



Stress Urinary Incontinence audit pack

**Clinical guidelines for the
Physiotherapy Management
of Females aged 16-65 with
Stress Urinary Incontinence**



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Foreword

The Clinical Guidelines for the Physiotherapy Management of Females aged 16- 65 years with Stress Urinary Incontinence provide evidence-based recommendations for the physiotherapy management of this group. These guidelines were developed to address the problem of differing practice across the profession. The Department Of Health highlighted the need to provide high quality continence services specifically advocating a role for the specialist physiotherapists in the document 'Good Practice in Continence Services' (DOH, 2000).

The incidence of urinary incontinence has been reported by many authors, Kuh et al (1999) reported in a general population sample of 1333 women aged 48 years that 50% reported symptoms of SUI in the previous years. Whilst Norton et al (1988) found that 60% of adult women with stress urinary incontinence avoid going away from home through fear of incontinence.

This audit pack contains a number of sections including a data collection form and notes on undertaking an audit to facilitate comparison of actual practice with the recommendations in the guideline. The pack emphasises the role of audit as a tool for continuous improvement and should form an important resource for services and individuals to support the implementation of the guidelines. The pack also contains a section on accessing suitable outcome measures to assist evaluation of the outcome of intervention. Physiotherapists and others should use this tool to assure the quality and effectiveness of their services and thereby contribute to the reduction of incontinence and the subsequent disability among those affected resulting in an overall improvement in the standard of services offered to this target group.

Claire Strickland MCSP

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Norton PA, MacDonald LD, Sedgwick PM, Standon SL (1988) Distress and delay associated with urinary incontinence, frequency and urgency in women. *British Medical Journal*. 297: 1187-1189

Introduction

Urinary incontinence is the involuntary loss of urine, which is objectively demonstrable, with such a degree of severity that it becomes a social or hygienic problem (Abrams et al, 1988). Stress Urinary Incontinence (SUI) is the most common form of urinary incontinence in women under 50 years of age. It is characterised by the loss of urine during physical exertion eg coughing.

The guideline recommends that conservative therapy should be an option for all incontinent women. Conservative therapy such as pelvic floor muscle exercises, biofeedback, cones and electrical stimulation is relatively inexpensive, readily available, has few complications and does not compromise future surgery (RCP,1995).

In 2001, the Clinical Guidelines for the Physiotherapy Management of Females aged 16-65 with Stress Urinary Incontinence were published. The guideline is available from the Chartered Society of Physiotherapy and can be downloaded at:

www.csp.org.uk/effectivepractice/clinicalguidelines/physiotherapyguidelines.

The guideline was developed by a guideline development group comprised of physiotherapists specialising in womens health and led by a physiotherapy manager .

The objectives of the guideline are:

- To provide an evidence-based reference tool for physiotherapists working in the field of stress urinary incontinence
- To provide reliable recommendations which facilitate a consistent approach by physiotherapists
- To enable services to pursue the most effective and efficient methods of managing this condition
- To act as a guideline for commissioners when considering the physiotherapeutic element of new services or extending existing ones.

This audit pack is a comprehensive tool developed to assist local services in comparing actual clinical practice with the recommendations in the guideline. All of the documents may be freely photocopied. The data collection form and guidance notes have been developed in consultation with the guideline development group and piloted on sites with a range of continence services. In addition to the clinical areas audited through this tool it is recommended that other aspects of the service be evaluated for example through the use of outcome measures and patient feedback. The pack includes a section on relevant outcome measures. A patient feedback form and suggested methodology for undertaking patient feedback can be found in The Standards of Physiotherapy Practice pack (CSP, 2000b).

Evaluating healthcare is a major issue for all health care providers. Clinicians are under increasing pressure to demonstrate the value of the services they provide and clinical governance has further heightened the demand for information that can be used to inform service delivery improvements. It is hoped that participation in the audit will facilitate service development as audit has been shown to be an effective means of ensuring quality and effectiveness of services,

facilitating the implementation of guidelines (CSP, 2000a) and improving the quality of patient care (Crombie et al, 1993 and Hopkins, 1996).

Put simply, audit is a method of comparing what is actually happening in clinical practice against agreed standards or guidelines. Audit was introduced as a systematic method of improving the quality of patient care in the reforms of the NHS in 1989. The National Institute of Clinical Excellence (NICE) defines clinical audit as 'a quality improvement process that seeks to improve patient care and outcomes through systematic review of care against explicit criteria and the implementation of change' (NICE, 2002).

To ensure that an improvement in quality of care arises as a result of the audit it is important that the audit process does not end once the data has been collected. The stages of evaluating the data, developing and implementing recommendations for change and subsequently undertaking a re-audit are essential to ensure actual clinical improvement that is 'closing the loop' or completing the cycle. The information in this audit pack has been developed to reflect the cyclical process of audit.

Further references including a useful bibliography is included in the information paper Clinical Audit CLEF1 (CSP, 2002).

Guideline Recommendations

This section presents the evidence statements and recommendations made in the Clinical Guidelines for the Physiotherapy Management of Females aged 16-65 years with Stress Urinary Incontinence (Laycock et al, 2001) available from the Chartered Society of Physiotherapy and at www.csp.org.uk/effectivepractice/clinicalguidelines/physiotherapyguidelines).

The section is here as an aide-memoire and to provide a clear rationale for the items in the data collection form. As the guideline is restricted to therapeutic interventions the use of insert devices is not covered.

Physiotherapy practitioners are advised to use their physiotherapeutic knowledge and clinical judgement in applying the principles and recommendations of this document to the management of individual patients. It is advised that practitioners familiarise themselves with the full guidelines document to understand the evidence and grading and to make informed clinical decisions.

Evidence Statements and Recommendations

The evidence statements were graded using The Canadian Task Force Evidence Classification (Canadian Task Force, 1979):

- Grade I Based on well-designed, randomised trials, meta-analysis or systematic review
- Grade II Based on well-designed cohort or case control studies
- Grade III Based on uncontrolled studies or consensus opinion

From these statements recommendations were developed. The key recommendations and evidence statements from the guideline are outlined in the table across the page. A complete list of recommendations with supporting evidence can be found in the guideline.

◆ Note. Throughout this summary reference is made to ◆ the PERFECT assessment scheme and muscle grading (grades 0-5). Further information is available from Laycock and Jerwood, 2001.

Assessment	
<p>Evidence statement</p> <p>Assessment of incontinence</p> <p>Completion of an appropriate assessment proforma, a frequency /volume chart and urinalysis prior to treatment, will assist in the planning of a patient specific treatment programme. Grade III</p>	<p>Recommendation</p> <ul style="list-style-type: none"> • Initial assessment and continuous reassessment are carried out • A proforma will facilitate the collection of relevant data • Evidence of a clinical examination and information gathered from the patient and other relevant sources, is recorded • A frequency/volume chart (bladder diary) is completed before and after treatment • Urinalysis is carried out prior to treatment
<p>Quality of life assessment</p> <p>It is important to take into account quality of life issues. Standardised tests are available to assist in this process. Grade III</p>	<ul style="list-style-type: none"> • A quality of life assessment is undertaken to assist in the overall evaluation of the outcome of intervention.
<p>Patient education & management</p> <p>Education is a key component of any successful treatment. Grade III</p>	<ul style="list-style-type: none"> • Patients are given information on the anatomy and physiology of the lower urinary tract and pelvic floor muscles • Information is given prior to any objective evaluation • Patient education is essential to assess the suitability for treatment • On-going education is essential for successful treatment.
<p>Pelvic Floor Assessment</p> <p>Consent to examination and treatment is essential. Situations requiring chaperoning must be considered. Grade III</p> <p>Digital assessment identifies whether or not a correct pelvic floor muscle contraction is performed. Grade II</p> <p>Pelvic floor muscle contractions can be graded. Grade III</p> <p>Careful pelvic floor assessment enables the planning of a patient specific exercise programme. Grade III.</p>	<ul style="list-style-type: none"> • Policies are in place to guide staff on the requirements for informed consent • Prior to assessment and treatment, patients' informed consent is obtained and recorded in their notes • The patient is given the opportunity to bring or have a chaperone • Standards of Physiotherapy Practice relating to privacy and dignity are adhered to • A digital assessment via the vagina is undertaken to assess correct pelvic floor muscle contraction • ◆ The PERFECT assessment scheme is used to provide a baseline measure of function (Laycock and Jerwood, 2001) • The results of the pelvic floor assessment are used to inform decisions about treatment • ◆ Women graded 0,1 or 2 are offered one or more of the following treatments: electrical stimulation, biofeedback and/or cones • ◆ Women graded 3, 4 or 5 are offered pelvic floor muscle exercises.

Precautions and Contraindications

As part of the assessment and treatment process the following precautions (P) and contraindications (C) should be considered.

Presenting Conditions	Assessment and Treatment options:				
	Vaginal examination	Pelvic floor muscle exercises	Biofeedback	Cone therapy	Neuromuscular Electrical Stimulation / Interferential Therapy
Pregnancy					C*
Pregnant with history of miscarriages or advised to avoid sexual intercourse whilst pregnant	C		C	C	C
Inflammation and/or infection of the vulva and vagina	P		P	P	C
Pelvic surgery in the previous three months	P		P	P	P
Psycho-sexual problems	P		P	P	P
Moderate and severe prolapse				P	
Menstruation & within 2 hours of intercourse - due to excess secretions				P	P
Atrophic vaginitis					C
Altered vaginal sensation					P
Patients on anticoagulant therapy, history of pulmonary embolus or deep vein thrombosis					C (IFT only)
Use of suction electrodes in patients who bruise easily					C (IFT only)
Application of electrodes over active or suspected malignant tumours					C
Patient with epilepsy should only be treated following consultation with an appropriate medical practitioner					P
Patients who do not comprehend instructions and are unable to cooperate	P	C*	C*	C*	C
Abnormal/malignant cells in pelvis or abdomen					C*
Severe allergic reaction to electrode/electrode gel					C
Recent or current haemorrhage or haematoma					C

Presenting Conditions	Assessment and Treatment options:				
	Vaginal examination	Pelvic floor muscle exercises	Biofeed-back	Cone therapy	Neuromuscular Electrical Stimulation / Interferential Therapy
Selection of appropriate stimulation parameters to avoid muscle damage					P
Compromised circulation					C
Open wounds and/or abrasions in the area of stimulation					C
Implanted pacemaker (especially demand type)					C

* **Note:** These contraindications are additions to the original guideline. They arose from comments made by the pilot sites, the guideline development group and subsequent discussions with researchers. Although there is no strong research evidence, there is consensus that these contraindications/precautions should be applied in clinical practice.

Treatment Options: Summary of Evidence statements and recommendations

Evidence Statement	Recommendation
<p>Adherence</p> <p>Adherence to a treatment programme improves outcome, Grade III</p>	<ul style="list-style-type: none"> • Written instructions for treatment are provided • Patients receive regular treatment sessions and contact with the therapist • Checks are made to ensure the patient understands the instructions • Individual goals for each patient, which minimise lifestyle changes are set • Positive feedback is given at every consultation.
<p>Pelvic Floor Muscle Exercises (PFME)</p> <p>Pelvic floor muscle exercises are effective in the treatment of stress urinary incontinence, Grade I</p> <p>Pelvic floor muscle exercises should be performed every day, Grade III</p> <p>In sports settings, strength training effects may occur during the first 6-8weeks; however, it may take a minimum of 15-20 weeks to produce muscle hypertrophy, Grade III</p>	<ul style="list-style-type: none"> • Pelvic floor muscle exercises are used to reduce the symptoms of Stress Urinary Incontinence • Pelvic floor muscle awareness is taught • The pelvic floor is assessed and exercised in functional positions • The use of anticipatory pelvic floor muscle contraction immediately prior to an activity that causes urine leakage, ("the Knack") is taught.

Evidence Statement	Recommendation
<p>Improvement in symptoms may be noted after one week, Grade II</p> <p>Muscle strength will be lost unless exercises are continued on a regular basis, Grade II</p> <p>Pelvic floor exercise increases the strength of the pelvic floor muscles, Grade II</p> <p>Pelvic floor muscle exercises should involve fast and slow twitch fibres and be performed in a variety of positions, Grade III</p>	<ul style="list-style-type: none"> • Patients are initially seen weekly but account may need to be taken of their circumstances and / or the available resources • A programme of Pelvic floor muscle exercises are tailored to individual patients and includes exercises for both fast and slow twitch muscle fibres (exercises should include both endurance & fast contractions) • Pelvic floor muscle exercises are performed until the muscle fatigues, several times a day • Pelvic floor muscle exercises are practised for 15-20 weeks • Pelvic floor muscle exercises are continued on a maintenance programme
<p>Biofeedback</p> <p>Biofeedback can help to ameliorate the symptoms of stress urinary incontinence, Grade II</p> <p>Biofeedback is a useful tool for teaching a correct pelvic floor muscle contraction, Grade II</p> <p>Biofeedback can increase motivation and adherence, Grade III</p>	<ul style="list-style-type: none"> • Biofeedback can be used to teach correct Pelvic floor muscle exercises • In the absence of manometry and electromyography, other forms of biofeedback should be used • Biofeedback can be used to increase motivation and adherence
<p>Cone Therapy</p> <p>Cone therapy can activate the pelvic floor muscles in women with and without a palpable contraction, Grade II</p> <p>Cone therapy can reduce the symptoms of stress urinary incontinence, Grade II</p>	<ul style="list-style-type: none"> • Cone therapy can be used as a useful exercise and biofeedback device even for patients without a palpable voluntary contraction
<p>Neuromuscular Electrical Stimulation (NMES)</p> <p>Selection of safe and suitable electrical parameters and will ensure safe and effective muscle training, Grade II</p> <p>Electrical stimulation can be used to facilitate and strengthen pelvic floor muscles, Grade II</p> <p>Acute maximal neuromuscular electrical stimulation via the vaginal route can produce a pelvic floor contraction, Grade II</p> <p>A patient's ability to contract the pelvic floor muscles will be improved by supplementing the use of electrical stimulation with their own efforts and vice versa. Grade III</p>	<ul style="list-style-type: none"> • The selection of safe and suitable electrical parameters is important. The guideline development group recommends the following, although different parameters have also produced effective pelvic floor muscle training: <ul style="list-style-type: none"> • Frequency: 35Hz • Pulse width: 250µs (0.25ms) • Current type: bi-phasic rectangular Intensity: maximum tolerated Duty-cycle: 5s on / 10s off. Very weak muscles: 5s on / 15s off • Treatment daily/twice daily (home treatment) • Treatment time: 5 minutes initially, gradually increasing to 20 minutes.

Patients with pelvic floor muscle contractions registering a grade 0 or 1 on the modified Oxford scale ◆ are unlikely to be able to undertake a course of pelvic floor muscle exercises; they may therefore benefit from a course of neuromuscular electrical stimulation, Grade III

- ◆ Neuromuscular Electrical Stimulation is a treatment for women who demonstrate a grade 0,1 (or possibly grade 2) on the modified Oxford scale and would otherwise be unable to re-educate their pelvic floor muscles
- ◆ Once a grade 3 voluntary contraction is achieved, electrical stimulation may be discontinued and physiotherapy continued with pelvic floor muscle exercises
- The vaginal route is recommended. However, nulliparous women who have not used tampons and are not sexually active, may find a vaginal electrode difficult and painful to insert
- Patients should "join in" with the electrically induced contraction
- Battery operated home stimulation units should be used between treatments.
- Precaution - Selection of appropriate stimulation parameters to avoid muscle damage



Outcome measures

The authors of the guideline described several measures that they suggested would be useful in evaluating change or no change in this patient population. The following section gives an outline of information about accessing these measures. The list is not exhaustive but exemplary and is designed to assist in accessing the measure, rather than be an appraisal of each measure. It is based on the recommendations of the Committee of the International Continence Society, and readers are directed to this for more detailed information (1). As far as the CSP is aware the measures described are free to use, and the details of distributors are correct, but these cannot be guaranteed.

Aim of intervention	Name of measure	Acronym	Number of Items	References
Symptom Assessment	Bristol Female Lower Urinary Tract Symptoms Questionnaire	BFLUTS	34	2
	Urogenital Distress Inventory Short Form	UDI-6	6	3,4,5
	Symptom Severity Index	SSI	5	6
	King's Health Questionnaire	KHQ	21	6,7
	Symptom Impact Index	SII	4	6
Impact on Quality of life - Incontinence specific questionnaires	International Consultation on Incontinence Questionnaire Short Form	ICIQ-SF	4	9,10
	Quality of life in persons with urinary incontinence (I-QOL)	I-QOL	22	11, 12
	Incontinence Impact Questionnaire Short Form	IIQ-7	7	3, 5, 13, 14
	Urge-Urinary Distress Inventory	U-UDI	9	15, 16
	Urge-Incontinence Impact Questionnaire	U-IIQ	30	15, 16
	Urge Impact Scale	URIS	24	17



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Outcome measures *continued*

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Guidance on carrying out an audit

This section provides general guidance for carrying out an audit project. It has been written to reflect the cyclical nature of audit as a system for continuous improvement. Section V contains information specific to the stress urinary incontinence audit regarding data collection and data analysis using the stress urinary incontinence data collection form.

The audit process can be broken down as follows:

The people

1. Identify a project co-ordinator
2. Identify a project team
3. Identify a data collector

The project

4. Define the timescale
5. Agree inclusion criteria
6. Agree the method of sampling and sample size
7. Brief project participants

Data collection

8. Collect the records and relevant documents
9. Collect the data
10. Analyse the data and report the results

Clinical improvement

11. Present and discuss the results
12. Formulate and agree recommendations
13. Implement the recommendations
14. Re-audit
15. Feedback.

Stage 1 Identify a project co-ordinator

A project co-ordinator should be identified to manage the audit and to lead a small project team. The project co-ordinator may be a member of the audit staff or a therapist. If a therapist, this may be a member of staff who is undertaking the role of project co-ordinator as part of their annual objectives or continuing professional development.

The role of the project co-ordinator, in association with the project team, is to:

- Manage the project ensuring completion of each stage including the implementation of recommendations and re-audit
- Formulate the project plan prior to formal commencement of the project considering each stage of the project and involving and informing the relevant person(s) in the project team
- Provide a link between the project and the audit department

- Maintain the momentum of, and interest in, the project.

Stage 2 Identify a project team

A project team should be formed which will provide advice at each of the stages. The project team should include the following:

- A physiotherapist directly involved with the service
- A manager to represent physiotherapists working with the target group
- The data collector
- The project team should consider the involvement of a consumer particularly during the development and implementation of the recommendations
- It may be appropriate to include another profession involved with delivering care to the target group e.g. a nurse continence specialist
- A member of the clinical audit department in an advisory capacity.

Even if the clinical audit department are not directly involved with the project, it is still important that the local audit department is informed of the project as early as possible. They then have the opportunity to include the project within their work plan. They may still be able to offer advice and practical help on a range of issues such as sampling or analysing the data.

Note that the clinical audit department may be known as a clinical audit, clinical governance or clinical effectiveness department, dependant on local circumstances. This document refers to clinical audit department as an all-encompassing term.

Stage 3 Identify a data collector(s)

The project co-ordinator should identify a data collector. The two will work closely throughout the project. If the project requires the interpretation of clinical case notes it will be helpful if the data collector is a physiotherapist. If the data collector is not a physiotherapist, for example if they are a member of the audit department, a physiotherapist will be required to assist the data collector during the data collection stage to interpret the case notes. To avoid bias and maintain objectivity the data collector should be a member of the therapy staff who did not complete the records and who is not directly involved with the delivery of the stress urinary incontinence service.

The role of the data collector is to:

- Identify the patient records and documents to be sampled
- Take a sample of the records
- Collect the data using the data collection forms
- Analyse the data
- Liaise with the project co-ordinator on each of the above
- Liaise with the audit department on each of the above.

Stage 4 Define the timescale

Agree a timescale. This should include:

- Start and finish dates for the project overall
- Start and finish dates for the patient record identification. A minimum period of three months for the inclusion of records for data collection is recommended.

If the audit is prospective a recommended start date for the patient record selection is six months prior to the start date for the audit, to allow for most patients to have completed the episode of care. The method of prospective audits is particularly appropriate where the aim of the audit is to explore the implementation of new information.

Audit is retrospective where there is collection of patient record information for patients who have already completed their episode of care. Retrospective audit is particularly appropriate to establish a baseline of activity prior to implementation of a guideline. A timescale should be selected for the inclusion of patient records.

Stage 5 Agree inclusion criteria

Criteria for the patients and records to be included in the audit should be agreed. For further information see Section V.

Stage 6 Agree the method of sampling and sample size

The project co-ordinator with the project team should decide on the sample size and sampling method. The data collector is responsible for taking the sample.

The sample size should be selected to reflect the distribution of the target group across the various clinical locations in the organisation and the variety of ways in which individual patients are managed. It is important that the method of selection is agreed and is adhered to by all parts of the service receiving referrals. If the data is being collected at more than one site, only by ensuring the same method for the sampling of patients, may comparisons be made between parts of the service. At this stage some preliminary discussion should take place concerning the analysis of data (Stage 9, Section IV).

Recommended method for taking a sample:

- Decide a method to identify the records for inclusion; those patients who meet the inclusion criteria and began their episode of care during the timescale. If this is a prospective audit, it may be useful to place an identifier on relevant records at the time the patient is first seen in the episode
- Keep a register of, or put to one side, the records of every person who meets the inclusion criteria during the timescale

- Physiotherapy records from all locations in the organisation where the patients have been managed must be identified. These should all be included in the audit and their data collected on a single data collection form. A single episode of care for a patient may consist of more than one set of records if the patient is managed in a number of locations or if they have been seen by a number of staff who each hold their own notes. Alternatively, a single set of multiprofessional notes may be included which includes documentation from other professions such as medical or nursing staff
- Calculate the total number who meet the criteria, and who have been discharged within the timescale. Document this number
- From the total number take a sample. Depending on the number of cases the service handles, these may be consecutive or, for example, every second or every fifth in consecutive order after discharge. If the total number is small, for example less than 20, include all the records collected.

Stage 7 Brief project participants

A briefing session led by the project co-ordinator should be held for all those involved with the project, including the data collector and the clinical staff delivering care.

The briefing session should include the following information:

- The guideline
- The project plan
- How the information from the audit will be used to improve clinical practice.

Stage 8 Collect the data

The data collector(s) should discuss the data collection form with the project team prior to collecting the data. It will be useful to discuss how the information in the data collection form can be found in the patient records, for example a standardised assessment form may have been developed locally. Section V provides guidance on completing the data collection form which will be useful during this discussion.

The following process should be followed by the data collector:

- Collect the records for each person who meets the inclusion criteria during the timescale
- Collect other documents relevant to the audit e.g. policies/ protocols for service delivery, patient information leaflets
- Take a sample (see Stage 6, Section IV)
- The forms should remain anonymous.

Stage 9 Analyse the data

The data collector should undertake the data analysis to maintain objectivity and prevent bias. For further information refer to Section V. Discussions on data analysis should be ongoing throughout this stage as suggestions for further analysis may be offered as trends arise.

During Stage 3 the data collector, the project co-ordinator and the project team should have discussed the following:

- The method for analysing the information collected from the records in Stage 8
- How the results should be presented, for example tables, pie or bar charts.

Stage 10 Present and discuss the results

A discussion about the results should be led by the project co-ordinator and include all those involved with the project; clinicians delivering care, the project team and the data collector. It would also be useful to involve all those whose work impacts upon the delivery of care to this group of patients, for example medical and nursing staff.

It is important that the discussion takes place in a supportive and non-judgmental environment. It may be useful to refer to the guidance on Peer Review in the Standards of Physiotherapy Practice pack, available from the Chartered Society of Physiotherapy (CSP, 2000b).

The aim of the discussion is to identify areas where actual clinical practice did not meet the recommendations in the guideline and to suggest reasons for this e.g. a need for staff training.

Stage 11 Formulate and agree recommendations

The recommendations should reflect areas from the analysis where actual clinical practice varied from that recommended in the guideline and from the discussions in Stage 10. In order to gain commitment from those responsible for implementing the recommendations, the relevant people should be involved in developing them. A table format is recommended to include:

- A statement of the recommendation
- Who is responsible for each element of the implementation process
- A timescale, where appropriate
- Additional space for comments where required.

Stage 12 Implement the recommendations

To ensure effective implementation of the recommendations, the following stages should be included:

- Dissemination of the recommendations to all those involved with delivering care and to whom responsibility for implementing the recommendations is apportioned
- Consideration of methods for change management

- Writing and dissemination of an interim report to communicate a clear rationale for how the project was undertaken, the results, how the recommendations were developed and a date for the re-audit.

Stage 13 Re-audit

A re-audit should be undertaken following implementation of the recommendations. A minimum of 6 months is recommended following the initial audit prior to the re-audit to allow for implementation of the recommendations.

The results of the re-audit should be compared with the results from the initial audit and should demonstrate an improvement.

Stage 14 Feedback

This is the final stage of the project, which should include all those involved in Stage 10. Feedback should address the following areas:

- A comparison of the results of the initial audit and the re-audit
- Final report
- Discussion of any qualitative information available, particularly where it relates to the guideline recommendations
- Action taken in response to the recommendations
- The effects of the recommendations and the value of audit.

Report

Both the interim and final report should be written in the third person i.e. 'it is recommended that...' instead of 'I recommend...' or 'we recommend'. The following framework for an audit report is suggested: Each section includes a list of components which may be included.

Introduction

- The aims of the project
- The general question that the audit intended to answer. For example, Audit to compare actual clinical practice with the recommendations in the Clinical Guidelines for the Physiotherapy Management of Females aged 16-65 years with Stress Urinary Incontinence.

Methodology

How the audit was carried out, to include:

- The data collection form used
- The method for sampling

- Whether the audit was retrospective or prospective
- How the data was collected
- How the recommendations were developed.

Results

- Results from the audit and re-audit
- Identification of any changes demonstrated by the re-audit
- The data should not be discussed here
- Present the data in tables and figures, highlighting key information in the tables within the accompanying text.

Discussion

- Whether the results could have been biased in any way
- Methodological problems with the study and whether it could be improved
- Any problems in carrying out the project
- Issues raised by implementing the recommendations
- Whether any of the results were surprising and reasons for this.

Conclusion

- The effect of the audit and what conclusions can be drawn from the results
- Reference should be made back to the aims and whether they were achieved, for example reflect the way in which practice has changed or the recommendations have been implemented
- Further recommendations and a suggested date for a further re-audit.

Guidance on carrying out the Stress Urinary Incontinence audit

This section provides specific information on carrying out the stress urinary incontinence audit and addresses the collection of data. Section IV provides general information on undertaking an audit project. The information in this section follows the structure of the data collection form. It will be useful to have the data collection form (Section VI) available whilst reading this section. For details of the recommendations and the evidence supporting them, reference should be made to the guideline.

Stage 5 Inclusion criteria

The inclusion criteria should reflect the guidelines, that is, Females aged 16 – 65 years with Stress Urinary Incontinence.

Stage 6 Agree the method of sampling and sample size

All questions require documentary evidence. However, It is possible that, due to local protocols, the required information will not always be found in individual patient records. Documentation on service structure, written home exercise programmes, patient information sheets, patient feedback forms, peer review and other written information provided to patients, may be required. Guidance notes throughout the data collection form suggest when additional information may be required and where it may be found.

Stage 8 Collect the data

The data collection form consists of 2 parts, A and B. Parts A and B should remain confidential. Relevant guidance notes are in italics on the data collection form.

Part A

Complete one form for each patient's episode of care. All of the questions require documentary evidence which should be found in the case notes. If a single patient has a number of records from a number of locations or from a number of therapists or a range of documents are used to provide evidence the data from all of these should be included on a single form.

Part B

Each patient in the sample should be allocated a code and their identity should be recorded on the Patient Identification Record, which should be stored securely as with other patient records. The original patient records can therefore be traced back if checking is required.

Stage 9 Analyse the data

Data analysis need only be performed on the Yes/No criteria that reflect adherence to the guideline.

Stage 10 Present and discuss the result

In discussing the results and developing the recommendations, specific attention should be given to areas where a recommendation was not implemented or where n/a was cited. For example (11.4) *The guideline recommends treatment parameters whilst acknowledging that different parameters have also produced effective pelvic floor muscle training.*

Section A - Assessment

Complete one form for each patient
Stress Urinary Incontinence audit pack

Data collection form

Patient Identification Code:

Details of person completing section:

Name: _____

Job title: _____ Department: _____

Date form completed: - -

1 Assessment of incontinence

Is there evidence that:	Yes	No	N/A
1.1 An initial assessment was carried out	<input type="checkbox"/>	<input type="checkbox"/>	
1.2 A proforma was used to collect relevant data <i>A Proforma is included in the guideline</i>	<input type="checkbox"/>	<input type="checkbox"/>	
1.3 A clinical examination was carried out and information was gathered from the patient and other relevant sources	<input type="checkbox"/>	<input type="checkbox"/>	
1.4 A frequency/volume chart (bladder diary) was completed before assessment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1.5 A frequency/volume chart (bladder diary) was completed after the treatment episode	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1.6 Urinalysis was carried out prior to treatment and the results recorded	<input type="checkbox"/>	<input type="checkbox"/>	
1.7 A quality of life assessment was undertaken.	<input type="checkbox"/>	<input type="checkbox"/>	

2 Patient education and management

Is there evidence that:	Yes	No
2.1 The patient was given information on the anatomy and physiology of the lower urinary tract and pelvic floor muscles. <i>A standard patient information leaflet may be used. For the content of this refer to the service protocols.</i>	<input type="checkbox"/>	<input type="checkbox"/>

3 Informed consent

Is there evidence that:	Yes	No
3.1 Policies are in place to guide staff on the requirements for informed consent <i>Refer to service protocols</i>	<input type="checkbox"/>	<input type="checkbox"/>
3.2 The Standards of Physiotherapy Practice relating to privacy and dignity were adhered to. <i>For further information see The Standards of Physiotherapy Practice (CSP,2000)</i>	<input type="checkbox"/>	<input type="checkbox"/>
3.3 Informed consent was recorded in the notes prior to assessment and treatment <i>Evidence may be found in the patient feedback questionnaire</i>	<input type="checkbox"/>	<input type="checkbox"/>
3.4 The patient was given the opportunity to bring or have a chaperone	<input type="checkbox"/>	<input type="checkbox"/>

Section A - Assessment

Complete one form for each patient

4 Pelvic floor assessment

- Is there evidence that:** **Yes No N/A**
- 4.1** A digital assessment via the vagina was undertaken to ensure correct pelvic floor muscle contraction
State N/A only if the case notes state that vaginal examination was considered and decided not to be appropriate eg due to contraindications.
- 4.2** The PERFECT assessment scheme was used to provide a baseline measure of function
For further information see Laycock and Jerwood, 2001
- 4.3** The pelvic floor was assessed in functional positions.

5 Precautions to carrying out a vaginal examination

If a digital assessment was undertaken is there evidence that the following conditions were eliminated or considered

A proforma or checklist may be used to gather this information

Yes No

- 5.1** Patients who are pregnant and have a history of miscarriages
- 5.2** Patients who are pregnant and have been advised to avoid sexual intercourse whilst pregnant
- 5.3** Inflammation and infection of the vulva and vagina
- 5.4** Pelvic surgery within the previous three months
- 5.5** Psycho-sexual problems
- 5.6** The patients understanding of the examination.

6 Treatment Adherence

Further information to support this section may be gathered from the patient feedback form

- 6. Is there evidence that** **Yes No N/A**
- 6.1** The patient received regular treatment sessions and contact with the therapist
Account should be taken of individual circumstances and / or the available resources.
- 6.2** Written instructions for treatment were provided
Copies of written instructions may be kept with the policies or protocols for service delivery and their issue recorded in the notes.
- 6.3** Checks were made to ensure the patient understood the instructions
- 6.4** Individual goals for each patient, minimising lifestyle changes, were set
- 6.5** Positive feedback was given at every consultation
- 6.5** Education was ongoing throughout treatment.

7 Analysis of assessment

- 7. Is there evidence that:** **Yes No**
- 7.1** The results of the pelvic floor assessment were used to inform the treatment
Information to support this section may be gathered from peer review. If the data collector is not a physiotherapist it may be helpful to gather information to support this section in association with a physiotherapist.

Section A - Assessment

Complete one form for each patient

- | | Yes | No |
|---|--------------------------|--------------------------|
| 7.2 If the patient was graded 0, 1 or 2 they were offered one or more of the following; electrical stimulation, biofeedback and / or cones. | <input type="checkbox"/> | <input type="checkbox"/> |
| 7.3 If the patient was graded 3, 4 or 5 they were offered pelvic floor muscle exercises | <input type="checkbox"/> | <input type="checkbox"/> |
| 7.4 The patient was reassessed throughout treatment. | <input type="checkbox"/> | <input type="checkbox"/> |

8 Pelvic floor muscle exercises

- | | Yes | No |
|---|--------------------------|--------------------------|
| 8.1 Were pelvic floor exercises used as a treatment method
(If no, proceed to section 9) | <input type="checkbox"/> | <input type="checkbox"/> |

8.2 If pelvic floor muscle exercises were used:

- | | | |
|---|--------------------------|--------------------------|
| 8.21 Was the patient graded 3, 4 or 5 | <input type="checkbox"/> | <input type="checkbox"/> |
| 8.22 If the patient was graded 0, 1, 2 was a rationale for pelvic floor exercises given | <input type="checkbox"/> | <input type="checkbox"/> |

- | | Yes | No | N/A |
|--|-----|----|-----|
| 8.3 Is there evidence that management with pelvic floor muscle exercises included: | | | |

- | | | | |
|--|--------------------------|--------------------------|--------------------------|
| 8.31 Education in pelvic floor muscle awareness | <input type="checkbox"/> | <input type="checkbox"/> | |
| 8.32 Exercises for the pelvic floor in functional positions | <input type="checkbox"/> | <input type="checkbox"/> | |
| 8.33 Instruction in the use of anticipatory pelvic floor muscle contraction immediately prior to an activity causing urine leakage ('the Knack') | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 8.34 An individually tailored programme of pelvic floor muscle exercises including exercises for both fast and slow twitch muscle fibres | <input type="checkbox"/> | <input type="checkbox"/> | |

Exercises should include both endurance and fast contractions. Further information may be gathered from peer review.

- | | | | |
|---|--------------------------|--------------------------|--------------------------|
| 8.35 Advice to perform pelvic floor muscle exercises until the muscle fatigues, several times a day | <input type="checkbox"/> | <input type="checkbox"/> | |
| 8.36 Advice to practice pelvic floor muscle exercises for 15-20 weeks | <input type="checkbox"/> | <input type="checkbox"/> | |
| 8.37 On discharge, advice to continue pelvic floor muscle exercises on a maintenance programme. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Further information and advice given to patients may be gathered from patient information leaflets and / or a patient feedback form.

9 Biofeedback

- | | Yes | No | N/A |
|--|--------------------------|--------------------------|--------------------------|
| 9.1 Was biofeedback used as a treatment method y/n/n/a
(If no, proceed to Section 10) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Indicate N/A only if biofeedback was considered and decided not to be appropriate eg due to contraindications.

9.2 If biofeedback was used as a treatment method:

Although the guideline recommends the use of biofeedback for patients graded 0,1,2. its use may also be considered for patients graded 3 or above. For further information on grading see Laycock & Jerwood, 2001

- | | Yes | No |
|--|--------------------------|--------------------------|
| 9.21 Was the patient graded 0,1 or 2 | <input type="checkbox"/> | <input type="checkbox"/> |
| 9.22 If the patient was graded 3,4 or 5 on initial assessment or reassessment was a rationale for biofeedback stated | <input type="checkbox"/> | <input type="checkbox"/> |

Section A - Assessment

Complete one form for each patient

- Yes No N/A**
- 9.22 In the absence of manometry and electromyography, other forms of biofeedback were used eg digital palpation.

9.3 Were the following indications for the use of biofeedback stated:

Information to support this section may be gathered from peer review. If the data collector is not a physiotherapist it may be helpful to gather information to support this section in association with a physiotherapist.

- Yes No**
- 9.31 To teach correct pelvic floor muscle exercise
- 9.32 To increase motivation and compliance

9.4 Is there evidence that the following conditions were eliminated/ precautions were considered. A proforma or checklist maybe used to gather this info.

- Yes No**
- 9.41 Patients who are pregnant and have a history of miscarriages
- 9.42 Patients who are pregnant and have been advised to avoid sexual intercourse whilst pregnant
- 9.43 Inflammation and/or infection of the vulva and vagina
- 9.44 Pelvic surgery within the previous three months
- 9.45 Psycho-sexual problems.

10 Cone Therapy

10.1 Was cone therapy used as a treatment method Y/N? NA (If no proceed to Section 11)

Yes No N/A

Indicate N/A only if the case notes state that cone therapy was considered and decided not to be appropriate e.g. due to contraindications.

10.2 If cone therapy was used as a treatment method:

Although the guideline recommends the use of cone therapy for patients graded 0,1,2 their use may be considered for patients graded 3 or above.

For further information on grading see Laycock & Jerwood, 2001

- 10.21 Was the patient graded 0,1 or 2
- 10.22 If the patient was graded 3,4 or 5 on either initial assessment or reassessment was a rationale for the use of cone therapy stated.

10.3 If cone therapy was used is there evidence that the following conditions were eliminated/precautions were considered.

A proforma or checklist maybe used to gather this information.

- Yes No**
- 10.31 Patients who are pregnant and have a history of miscarriages
- 10.32 Patients who are pregnant and have been advised to avoid sexual intercourse
- 10.33 Inflammation and/or infection of the vulva and vagina
- 10.34 Pelvic surgery within the previous three months
- 10.35 Psycho-sexual problems
- 10.36 Moderate and severe prolapse
- 10.37 Menstruation and within two hours of intercourse - due to excess secretions
- 10.38 *Patients who do not comprehend instructions and are unable to cooperate.

Section A - Assessment

Complete one form for each patient

11 Neuromuscular Electrical Stimulation (NMES) / Inferential Therapy (IFT)

11.1 Was the vaginal route for Neuromuscular electrical stimulation (NMES) used as a treatment method. If no, proceed to 11.8. **Yes No**

11.2 If Neuromuscular electrical stimulation (NMES) was used as a treatment method:

The guideline recommends the use of NMES for patients graded 0,1,2 however its use may be considered for patients graded 3 or above.

For further information on grading see Laycock & Jerwood, 2001

Yes No N/A

11.21 Was the patient graded 0,1 or 2

11.22 If the patient was graded 3, 4 or 5 on initial assessment or reassessment was arationale for NMES stated

11.23 Once a Grade 3 voluntary contraction was achieved was physiotherapy continued with pelvic floor muscle exercises.

11.3 Were the following treatment parameters documented in the clinical notes: **Yes No**

11.31 Frequency

11.32 Pulse width

11.33 Current type

11.34 Intensity

11.35 Duty cycle.

11.4 Were the following treatment parameters applied:

11.41 Frequency: 35Hz

11.42 Pulse width: 250 μ s (0.25ms)

11.43 Current type: bi-phasic rectangular

11.44 Intensity: maximum tolerated

Information may also be guaranteed from a patient feedback form

11.45 Duty cycle: 5s on/10s off. Very weak muscles: 5s on / 15s off

11.46 Treatment daily/ twice daily(home treatment)

11.47 Treatment time: 5 minutes initially, gradually increasing to 20 minutes.

11.5 Did treatment with NMES include:

11.51 Instruction to the patients to "join in" with the electrically induced contraction

Information may also be gathered from a patient feedback form

11.52 The use of battery operated home stimulation units between treatments.

11.6 If NMES was used is there evidence that the following precautions were considered:

A proforma or checklist may be used to gather this infomation

11.61 Altered vaginal sensation

11.62 Patients with epilepsy treated following consultation with an appropriate medical practitioner.

Section A - Assessment

Complete one form for each patient

11.7 Were the following contraindications to the use of NMES (or IFT) eliminated prior to its implementation:

Yes No

A proforma or checklist may be used to gather this information.

- | | | |
|--|--------------------------|--------------------------|
| 11.71 Patients who do not comprehend instructions and are unable to co-operate | <input type="checkbox"/> | <input type="checkbox"/> |
| 11.72 Implanted pacemaker (especially the demand type) | <input type="checkbox"/> | <input type="checkbox"/> |
| 11.73 Severe allergic reaction to electrode or electrode gel | <input type="checkbox"/> | <input type="checkbox"/> |
| 11.74 Inflammation and / or infection of the vulva and vagina | <input type="checkbox"/> | <input type="checkbox"/> |
| 11.75 Recurrent or current haemorrhage / haematoma | <input type="checkbox"/> | <input type="checkbox"/> |
| 11.76 Open wounds and / or abrasions in area of stimulation | <input type="checkbox"/> | <input type="checkbox"/> |
| 11.77 Atrophic vaginitis | <input type="checkbox"/> | <input type="checkbox"/> |
| 11.78 Abnormal smear | <input type="checkbox"/> | <input type="checkbox"/> |
| 11.79 *Pregnancy | <input type="checkbox"/> | <input type="checkbox"/> |
| 11.710 *Presence of abnormal or malignant cells in the pelvic or abdominal area. | <input type="checkbox"/> | <input type="checkbox"/> |

11.8 If Interferential Therapy was used in place of NMES is there evidence that the following contraindications were eliminated:

A proforma or checklist maybe used to gather this information.

- | | | |
|--|--------------------------|--------------------------|
| 11.81 Patients on anticoagulant therapy | <input type="checkbox"/> | <input type="checkbox"/> |
| 11.82 History of pulmonary embolus | <input type="checkbox"/> | <input type="checkbox"/> |
| 11.83 History of deep vein thrombosis | <input type="checkbox"/> | <input type="checkbox"/> |
| 11.84 Use of suction electrodes for patients who bruise easily | <input type="checkbox"/> | <input type="checkbox"/> |
| 11.85 * Pregnancy | <input type="checkbox"/> | <input type="checkbox"/> |
| 11.86 * Presence of abnormal or malignant cells in the pelvic or abdominal area. | <input type="checkbox"/> | <input type="checkbox"/> |

* **Note:** These contraindications are additions to the original guideline. They arose from comments made by the pilot sites, the guideline development group and subsequent discussions with researchers. Although there is no strong research evidence, there is consensus that these contraindications should be applied in clinical practice.

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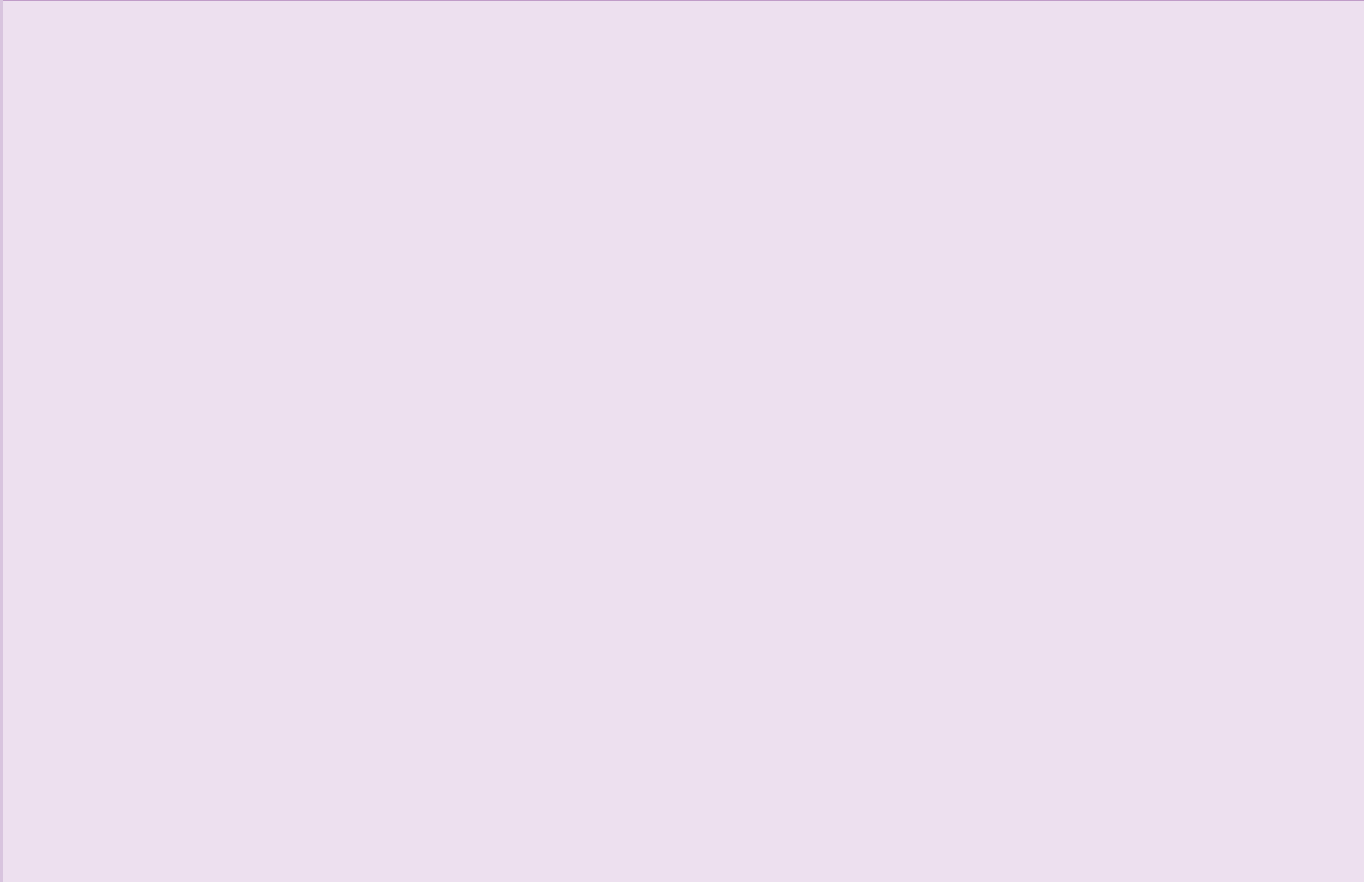
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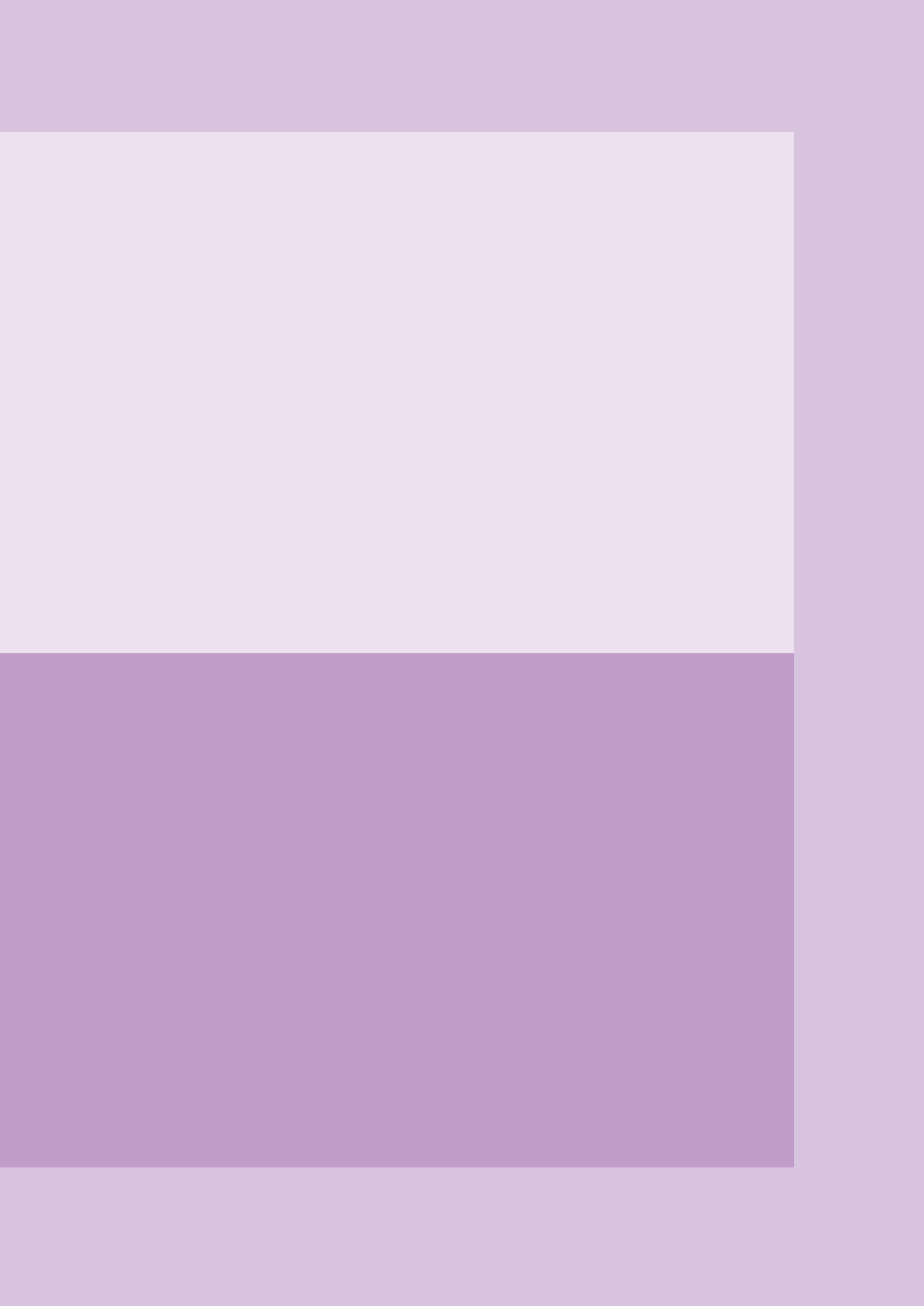
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