIONS

The following abbreviations are used throughout this report:

ADGP	-	Australian Divisions of General Practice
CFA	-	Continence Foundation of Australia
CPD	-	Continuing Professional Development
CPGs	-	Clinical Practice Guidelines
GPs	-	General Practitioners
GPCE	-	General Practitioner Continence Education
QA	-	Quality Assurance
RACGP	-	The Royal Australian College of General Practitioners

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## 2. ABSTRACT

This project has been funded by the Commonwealth Department of Health and Ageing and follows the successful “*Continence Care in the Community*” demonstration project of 2000-2001. As described in our Second Progress Report of July 31, 2002, a variety of educational resources and activities were designed for the purpose of educating GPs about the prevalence, presentation, assessment, and management of both urinary and faecal incontinence. The national implementation of this educational program was coordinated by the WA Research Unit of the RACGP, with the assistance of the State-based Divisional organisations and 48 divisions of general practice, and is the subject of this final report.

Since the preparation and delivery of the Second Progress Report, all of the components of the “Managing Incontinence in General Practice” package were assembled, delivered and made available for dissemination by the first week of August, 2002. The first of the nationwide sessions designed to disseminate the education program were conducted during August and September, of 2002. These were in the form of “Train-the-Trainer” workshops conducted on a State-by-State basis for each of the State-based divisions of general practice organisations, attended by representatives from 48 of the 123 divisions invited. During this time period, a substantial media campaign was conducted to provoke and maintain widespread General Practitioner interest in the project. Of the 48 divisions of general practice represented at the state “Train-the-Trainer” sessions, 13 divisions of general practice decided they had the resources to devote to this training programme. Their designated training officers then conducted educational workshops and delivered the Clinical Practice Guidelines to a total of 229 general practitioners between October, 2002 and April, 2003.

Significant improvement in GP knowledge of incontinence management resulted from workshop participation. Qualitative data obtained from nurse continence advisers and physiotherapists indicated increased GP referrals and other signs of improved GP incontinence management in regions where the GPCE program had been conducted. Other data concerning the effectiveness of the GPCE program are also presented. Feedback regarding the rollout and content of the program was overwhelmingly favourable.

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### 3. INTRODUCTION

#### 3.1 Background

Incontinence is largely a “hidden” condition. Patients do not readily admit to symptoms, and many doctors are unaware of their prevalence. Within the general population, up to 19% of children <sup>(1)</sup> and at least 20% of women and 10% of men <sup>(2)</sup> may be affected by some form of urinary incontinence. Rates of faecal incontinence in the adult population are also thought to be high, with recent Australian statistics highlighting a 12-month incidence of 11% <sup>(3)</sup>. These largely under-reported conditions often have a significant negative influence on quality of life and mental health <sup>(4, 5)</sup> and are usually a major influence on decisions to place an elderly person in long-term institutionalisation <sup>(6)</sup>.

A large proportion of incontinence can be cured or improved <sup>(7)</sup>. General practitioners (GPs) are ideally placed within the Australian Health System to provide and coordinate care for persons affected by incontinence. GPs are the leading providers of health-care to the Australian community, averaging 6000 consultations each per year <sup>(8)</sup>. Up to 9 out of 10 Australians visit a GP each year <sup>(8)</sup>. It is clear, however, that a large amount of incontinence remains unmanaged.

The General Practitioner Continence Education (GPCE) project was designed to provide means of assisting GPs in recognising and managing patients who suffer from urinary and/or faecal incontinence. An educational package including Clinical Practice Guidelines (CPGs) and a variety of other resources and Continuing Professional Development (CPD) activities was created by the WA Research Unit of the Royal Australian College of General Practitioners. The delivery of guidelines and educational activities to GPs throughout Australia was achieved with the assistance of the State-based Divisional GP organisations, and 48 of the 123 divisions of general practice.

The CPGs and educational activities offered provided sufficient information to enable GPs to feel confident in their ability to identify and manage incontinence within their own practices. The guidelines represent a summary of the strongest available data and management

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recommendations for urinary and faecal incontinence, contextualised to the particular needs of Australian general practice. Information was presented in three levels, providing detailed background, summarised guidelines, and an assessment and management algorithm that provided a convenient visual representation of the major decision points and preferred management pathways. CPGs were also present on CD-ROM, along with a video that provided guidance in approaching the topic of incontinence with patients.

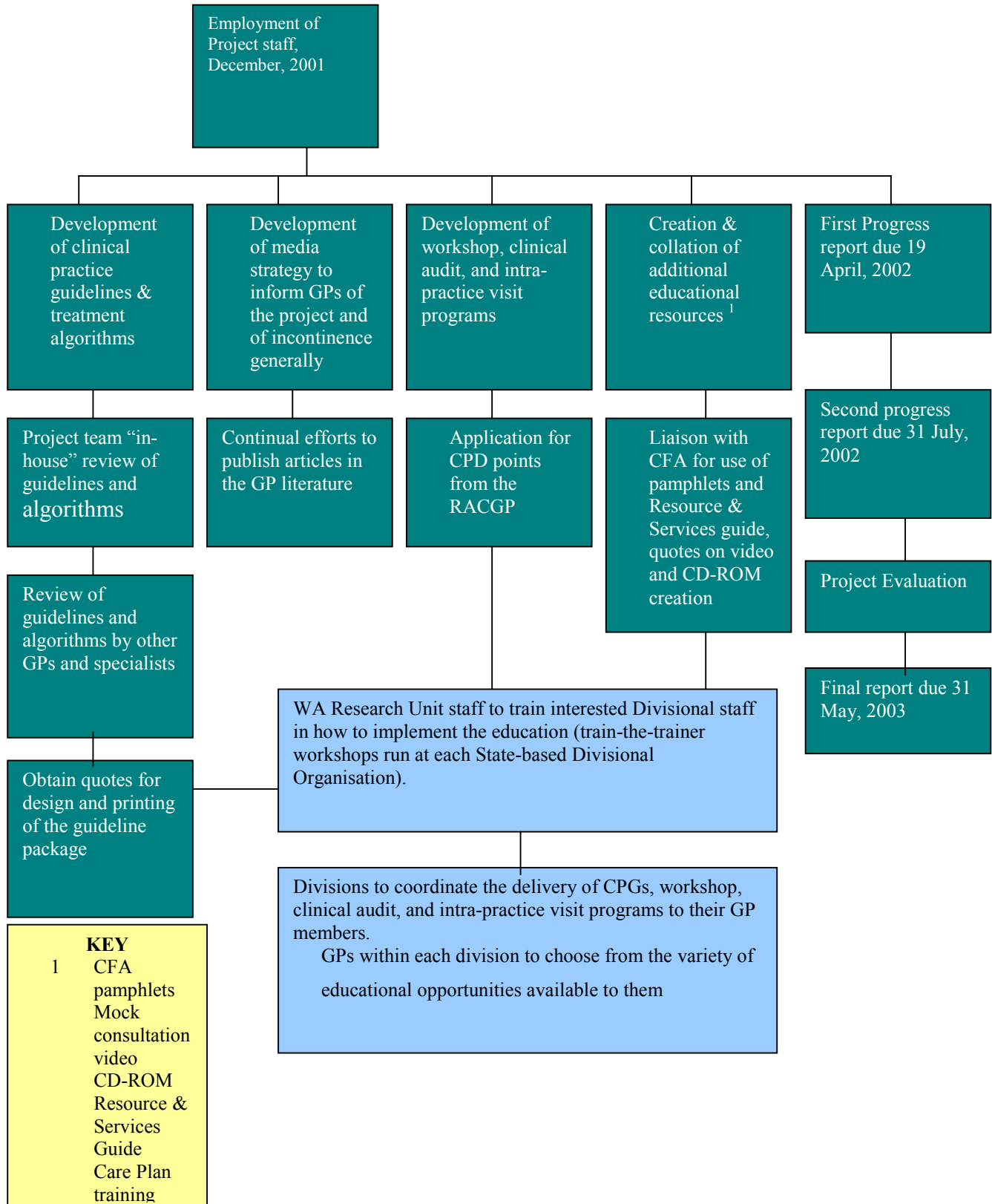
We believe that the use of the resources within the “Managing Incontinence in General Practice” package, and the educational opportunities, will assist GPs in uncovering and managing a substantial amount of previously unreported incontinence.

#### *References*

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### 3.2 Structure of the project

Figure 1 (below) illustrates the stages of development and implementation of the project.



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### 3.3 STAFFING

Staff employed on the GPCE project were:

Dr Farida Tilbury	Project Manager (to August 2002)
Dr Clare Matthews	Consultant GP (as required)
Jan Taylor	Research Officer (to November 2002)
Lee Barclay	Research Officer (to October 2002)
Dr Douglas Cordell	Project Manager (August 2002 to July 2003)
Liz Williams	Research Officer (November 2002 to May 2003)
Eric Miles	Research Officer (January to May 2003)

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#### 4. REQUIREMENTS OF THE FINAL REPORT

The schedule (Section B) of the contract for services between the Department of Health and Ageing and the Royal Australian College of General Practitioners details the following requirements of the Final Report:

*The Final Report shall be provided to the Department by 31 May 2003. In this report the Contractor shall provide a report that evaluates the program and reports on the activities undertaken to maintain ongoing awareness of continence issues as outlined in parts (a) to (c) under Awareness Program in Item A.*

*The final report shall describe clearly:*

- *The methodology that the project team followed in conducting the project;*
- *Any difficulties encountered in the course of the project;*
- *Any elements of the process followed by the team that have implications for future education of general practitioners; and*
- *All evaluation mechanisms used and the outcome of the evaluation process.*

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## 5. PROJECT METHODOLOGY

### 5.1 Awareness Program

The GPCE project was publicised nationally through both public and private media between May and August 2002, with the objectives of stimulating interest in the GPCE project in particular and raising GP awareness about incontinence in general. An experienced newspaper journalist was employed to act as Media Officer. Her involvement ensured that high quality articles were produced to inform GPs of the project and of incontinence more generally. Consultant GPs were utilised to ensure that technical information was correct.

In establishing relations with medical media outlets, the GPCE Project media officer made contact with:

- Over 100 divisions of general practice throughout Australia – reach estimated at 18,000 GPs
- State RACGP media outlets throughout Australia – reach estimated at 10,000 GPs
- State Australian Medical Association (AMA) media outlets throughout Australia – reach estimated at 26,000 medical professionals
- Rural medical outlets throughout Australia
- Private medical media outlets

The GPCE project negotiated two commissioned articles with national medical journals including,

- Australian Family Physician - a set of feature articles on investigating and treating incontinence, including a practice tip handout for doctors on how to do a correct pelvic floor assessment and a patient handout on incontinence for doctors to give to patients.
- Medicine Today – a clinical case review of an elderly incontinent male patient.

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Between the months of May and August 2002, the GPCE Project was publicised in ADGP newsletters throughout Australia. During this same time period, the GPCE Project was also publicised in RACGP newsletters throughout Australia, in AMA newsletters, through the RACGP “Friday Fax” and the ADGP fortnightly e-mail. The GPCE Project was also publicised via approximately 13,000 flyers distributed to GPs in WA, Victoria, Queensland, South Australia, Northern Territory and Tasmania. The GPCE project was publicised via its link on the national RACGP website where doctors were able to obtain information about the GPCE project and register electronically. The GPCE project was launched officially through the national media on August 4, 2002 via an official press release announcing the national rollout of the project. In addition, articles about incontinence or the GPCE Project have appeared in GP Review, The West Australian, and the Medical Observer.

In August 2002 the RACGP Research unit was informed by the legal officer of Read Exhibitions Australia that the acronym GPCE was the property of their company and used as the name of its biennial conference General Practitioners Conference and Exhibition-(GPCE). The legal officer insisted that the College desist from the use of the acronym to avoid confusion in the GP market place.

The College, through its national office in Melbourne, resolved the issue with the company such that it would refrain from using the freestanding acronym GPCE except where it was preceded by the full title. In practice, this required the Research Unit to black out the acronym on audit packages yet to be sent to the divisions, sending letters to the divisions who had received packages advising them accordingly and removing the acronym from the College’s Web site which contained information on the project.

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## **5.2 Implementation of Educational Program**

As reported in our Second Progress Report of July 31, 2002, the “Managing Incontinence in General Practice” package contains the following educational resource materials:

- a. Two versions of the Clinical Practice Guidelines (A4 and A5 sizes);
- b. Three treatment algorithms (urinary, faecal, and childhood incontinence);
- c. A CD-ROM containing Clinical Practice Guidelines and a mock consultation video;
- d. GP/patient information pamphlets (x15);
- e. Practice posters;
- f. A Care Plan template;
- g. A Resource and Services guide template

The above materials were produced and assembled as a complete package by a Perth-based marketing/design company at the end of July 2002. Six hundred and fifty of these complete packages were delivered during the first week of August 2003, in preparation for the training workshops to be conducted between August 9, 2002 and April of 2003. Additional quantities of the “Practice Posters” were also produced for promotional purposes.

The “Managing Incontinence in General Practice” package was provided to GPs who participated in one or more of several CPD opportunities approved by the RACGP. As detailed in the Second Progress Report, CPD points were granted for workshops, clinical audits, and intra-practice visits. These educational opportunities were advertised nationwide in RACGP publications, through the divisions of general practice, and in the wider media (refer to section 5.1 Awareness Program).

In addition to the widespread media campaign, project staff liaised with each of the State-based divisional organisations in an effort to develop the most efficient strategy for dissemination of the education program. A “Train-the-Trainer” approach was devised in an effort to achieve the widest possible implementation of the GPCE program. This represents an alteration to the original plan, which entailed employment of a project officer at the ADGP

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to oversee dissemination of the education program. An amended contract was prepared and signed by both the Commonwealth and the RACGP in order to authorise and clarify this change.

Each State-based divisional organisation organised an information session on the GPCE project for the benefit of their divisions of general practice. Appropriate representatives from every division within each State, were invited to attend these training sessions. Fifty of the 123 divisions of general practice throughout Australia agreed to participate in these training sessions, receiving a 2-hour presentation by GPCE project staff on the project and how to implement the education opportunities within their own divisions. Each divisional representative (Program Officer or equivalent) participating, received a “Managing Incontinence in General Practice” package in order to further familiarise themselves with the content and value of the educational program. They were also issued guide packages designed to advise on the implementation of workshops, clinical audits and intrapractice visits. These packages contained step-by-step guides to planning and conducting each of the particular educational activities and provided all necessary documentation.

The first of the “Train-the Trainer” sessions were held in Sydney on August 6 and 9, 2002. Staff from up to 20 divisions of general practice, including the ACT Division, were expected to be present at this event. In actuality, 14 Divisions were represented directly and six people from other interested organisations also attended. The Tasmanian “Train-the Trainer” session was conducted in Launceston on August 12, 2002, with staff from three divisions participating in the training. Another “Train-the Trainer” session was conducted in Adelaide on August 21, 2002, for South Australian Divisions of General Practice with representatives from six divisions receiving instruction.

The “Train-the Trainer” session for Western Australia was conducted on September 4, 2002, with Program Officers from five divisions receiving training. On September 23 and 24, 2002, “Train-the Trainer” sessions were conducted in Townsville and Brisbane for the Queensland Divisions of General Practice. Of the 20 Divisions invited, Program Officers from 10 divisions participated. The “Train-the Trainer” session for Victoria was conducted in

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Melbourne on September 26, 2002, with Program Officers from 10 divisions (out of a possible 31) attending. In response to their request, the Central Australian Division of Primary Health Care in Alice Springs also received a training package but additional training was conducted by telephone and e-mail. Of the 50 divisions that had stated their intention to attend, 48 actually participated.

Subsequent to the state “Train-the Trainer” sessions, feedback received from the divisions of general practice was extremely favourable and highly encouraging. In declining to participate, most divisions expressed regret that they were unable to participate within the time frame of the GPCE project due to other priorities competing for limited time, staffing and financial resources.

However, 12 of the 48 divisions of general practice decided that GP continence education was of sufficiently high priority that they could allocate the time and resources to implement the GPCE program amongst their constituent general practitioners in the form of 2-3 hour workshops. Five of the twelve divisions utilised clinical audits in addition to 2-3 hour workshops. No divisions utilised self-learning through clinical audits alone. An additional division (South Queensland Division of General Practice) participated in the form of intrapractice academic detailing visits, training two GPs in this manner. The divisions that participated in any of the GPCE training activities are listed in Appendix A.

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## 5.3 Evaluation Mechanisms and Results

### 5.3.1 Background

This section describes the evaluation processes used in the General Practitioner Continence Education (GPCE) Project conducted by the WA Research Unit of the Royal Australian College of General Practitioners (RACGP). This evaluation framework is based partly on that devised for the three “Continence Care in the Community” demonstration projects completed in 2001, which sought to effect change in four main groups (continence services, primary health care providers, people with continence problems, and the wider community). In the “Continence Care in the Community” projects change was measured at three levels. *Process evaluation* was used to analyse the process of program delivery, *impact evaluation* to measure the effect of the program on health care providers (attitudes, beliefs and knowledge), and *outcome evaluation* to measure the effect of the program on those with incontinence.

By contrast, the GPCE project is specifically targeted at effecting change in GP knowledge, behaviour and attitudes. Consequently, the evaluation of the GPCE project focuses on *process* and *impact evaluation*. Outcome evaluation, applying principally to health service consumers, is not a primary goal of this GP-focused project. From the outset of the GPCE project, it was intended that the process of program delivery would be evaluated from two perspectives, that of the program recipients and by independent external review.

#### *Role of the Independent Evaluator*

The GPCE Project was to have been evaluated through an independent evaluator. It was intended that this report would have evaluated the methodology of the project in relation to theoretical considerations and previous experience of similar projects. The independent evaluator’s report was also intended to include an analysis of the documentation and analysis of the program delivery. Concerns regarding the inactivity and lack of cooperation of the independent evaluator were detailed in the Second Progress Report (p.16), as follows:

*“At the time of the first report, GPCE project staff had initiated contact with the Commonwealth-appointed evaluator, Professor McCallum, and had provided a draft*

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*evaluation strategy for his teams' perusal. Despite repeated attempts to elicit a response from the evaluator regarding the evaluation of the project, we have to date received no correspondence regarding this strategy."*

An evaluation strategy was designed for the project and this was mailed to the independent evaluator in November 2002. The Research Unit did not receive a response from the independent evaluator in regard to the intended evaluation methodology and therefore proceeded to implement the strategy without their confirmation.

### **5.3.2 Process Evaluation**

Within the context of the GPCE project, process evaluation was concerned with assessing the quality of the educational activities and the effectiveness of their delivery to the divisional training officers and the general practitioners who participated in the continence training program. Process evaluation was also concerned with analysis of the theoretical and empirical basis for the project, and analysis of the formal documentation and quality assurance procedures (including expert review of education materials) undertaken by the project. It also included analysis of the success (or otherwise) of the rollout method used.

Several elements of process evaluation were included within the implementation of the GPCE project so that the quality of the educational activities and the effectiveness of their delivery could be assessed from the perspective of the program recipients. The specific assessment mechanisms that were utilised included:

- evaluation of the "Train-the Trainer" sessions using standardised interviews with the training staff of the participating Divisions of General Practice;
- evaluation of the GPCE workshops using GP Workshop Feedback questionnaires; and,
- evaluation of the program rollout using a questionnaire completed by staff of the divisions of general practice.

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### 5.3.2.1 Evaluation of the “Train-the-Trainer” sessions

Of the training officers from the divisions of general practice participating in the “Train-the-Trainer” sessions, 34 responded to the invitation to provide feedback concerning the conduct and quality of the GPCE training sessions. The interview questionnaires they completed elicited both quantitative and qualitative data. The quantitative data, collated and analysed using SPSS (version 11.0.1) software, are summarised in the form of descriptive statistics in Appendix B. The questionnaire is also included in Appendix B for convenient reference. Likert value scales have been added to the questionnaire for the purpose of evaluation and means of responses have been recorded where questions have been scored with an ordinal scale ie questions 1, 5, 6, 8 and 9.

The “Summary of Descriptive Statistics” in Appendix B indicates an enthusiastic response by the training officers of the divisions of general practice to the conduct and quality of the GPCE Program. The mean scores of ordinal questions were all very high, being within 15% of the maximum possible score. Question 2 elicited 34 responses of which 20 (58.8%) had no preconceived expectations of the session, 4 respondents (11.8%) felt the session mostly met their expectations while 9 (26.5%) judged the session to have exceeded their expectations.

Question 3 was omitted from analysis because the questionnaire was delivered before the workshops were run, thus rendering it irrelevant. There were 22 responses to Question 4 with 3 expressing no intention to run a workshop and 19 expressing an intention to do so.

In addition to the quantitative data reported above, questions 7 and 10 provided qualitative feedback on the “Train-the-Trainer” sessions. Responses to question 7 indicated that the most commonly perceived barriers to the various divisions of general practice participating in the rollout of the GPCE Project related to timing. Analysis of the wording of the responses indicated that the major difficulty was fitting the GPCE program into their CPD diary within the time frame of the project.

Question 10 invited respondents to “make any other comments”. Most of the comments were very positive, expressing the perception that the GPCE Program was a comprehensive, easy to

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use package that was well resourced, promoted and delivered. Other comments included an expression of disappointment that such a high quality program would not be able to be utilised because of the time of the year in which the GPCE Project was running (i.e. holiday season). Yet others stated that their divisional education program was too busy to accommodate the time frame requirements of the GPCE Project.

### **5.3.2.2 GP workshop feedback**

At the end of each GPCE workshop, the participating general practitioners completed workshop feedback questionnaires (titled “Evaluation Survey – CPD Event”). These questionnaires (see Appendix C) were then gathered by the divisional training staff who conducted the workshops, and sent on to the WA Research Unit of the RACGP for subsequent entry into computer spreadsheets, on a division-by-division basis.

One hundred and eighty general practitioners, from 9 divisions of general practice, reported their perceptions of the GPCE workshop they attended. Each divisional training officer received a summary of the perceptions of their GP attendees regarding the running and impact of their particular GPCE workshop. The accumulated results of all the workshops regarding “Setting” and “Presentation” are summarised on the first page of Appendix C.

The participating GPs were asked to evaluate the “Setting” of the GPCE workshop against three particular criteria, and the “presentation” of the workshop against five specific criteria. Out of the eight criteria evaluated, seven achieved satisfaction ratings above 90% (and the exception, “venue”, scored 89.4%). Of the 19 GPs who expressed dissatisfaction with the “venue”, 14 were attendees at the one workshop (14 of 39) indicating a problem specific to that particular workshop. The other dissatisfied GPs, in relation to this criterion, were scattered across three different workshops. Overall, the results are indicative of a very successful rollout process.

### **5.3.2.3 Divisional staff evaluation of GPCE program rollout**

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The success of the rollout was also assessed from the perspective of the divisional training staff who implemented the GPCE workshops, obtained through telephone interviews. Their evaluation of the rollout of the GPCE program is summarised in Appendix D.

In regard to this evaluation, the training staff of the divisions reported that there was a high level of interest in the GPCE program, with GPs in all divisions initiating enquiries regarding the availability of the training program. The divisional staff also sent “flyers” by fax and post, advertising the program to their GPs, and were very pleased with the response. Each of the divisions reported no difficulty in enrolling GPs, although two reported a minimal dropout rate due to last-minute unforeseen circumstances. Each divisional training officer reported that their Division had been very supportive of the GPCE program. Each divisional training officer reported no difficulty finding a venue, all found the workshop package easy to work with and all reported feeling equipped to run the workshop. Every division reported that the GP response to the workshop was very positive, with some adding descriptive terms such as “excellent” and “extraordinary”.

The other comments received from divisional staff in relation to the GPCE program (question 8) are also summarised in Appendix D. Overall the feedback was extremely complimentary, with positive comments about the clinical practice guidelines (CPGs), comprehensiveness of the workshop, professional presentation of the materials, and organisation of the program rollout. Of greater importance were the other comments about the GPCE workshop provoking a more thorough approach to continence management, increasing GPs confidence and providing greater awareness of patient needs and the paramedical resources locally available. Feedback from one division implied criticism of the case study used in the workshop but did not state their specific concern. One division reported that some GPs were very happy with the workshop but were concerned that the amount of work required to complete the audit was huge compared to the number of QA/CPD points earned. Consequently, of the 12 GPs who attended the GPCE workshop in that particular division of general practice, none completed the audit.

### **5.3.3 Impact Evaluation**

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The impact of the GPCE program on the management of incontinence by participating GPs was evaluated both quantitatively and qualitatively. The changes in their knowledge, behaviour and attitudes with respect to critical components of continence care were assessed by questionnaires. The evaluation mechanisms included:

- measurement of the change in GP knowledge, behaviour and attitude between pre- and post-intervention with the variety of educational opportunities, including: clinical audit; workshop; academic detailing; and small-group learning;
- measurement of GP satisfaction with the educational material and learning opportunities offered to them; and,
- monitoring (by qualitative means) of the perceptions of nurse continence advisers and physiotherapists regarding changes in the management of incontinence by GPs, including the frequency of GP referral of incontinent patients.

#### **5.3.3.1 Measurement of change in GP knowledge, behaviour and attitudes**

Through the various divisions of general practice, GPs were invited to undertake either a four or five step RACGP clinical audit, allowing them to examine their management of incontinent patients and evaluate their practice. The format of the clinical audit is detailed in Appendix E.I Briefly, following the first audit of 10 incontinent patients (reported on individual Screening/Data Collection forms) the GPs elected to attend a workshop or receive a practice visit from divisional training personnel. In both cases the GP received a copy of the clinical guidelines. The second audit of 10 patients occurred three months later and the Screening/Data Collection forms for each patient assessed by the GP in both audits were analysed by the WA Research Unit of the RACGP for changes in clinical practice. The data thus obtained were coded and entered into an SPSS (version 11.0.1) spreadsheet for statistical analysis. Of the 14 GPs that participated in the pre-workshop clinical audit, all attended the GPCE workshop but only 5 went on to complete the post-workshop clinical audit.

#### *Results of Pre-Workshop Clinical Audit*

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The results of the pre-workshop clinical audit are presented in Appendix E. Generally speaking, these pre-audit data suggest a paucity of knowledge of incontinence management in the primary care setting. However, the numbers are small and the instrument used to measure knowledge may not be highly sensitive. Therefore, some caution must be exercised in interpreting these results.

Each participating GP received a summary of their performance in comparison with the clinical guidelines, written in a non-critical and helpful manner with the intention of encouraging better management of incontinence in the future.

#### *Comparison of Pre-Workshop and Post-Workshop Clinical Audit Results*

Five GPs proceeded to complete the fifth stage of the audit process. The accumulated management data obtained from each participating GP's pre-workshop and post-workshop "Screening/Data Collection Forms", were compared using SPSS software. Appendix F compares the pre-workshop & post-workshop management scores of these 5 GPs.

The first table of data in Appendix F refers to the management of urinary incontinence as measured against the most important criteria cited in the clinical practice guidelines (CPG). These are: testing midstream urine (msu); medication review (medrev); utilisation of a bladder diary (bladdia); and, providing advice regarding the services of the CFA, nurse continence advisers or physiotherapists (advicfa). The column "total urinesc" is the sum of the GPs management strategies, the highest possible score being "4".

In comparing the pre-workshop and post-workshop scores, there were several slight improvements in the clinical management of urinary incontinence. Three of the five GPs achieved somewhat improved management scores, with medication review and advice regarding continence adviser resources improving notably. However, the improvement in the mean total score cannot be interpreted as being statistically significant. It should be noted that

comparisons of this nature are fraught with potential errors because although in both cases (pre- and post-) the GP subjects are the same, the patients assessed by the GPs are *not* the same and urinary incontinence is *not* a homogeneous condition.

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The change in management scores for faecal incontinence, also reported in Appendix F, are impossible to interpret meaningfully. The number of patients is too small and their distribution amongst the GPs is too disparate for valid pre-workshop/post-workshop statistical comparisons.

*Comparison of Pre-Workshop and Post-Workshop Knowledge*

Many general practitioners elected to attend workshops without doing clinical audits. The GPCE workshop package (contained in Appendix H of the Second Progress Report) included a “Pre-Workshop Continence Questionnaire” and a “Post-Workshop Continence Questionnaire” for each participating GP. For all workshop attendees, changes in knowledge were assessed by the pre-workshop questionnaires sent out by divisional training staff one month before the GPCE workshop, and post-workshop questionnaires distributed one month after the workshop. The questionnaires were then retrieved from the participating GPs by divisional staff and sent on to the WA Research Unit of the RACGP.

Upon receipt by staff of the WA Research Unit of the RACGP, the answers from each questionnaire were entered as coded data into a spreadsheet for subsequent analysis.

In regard to these results, 229 GPs completed the pre-workshop questionnaires and of these 163 completed a post-workshop questionnaire. Utilising SPSS (version 11.0.1) statistical software, the increase in the GP’s scores were highly statistically significant; pre-test mean-38.4, post-test mean-44.38  $P=0.000$ . (*paired samples t test*) Thus it seems GPs knowledge has significantly improved by the educational intervention.

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### **5.3.3.2 Measurement of GP satisfaction with educational material and learning opportunities**

This part of the evaluation was accomplished utilising two evaluation instruments. Firstly, each GP attending a GPCE workshop completed an “Evaluation Survey – CPD Event”, the results of which are contained in Appendix C. In addition to the questions asked concerning satisfaction or otherwise with the setting and quality of the program presentation (already discussed under “Process Evaluation” in section 5.3.2.2), other perceptions were sought concerning the impact of the GPCE workshop. Specific questions were directed at the impact of the GPCE package on the GP’s knowledge, confidence and attitudes. This is discussed below, in more detail, under the subheading “Evaluation Survey – CPD Event”.

Secondly, in fulfilment of RACGP Clinical Audit/CPD requirements, each of the GPs

completing the full audit submitted a “GP reflection on feedback” form that sought qualitative information concerning their perceptions of their performance in the GPCE program’s clinical audit. This is discussed below under the subheading “GP reflection on feedback”.

#### *Evaluation Survey – CPD Event*

The impact evaluation results, summarised in Appendix C, report a highly favourable response to the GPCE workshops. In regard to usefulness in their clinical practice, 176 out of the 180 GPs (approximately 98%) who responded rated the contribution of the workshop at “moderately” or above, with 129 (72%) rating it “a lot” or “extremely”. In relation to the increase in knowledge of the topic, 166 of the 180 respondents rated the workshop at “moderately” or above, with 110 of them (61%) rating it higher. One hundred and sixty five of the 180 GPs (92%) rated the workshops as increasing their level of confidence “moderately” or better, with 89 (almost 50%) rating it higher. In regard to the event increasing their level of competence, 164 of the 180 GPs (91%) rated the workshop “moderately” or better, with 93 (approximately 52%) rating it higher.

Other results relating to awareness of specific issues are also presented. Most importantly, 169 of the 177 GPs (96%) responding to the question on “increased awareness of continence

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services and resources” rated the workshop at “moderately” or above. Moreover, 138 (78%) of them rated their increased awareness as being higher. Another very important issue is that of the “high levels of success” achieved by conservative treatments. In regard to this issue, it was found that 162 of the 175 respondents (93%) rated their increased awareness at “moderately” or above, with 117 (67%) rating higher. In relation to the issue of “best practice in assessment and treatment of incontinence”, 165 of the 177 GPs (93%) responded with a rating of “moderately” or above, 112 (63%) GPs rating higher. The question relating to increased awareness of the issue of “the significant social impact of incontinence on sufferers” was rated “moderately” or higher by 147 of the 175 GP respondents (84%), with 104 (58.5%) rating higher. By contrast, awareness of “how to prepare a Care Plan for a continence sufferer” displayed a much broader range of scores than the other criteria. Ninety six of the 164 GPs (59%) who responded to this question rated their increased awareness at “moderately” or above, with only 50 (30%) rating higher and 68 (almost 41.5%) rating lower.

Overall, as reported by the participating GPs, the GPCE workshops were very successful, with impact ratings of “moderately” or above registered by more than 90% of the participating GPs for seven of the nine criteria. Furthermore, higher impact ratings (above “moderately”) were registered by 50% or more GPs for eight of the nine criteria.

#### *GP reflection on feedback*

As previously mentioned, each of the GPs completing the full audit submitted a “GP reflection on feedback” form that sought qualitative information concerning their perceptions of their own performance in the GPCE program’s clinical audit. Appendix H includes the reflection questionnaire and a summary of the major themes derived from their combined responses.

Unfortunately, as mentioned previously, only five GPs completed the full audit process, therefore only five reflection forms were received. However, four of the five GPs reported that their results had not been what they expected and that they were not satisfied with their results. Amongst the factors that may account for variation from best practice, the most commonly reported were “time constraints”, “not asking questions about incontinence” and “patient unwillingness to report problems ... and comply with treatment”. All the GPs

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expressed the need to improve their performance, suggesting that they needed to follow clinical practice guidelines (CPGs) more closely, ask patients the right questions and learn more about the management of incontinence. Importantly, several stated the need for desktop CPGs and flowcharts (algorithms) that are easier to understand and use. They all expressed interest in further continence education either by “self learning” (printed information), attendance at workshops, or both.

### **5.3.3.3 Changes in GP management of incontinence reported by continence advisers and physiotherapists**

One of the most effective measures of improvement in GPs management of incontinence is the referral of patients to specialist nurse continence advisers and/or physiotherapists for expert conservative treatment. With the assistance of the Divisional staff who conducted the GPCE workshops a convenience sample of specialist nurse continence advisers and physiotherapists, working within Divisions of General Practice in which the GPCE project had been implemented, were identified and contacted by telephone.

Utilising a standard questionnaire, telephone interviews were conducted asking a series of questions concerning their observations and perceptions of the management of incontinence by GPs in their geographical area, subsequent to the GPCE program being conducted by their local Division of general practice. They were also asked specifically whether or not they had received increased numbers of patients from local GPs since the GPCE workshop had been conducted in their area.

The telephone interviews were conducted during the last week of April and the first week of May 2003. For the purpose of consistency and reliability, all the interviews were conducted and answers recorded in writing by the same research officer. The telephone interviews of continence advisers and physiotherapists provided qualitative data of GP referral behaviour and perceptions of other changes in GP management of incontinence. Their answers and comments were recorded for subsequent analysis. Calculation of increases in referral rates was not possible due to the small number of divisions of general practice able to participate in

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this survey and the consequent small numbers of referees, resulting in difficulty in determining statistical significance.

Appendix I is a copy of the questionnaire used to elicit responses from nurse continence advisers (CAs) and physiotherapists (PTs). The wording in *italics* represents the themes provided by the combined answers of the respondents to this questionnaire. Of the 14 participants in this survey, seven were PTs and seven were CAs. Of the total group surveyed, eight were located within divisions of general practice that had conducted the workshop during the previous six weeks, and six were located within divisions of general practice that had conducted the workshop more than four months previously.

Nine of the 14 participants in the survey were aware of the GPCE project prior to the actual survey, with five of the nine being participants in the expert panel at a GPCE workshop. Seven of the 14 participants reported an increase in GP referrals, with the greatest proportional increase being reported by the CAs and PTs surveyed four months after the workshop. One of these participants reported that the GP referral rate had increased by more than 100% in her practice located within an area where a GPCE workshop had been conducted. This was in absolute contrast to the other locations where she worked and where the GPCE program had not been conducted. One of the two participants reporting no increase in GP referrals 4 months after the workshop stated that she had always had a very high referral rate from her local GPs. Amongst the eight CAs and PTs surveyed within six weeks of a GPCE workshop being conducted, three expressed the opinion that it was too early to identify changes in GP referral rates and management because of the intervening Easter, ANZAC Day and school holidays. However, four of the eight had already noticed an increase in GP referrals.

Of the eight CAs and PTs surveyed within six weeks of a GPCE workshop being conducted, five reported improvements in management of incontinence by their local GPs, whilst three participants felt that it was too soon to have identified any real changes. Four of the six CAs and PTs surveyed more than four months after the GPCE workshop was conducted in their area reported improvements in management of incontinence by their local GPs. Of the two

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CAs who reported no change in the GP management of incontinence, one reported a large increase in referrals and the other stated that the GPs in her area had always provided a high referral rate but needed to improve other aspects of incontinence management.

In summary, from the perspective of nurse continence advisers and physiotherapists, the GPCE project impacted positively on GPs management of incontinence. In particular, a majority experienced an increase in GP referral rates after the GPCE workshops were conducted. A majority of CAs and PTs also reported other improvements in various aspects of the management of incontinence by GPs, also noting improvements in GP interest and awareness. Several conveyed feedback from their local GPs that the GPCE workshop was the most successful educational program ever conducted within their division of general practice, expressing the hope that further training on managing incontinence would be forthcoming.

## **6 DISCUSSION**

### **6.2 Difficulties Encountered**

Several difficulties were encountered during the course of the GPCE project. One potential difficulty was that of obtaining the cooperation of the GPs in completing GPCE tasks, activities and communications within the required time frames. The cooperation and professional approach of the divisional staff secured success against this potential difficulty in all but a few instances.

Another difficulty was encountered in meeting the target of obtaining the participation of 50 divisions of general practice in the “Train-the-Trainer” program due to competing priorities and late withdrawals (for unexplained reasons). However, of the 50 divisions that had stated their intention to attend, 48 actually participated. Further to this situation, it proved impossible to obtain the participation of all of these divisions of general practice in conducting the GPCE program. This was because of the difficulties they perceived in fitting the GPCE program into their CPD diaries within the required time frame (September 2002 to March 2003) due to pre-existing training commitments, competing priorities and the impact

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of the Christmas/New Year/school holidays. Ultimately, only 13 of the 48 divisions of general practice participated in the GPCE project.

Despite the high level of GP interest and frequently expressed enthusiasm for the GPCE project, the divisional training staff encountered difficulty in involving GPs in the clinical audit component of the GPCE program. The implications of this are discussed within the next section.

For reasons that remain unexplained to the GPCE project team, difficulties were encountered in obtaining the cooperation of the originally appointed independent evaluator. However, this has been previously discussed and requires no further comment.

## **6.1 Implications for Future Education of General Practitioners**

At first glance, the results of the pre-workshop clinical audits suggest that there is a relative paucity of knowledge amongst GPs when dealing with incontinence. Certainly, the results of the pre-workshop clinical audits indicate that GPs' incontinence management skills are much less than desirable, with the mean urinary management score being 36.5% (ie. 1.46 out of a possible four) and the mean faecal management score being 23.7% (ie. 0.71 out of a possible three). By contrast, the pre-workshop knowledge scores achieved a mean of 80%. (ie. 38.74 compared with a possible score of 48).

Interestingly, the results of the post-workshop questionnaire indicate a statistically significant improvement in participant GPs knowledge of the effective management of incontinence, with a mean score of 92% (ie. 44.38 compared with a possible score of 48) being achieved. Whether or not this improved knowledge translates to more effective management of incontinence by GPs is not known. It would be difficult to measure in practice. The post-workshop audit showed a minimal improvement in the management of urinary incontinence in the small sample of GPs (5) who participated but the statistical significance of this

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improvement was not able to be determined due to the different mix of patients seen in the pre- and post-workshop audits.

By contrast, the qualitative feedback obtained from continence advisers and physiotherapists working in the same geographical areas as the GPs who had participated in the GPCE workshop, was very encouraging. Overall, they reported an increase in referrals from GPs and a reasonably consistent increase in the practice of MSU testing. Improvement in other management criteria displayed inconsistent results, however. The obvious conclusion is that GPs can do more in the conservative management of incontinence.

There are a number of possible reasons for the discrepancy between knowledge of continence management and the actual management behaviours. Upon closer inspection, the first question in the pre-workshop knowledge questionnaire (relating to confidence in managing patients with urinary and/or faecal confidence) elicited a mean score of 28% (ie. 0.83 compared to a possible three). It is therefore possible that it is a lack of confidence, based on “not knowing that you know”, that is responsible for the poor management scores. The GP reflection on feedback from the RACGP Clinical Audit Appendix H) provides other possible explanations. GPs reported that time constraints, conflicting demands, patient inertia and non-compliance, not having CPGs in an easy to follow format, and not asking the patient specific questions about incontinence, contributed to their variation from management guidelines. Taken together, it is possible that many of these perceived barriers to effective management could be overcome by providing GPs with accurate and easy to follow CPGs and desktop treatment algorithms. Further educational opportunities would also be appropriate in the format of “Managing Incontinence” workshops and clinical audits. The widespread and urgent need for further GP education on this topic has been expressed repeatedly through all of the impact evaluation mechanisms.

Bearing in mind the scope of this project, the WA Research Unit of the RACGP has received almost unanimous praise for the manner in which the GPCE package was presented to each division. All the necessary documentation was provided along with instructions for management of each step in the process. This had the effect of minimising the amount of work divisional staff had to perform in promoting the program, organising and implementing

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the educational activities, liaising effectively with their GPs, managing their documentation and distributing and returning questionnaires and audit documents. It has been uniformly stated that the GPCE program was easier to rollout to their GPs than any other educational program they had administered.

The impact evaluation results, summarised in section 5.3.3.2 (and Appendix C) report a highly favourable response to the GPCE workshops from the participating GPs, with impact ratings of “moderately” or above registered by more than 90% of the participating GPs for seven of the nine criteria. Furthermore, higher impact ratings (above “moderately”) were registered by 50% or more of the GPs for eight of the nine criteria. Positive feedback was also given both formally (Section 5.3.2.3 and Appendix D) and anecdotally by divisional training officers concerning the reaction of their constituent GPs to the GPCE program. In addition, several of the continence advisers and physiotherapists surveyed after the workshops provided highly favourable anecdotal feedback. They reported that the GPCE workshops had developed the reputation amongst their local GPs of being the best educational event ever provided through their divisions of general practice. This positive feedback is important because it reflects the perception that the GPCE program was appropriately designed and delivered, providing GPs with information they regarded as being valuable, up-to-date and well presented.

With the benefit of hindsight, the most significant weakness of the GPCE program was its failure to involve more GPs in the complete clinical audit process. Although only one divisional training officer reported negative comments from GPs regarding a perception of imbalance between the amount of work involved in the clinical audit and the number of QA/CPD points awarded, the fact remains that of 229 GPs participating in the GPCE workshops, only 14 engaged in the pre-workshop clinical audit component and only five completed the 5-step audit process. It remains uncertain as to why this was so. Nevertheless, it is clearly important in future educational program designs to ensure that GPs are appropriately rewarded for their efforts in continuing education. It is also important to anticipate the possibility of inaccurate perceptions and to prevent them from occurring.

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In conclusion, the formal and informal feedback received from participating general practitioners, divisions of GP training staff, nurse continence advisers and physiotherapists was overwhelmingly supportive of the GPCE initiative. It is also clear that there is a very real demand for a more widespread educational program to reach the general practitioners of Australia. Furthermore, it is clear that further simplified and updated desktop Clinical Practice Guidelines and treatment algorithms would be valued by most GPs. The GPCE project has demonstrated that improvements in GP knowledge and management of incontinence can be achieved. It has also found that many GPs are enthusiastic about improving their performance in this important area of patient management.