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Knowledge, Attitude, Practices and Obstacles to Provide Urinary Incontinence Care among Nurses

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Abstract

Purpose: Nurses are personalities who stand with patients at all times to listen and solve their problems. Excellent knowledge, good practices and positive attitude of nurses proves very effective for improving patients with urinary incontinence in a mannered way. The study objective was, (a) evaluate the knowledge, attitudes and practices among nurses of urinary incontinence, (b) reveal the relationship between knowledge, attitudes and demographic characteristics and (c) evaluate obstacles faced by nurses during urinary incontinence care.

Methodology: A cross-sectional study was accompanied in a government tertiary care hospital in Lahore, Pakistan. To analysis the variables statistical packages for social sciences version 25 was used. Pearson correlation test was used to correlate the knowledge, attitude and practices regarding urinary incontinence. Less than P>0.05 is significant.

Findings: 164 nurses contributed in the studies and 157 completed and return the survey questioner, with return rate of 95.7%. Of those, 117(74.5%) were female nurses and 40(25.5%) were male nurses. There is a significant correlation found between knowledge with attitude items 0.046 and knowledge with practice items 0.039. The study respondents have good knowledge, positive attitude but wrong practices regarding urinary incontinence.

Unique contribution to theory, practice and policy: It is concluded that Nurses have good knowledge, positive attitude but wrong practices that require special training or workshops to managing and treating incontinence more efficiently. This helps to bring significant improvement in urinary incontinence care and helps to lower the heath care cost. Such clinical guidelines need to be made within the organizations to manage a significant proportion of patients with urinary incontinence.

Keywords: *Knowledge, Attitude, Practices, Obstacles, Urinary incontinence, Nurses*

INTRODUCTION

Urinary incontinence is a condition, when volunteer bladder control is lost. This could occur even though a person is sneezing or coughing. Leakage of urine without control can be annoying and any person can experience it at any age group. It effect on both men and women. This condition is generally Studies shows that this is a common issue with women and it can cause emotional restrain among physical and social activities resulting in compromised quality of life. UI cannot put the on risk but strongly impact on patients' life style in sense of social interactions and physical comfort. For treating and curing urinary incontinence the yearly health care expenses have been projected to be more than 65 billion dollars (Hu & Pierre, 2019).

The occurrence of urinary incontinence during the period of pregnancy in Europe is 26 to 71%, south and north America is 43 to 63% and in Pakistan 45%. There are many types of UI are found all around the world but the most common types are mix and stress incontinence. The women with late weeks of pregnancy face UI with low standard of living. During the period of pregnancy UI needs prompt evaluation by physician to provide quality care. Statics revealed that about 50% of women experience UI during their life span (Yaqub, Habib, & Shaheen, 2019). Nurses play a vital role in detecting, evaluating, monitoring, and preventing patients from facing urinary incontinence (Caliskan, Gulnar, Aydogan, Bayram, & Yagci, 2019). A descriptive study accompanied amongst 756 health care providers showed that health care providers' knowledge, attitudes, and practices are highly important to improve patients' quality of life. Nurses play more effective role than other healthcare professionals in providing education, exercises and treatment of urinary incontinence (Jang et al., 2015). However, many cross-sectional studies have shown that many nurses have very low knowledge of prevention, treatment and management of UI (Keilman & Dunn, 2010).

An optimistic attitude is necessary to put knowledge into practice as knowledge without help of attitude is not adequate for positive behavior. Practice short fall is a gap between knowledge and practice which suppress positive attitudes towards UI (Kelly & Byrne, 2006). Although UI is very common but only few women seek regardless of many effective treatments. Physicians should identify and treat the issues along with UI. If they are unable to treat the underlying cause then they must refer the patient to a specialist (Lukacz, Santiago-Lastra, Albo, & Brubaker, 2017). Complications related to chronic urinary incontinence include: skin problems such as sores on wet skin, rashes or skin infections, urinary tract infection (UTI) and impact on personal life can happen. Urinary incontinence is not constantly preventable. However, UI can be reduced by healthy balance weight, pelvic floor exercises, avoid use of caffeine or alcohol, quit smoking (Abrams et al., 2018).

Categories of UI consists of, stress urinary incontinence is leakage of urine with compression on bladder by lifting heavy objects or even a person laughs, sneeze and cough. Urge urinary incontinence is a condition in which involuntary urine lost by a strong urge, caused by diabetes, infection or acute brain disorder. Overflow urinary incontinence a continuous dribbling of urine, caused by bladder that doesn't empty totally. Functional urinary incontinence is state of mental or physical impairment that keeps a person to making it to the toilet. Mixed urinary incontinence is experienced by a people who have more than one type of urinary incontinence. UI assessment depends on clinical signs and symptoms and is different in children, men, women and older adults. On initial assessment diagnostic test are performed to rule out the underline cause like infection. Most of the time conservative treatment is used which includes physiotherapy and lifestyle changes. If diagnosis is not clear or primary therapies are failed to

overcome the issue then invasive interventions or surgery methods are being used (Thüroff et al., 2011).

LITERATURE VIEW

The analyses of the literature make known that there are negative responses by nurses toward urinary incontinence. Knowledge among nurses related to urinary incontinence is a central blockade in the application of actual incontinence treatments. As a result, it is important to assess nursing staff knowledge, attitude and practice in urinary incontinence care so that nurses can obtain satisfactory training and education to overcome the obstacles in providing care for patients with urinary incontinence. A study was conducted by Jokhio, Rizvi, & MacArthur in 2013 in a community in a village Sindh, a province of Pakistan and study shown that the occurrence of urinary incontinence compared to other developing countries of the world in rural areas of Pakistan registration of urine problem has been found very low, but this problem is usually found in women and affects their daily lives very much. There are very few people who get medical facilities to get out of urinary problem. A descriptive study was done in 2017 in a Military Hospital Rawalpindi to approach the incidence of UI and its related risk factors during pregnancy. Women quality of life during pregnancy can be improved with the help of communicating knowledge about preventive strategies during pre-birth period (Yaqub, Habib, & Shaheen, 2019). Urinary incontinence is predominant during the period of pregnancy. There was association in reduced risk of UI throughout pregnancy with previous use of contraceptive hormones (Kok, Seven, Guvenc, & Akyuz, 2016).

For the very first-time international consultation on incontinence was developed in 1988. According to that flow process, an algorithm was presented for the management of incontinence in a detailed structure (Abrams et al., 2018). Incontinence related screening questionnaires, at least three-day voiding record, measure the post-void residual and cough stress test are helpful tools during initial assessment. For all patients urinalysis should be well-arranged. In a series of distinct stages, methods to treat are directed at the subtype of urinary incontinence, which start with conservative management, mounting to physical devices and then medications, followed by referral to surgical interventions. Lifestyle changing, pelvic floor (strengthen) exercises, proper fluid intake, weight loss and cessation of smoking are proposal as to the best course of action for all types of urinary incontinence. FDA (Food and Drug Administration) from America (USA) have still not permitted stress incontinence treatment with medication. Pharmacologic therapy includes antimuscarinic and mirabegron medications are recommended for urge incontinence (Hu & Pierre, 2019).

Urinary incontinence is a medical problem with major influence equally on the lives of people experiencing incontinence and their caregivers as well. It causes significance inferences for local health economies in terms of delivery of health and social care to individual client or a whole community. Study reveals that Optimum Continence Service Specification (OCSS) helps in a decrease of urinary incontinence, better-quality of life, and also lesser healthcare costs (Franken, Corro Ramos, Los, & Al, 2018). Women of every age are victim of urinary incontinence. Past history, physical examination related to incontinence and UI stress diagnostic test can guide physician to diagnose urinary incontinence. Initial managing steps consist of alteration in behavior and lifestyle changes. Treatment of urgency incontinence can be done with drug therapy but in conservative measures it is not helpful. Furthermore posterior tibial nerve stimulation and sacral neuromodulation are used for drug refractory urgency

incontinence. For stress urinary incontinence midurethral synthetic slings are Safe surgical option (Wood & Anger, 2014).

Urinary incontinence effects on the quality of life on both gender and is parallel in frequency by age. Family physicians evaluate the rout cause and there is no need for further evaluation by urologist or gynecologist. The rudimentary workup is targeted at recognizing possible revocable causes and it is considered as chronic if there no reversible cause is acknowledged and needs to be jump on the next step. The subsequent phase is to detect the type of urinary incontinence which includes overflow, stress, and urge, functional and mixed. If it comes to know what kind of disease is, it is easy to treat it, if the type of urinary incontinence is not clear including laboratory test, then appointment to urologist or gynecologist should be considered (Khandelwal & Kistler, 2013).

METHODOLOGY

A descriptive study was accompanied during February, 2021 to April, 2021 in a government tertiary care hospital in Lahore. The study sample included 164 nurses who participated in study but only 157 nurses return the form after completion. Nurses who participated in study were working in radiation department, urology wards, dialysis wards, ICU (medical and surgical), coronary care units, neurosurgery department, gynecology wards and outpatient clinics. Participants were explained about the study plan and purpose. Inclusion criteria for the participants was, participants must be nurses and agree to participate in the studies. Nurses who were not willing to participate and those who will not complete the forms, student nurses and other healthcare professionals were excluded from the study.

After taking informed consent, participants were requested to fill-up a questioner including 5 tables covering demographic data (characteristics), urinary incontinence practices form, urinary incontinence knowledge questioner, urinary incontinence attitude scale that comprised likert-type questions and obstacles faced by nurses while providing urinary incontinence care to patients in different settings. These tables were established by the researchers based on the existing literature and studies. The characteristics data table kept in check about nurses' gender, education status, workplace, and duration of service providing, special education on urinary incontinence, any tool used by nurses to evaluate UI and provide nursing interventions. Practice form included whether they inquire about the number of continent voids, inquire as to alterations in bowel habit and ask about use of pads or any other protective devices. The answer always scored as 03, usually as 02, sometimes as 01, never as 0 score were marked. Maximum score for practice form was 09 and minimum was 0 (Henderson & Kashka, 2000). The obstacles faced by nurses in provision of urinary incontinence care were, no patient follow-up may be due to lack of education or lack of interest, patients are not stick to treatment and care plans at home, patient education material is not available and there is no proper space in hospital to evaluate patient with urinary in continence, no record keeping method, patient feel hesitate to share their sensitive issues and one of the most common and important issue was lack of knowledge and training for nursing staff. The urinary incontinence knowledge table was established by the researchers' existing literature (Caliskan, Gulnar, Aydogan, Bayram, & Yagci, 2019). Those questions measured nurses' knowledge regarding urinary incontinence and its types, drugs and diseases that lead to UI, different type of UI, intervention for UI, impact of UI on person's life and his or her personal and social relationships. The questions contained true and false statements to which contestants answered true, false, and I don't know (which was scored as false). Correct replies were given 1 point and incorrect replies were given as 0

points. The urinary incontinence attitude scale table was developed by the researchers' existing literature (Yuan, Williams, Liu, & Nursing, 2011). Statements on the urinary incontinence attitude scale were related to nurses' attitude in relation to care of the incontinent adults. Responses on the Likert scale went from "strongly disagree" to "strongly agree". Items were scored as following, strongly disagree as 1, disagree as 2, agree as 3 and strongly agree as 4. The statements were, initial involuntary loss of urine can be ignored, urinary incontinence is shameful, urinary incontinence is frustrating to take care of and managing urinary incontinence in time consuming.

Ethical Considerations

The guidelines and protocols set by the ethical committee were followed while accompanying the research. Written informed approval was taken from nurses (participants). All evidence and data collection was set aside confidential. Participants were left over unspecified throughout the study. Participants were assured that their identity will not be exposed in any publication consequential to this study.

Data Collection

For collect of data from different hospitals, permission was taken from the head nurses of the different wards and clinics to arrange suitable hours to reach the nurses participating in the study to explain the plan and procedure. At pre-set time, nurses were clarified about the study purpose of the study, and then questioner along with informed consent was distributed among nurses who participated in the study. It took about 20 to 25 minutes to solve the questioner.

Data Analysis

Data was analyzed by research supervisor and questioner was removed with missed or incomplete data, then questions and their answers were input on the IBM SPSS, version 25. The Pearson correlation test was used to correlate the knowledge, attitude and practice of urinary incontinence. Less than $P>0.05$ is significant.

FINDINGS AND PRESENTATION

164 nurses contributed in the studies and 157 completed and return the survey questioner, with return rate of 95.7%. Of those, 117(74.5%) were female nurses and 40(25.5%) were male nurses 146(93.0%) had diploma in general nursing, 11(7.0%) had bachelor's degree. All 157(100%) were working in government hospital, with 31(19.4%) of work experience equals or less than 1 year, 54(34.4%) had 2-3 years, 52(33.1%) had 4-5years and 20(12.7%) had 6-10 years' experience. Only 4(2.5%) had postgraduate education on urinary incontinence. Out of 157 the 79 (50.3%) were evaluating patients for incontinence, 61(38.9%) were using tool to evaluate the patients for urinary incontinence, 58(36.9%) were providing nursing interventions for patient with urinary incontinence. Moreover only 39(24.8%) nurses were willing to specialize in incontinence care in nursing if available. The highest obtainable score was 57 and the lowest was 0. The scale provided data to evaluate self-reported practice of nurses with regard to UI in adults (Table 1).

Table 1: Participant Characteristics and Urinary Incontinence Practices

Characteristics	*f* (%)
Gender	
Female	117(74.5)
Male	40(25.5)
Educational attainment	
Diploma in General Nursing	146(93.0)
Bachelor's degree	11(7.0)
Workplace	
Government hospital	157(100.0)
Duration of employment	
≤1 year	31(19.7)
2–3 years	54(34.4)
4–5 years	52(33.1)
6–10 years	20(12.7)
Postgraduate education on UI	
Yes	4(2.5)
No	153(97.5)
Evaluate patients for in continence	
Yes	79(50.3)
No	78(49.7)
Use tools to evaluate ui	
Yes	61(38.9)
No	96(61.1)
Provides nursing intervention for ui patients	
Yes	58(36.9)
No	99(63.1)
Willing to specialize in incontinence care nursing (if available)	
Yes	39(24.8)
No	118(75.2)

Table 2 provides the information regarding participant's knowledge towards urinary incontinence. 105(66.9%) participants' response was true that the UTI may cause urinary incontinence. Only 38(24.2%) respondents' response was negative that urinary incontinence is normally, a part of aging. Out of 157 participants 122(77.7%) have a knowledge that antihypertensive drugs and other medications cause urinary incontinence. Only 1(0.6%) response was false that urinary incontinence may be caused by coughing, sneezing, or running. Perianal sutures may cause urinary incontinence stated true by 62(39.50%) participants. Most of the participants true answered that involuntary urinary incontinence is called urinary incontinence. 4(2.5%) participants stated false that involuntary urinary incontinence is called stress urinary incontinence after a strong need to urinate. Mixed urinary incontinence is usually seen in immobilized patients true answered by 77(49.0%) participants. Most of the participants 108(68.8%) answered false that urge incontinence. 2(1.3%) answered true that urinary incontinence can only be treated by surgical intervention. 105(66.9%) participants answered true that it is not related to persons weight. Prevention are important true stated by 153(97.5%) participants. Only 5(3.2%) participants answered false that pelvic floor muscle exercise should be included in treatment. 41(26.1%) participants answered true that Urinary incontinence does

not cause an individual to become irritable, anxious and depressed. Most of the participants 116(73.9%) answered true that urinary incontinence affects the quality of life of individuals.

Table 2: Urinary Incontinence knowledge Items

S/no	Variable	True *f* (%)	False *f* (%)
1	Urinary tract infection may cause urinary incontinence.	105(66.9)	52(33.1)
2	Urinary incontinence is a part of normal life over 65 years.	119(75.8)	38(24.2)
3	Antihypertensive drugs, anxiety or sleep medications can cause urinary incontinence.	122(77.7)	35(22.3)
4	Urinary incontinence may occur after prostate surgery.	93(59.2)	64(40.8)
5	Diseases such as diabetes mellitus, stroke, Parkinson's can cause urinary incontinence.	140(89.2)	17(10.8)
6	Urinary incontinence may be caused by coughing, sneezing, or running.	156(99.4)	1(0.6)
7	Perianal sutures may cause urinary incontinence.	62(39.50)	95(60.5)
8	Involuntary urinary incontinence is called urinary incontinence.	122(77.7)	35(22.3)
9	Involuntary urinary incontinence is called stress urinary incontinence after a strong need to urinate.	153(97.5)	4(2.5)
10	Mixed urinary incontinence is usually seen in immobilized patients.	77(49.0)	80(51.0)
11	A 54-year-old female patient reported "very little urine leakage when exercising" and patient had urge incontinence.	49(31.2)	108(68.8)
12	Urinary incontinence is most common in men	30(19.1)	127(80.9)
13	Urinary incontinence can only be treated by surgical intervention.	2(1.3)	155(98.7)
14	Urinary incontinence is not related to a person's weight	105(66.9)	52(33.1)
15	Regarding urinary continence and bladder health, regulation of fluid intake, smoking cessation, weight loss, and constipation prevention are important.	153(97.5)	4(2.5)
16	Pelvic floor muscle exercise should be included in urinary incontinence treatment.	152(96.8)	5(3.2)
17	Drug therapy is not effective in the treatment of urinary incontinence.	88(56.1)	69(43.9)
18	Prevention is a secondary method used in the treatment of urinary incontinence.	26(16.6)	131(83.4)
19	Conservative treatment is only effective in the prevention process if it is provided before urinary incontinence occurs.	0(0.0)	157(100.0)
20	If fluid intake is restricted, incontinence decreases.	0(0.0)	157(100.0)
21	Urinary incontinence limits the individual's social life.	116(73.9)	41(26.1)
22	Urinary incontinence limits the individual's daily life activities and sexual life.	0(0.0)	157(100.0)
23	Urinary incontinence does not cause an individual to become irritable, anxious and depressed.	41(26.1)	116(73.9)
24	Urinary incontinence affects the quality of life of individuals.	116(73.9)	41(26.1)

Table 3 provides the information regarding attitude of study participants towards urinary incontinence. All of the study participants 157(100.0) disagree that initial onset of involuntary urine loss can be ignored. Only 45(28.6) study participants disagree that urinary incontinence is hard to talk. Most of the participants 148(94.3) agree that urinary incontinence is shameful. 119(75.8) out of 157 participants disagree that urinary incontinence is a person's fault. 116(73.9) participants agree that it may be prevented. Only 7(4.5) participants agree that surgical treatment of urinary incontinence is unnecessary and unsafe for the elderly. Most of the participants 135(86.0) agree that urinary incontinence is not serious. Only 5(3.2) participants agree that urinary incontinence can be effectively treated. 137(87.2) participants agree that urinary incontinence can be treated with medications. 20**(**12.8) participants disagree that urinary incontinence is frustrating to take care of. Only 6(3.8) participants agree that urinary problem should be reported when health problems are assessed. 100(63.6) participants disagree that managing urinary incontinence is time-consuming. 127(80.9) participants agree that family support is important in dealing with urinary incontinence. All the participants 157(100) agree that urinary incontinence is manageable. 7(4.5) out of 157 participants disagree that urinary incontinence hinders social interactions.

Table 3: Urinary Incontinence Attitude Items

S/no	Variable	Disagree *f* (%)	Agree *f* (%)
1	The initial onset of involuntary urine loss can be ignored.	157(100.0)	0(0.0)
2	Urinary incontinence is hard to talk about because it is an embarrassing problem.	45(28.6)	112**(**71.4)
3	Urinary incontinence is shameful.	9(5.7)	148(94.3)
4	It is the person's fault if they have urinary incontinence.	119(75.8)	38(24.2)
5	Urinary incontinence may be prevented.	41(26.1)	116(73.9)
6	Surgical treatment of urinary incontinence is unnecessary and unsafe for the elderly.	150(95.5)	7(4.5)
7	Urinary incontinence is not serious enough to warrant treatment.	22**(**14.0)	135(86.0)
8	Urinary incontinence can be effectively treated.	5(3.2)	152(96.8)
9	Urinary incontinence can be treated with medications.	20(12.8)	137(87.2)
10	Urinary incontinence is frustrating to take care of.	20**(**12.8)	137(87.2)
11	Any urinary problem should be reported when health problems are assessed.	6(3.8)	151(96.2)
12	Managing urinary incontinence is time-consuming.	100(63.6)	57(36.4)
13	Family support is important in dealing with urinary incontinence.	30(19.1)	127(80.9)
14	Urinary incontinence is manageable.	0(0.0)	157(100)
15	Urinary incontinence hinders social interactions.	7(4.5)	150(95.5)

Practice regarding urinary incontinence was observed in table 4. Out of 157 88(56.1) participants were sometimes explore the amount of continent voids (a tablespoon, a cup, etc.). Only 31(19.7) participants were always inquire about alterations in bowel habit. Most of the participants 67(42.7) were never ask about use of pads, briefs, or other protective devices.

Table 4: Urinary Incontinence Practice items

S/no	Variable	Always *f* (%)	Usually *f* (%)	Sometimes *f* (%)	Never *f* (%)
1	Explore the amount of continent voids (a tablespoon, a cup, etc.).	7(4.5)	19(12.1)	88(56.1)	43(27.4)
2	Inquire as to alterations in bowel habit.	31(19.7)	11(7.0)	45(28.7)	70(44.6)
3	Ask about use of pads, briefs, or other protective devices.	27(17.2)	4(2.5)	59(37.6)	67(42.7)

Obstacles to urinary incontinence care were showed in table 5. Most 103(65.6) of the participants were agree that there is lack of system for follow-up patients. 82(52.2) participants agree that at home patients not completing urinary incontinence treatment task. Out of 157 participants 104(66.2) disagree that urinary incontinence patients not being referred to nurses in outpatient clinics. 73(46.5) participants disagree that there is lack of patient standard record form. Only 25(15.9) participants disagree that there is lack of urinary incontinence trainings for nurses. 101(64.3) participants agree that treatment being rendered by physicians. Only 56(35.7) participants agree that urinary incontinence treatment in long-term nursing care. Most of the participants were agree that nurses not being assigned to provide urinary incontinence care.

Table 5: Obstacles to Urinary Incontinence Care

S/no	Variable	Agree *f* (%)	Disagree *f* (%)
1	Lack of systems for patient follow-up	103(65.6)	54(34.4)
2	Patient not completing urinary incontinence treatment tasks at home	82(52.2)	75(47.8)
3	Patient lack of interest	41(26.1)	116(73.9)
4	Lack of patient education materials	80(51.0)	77(49.0)
5	Lack of the physical space in the hospital to evaluate and train patients	77(49.0)	80(51.0)
6	Urinary incontinence patients not being referred to nurses in outpatient Clinics	53(33.8)	104(66.2)
7	Lack of patient standard record forms	84(53.5)	73(46.5)
8	Lack of urinary incontinence training for nurses	132(84.1)	25(15.9)
9	Treatment being rendered by physicians	101(64.3)	56(35.7)
10	Urinary incontinence treatment in long-term nursing care	56(35.7)	101(64.3)
11	Nurses not being assigned to provide urinary incontinence care	108(68.8)	49(31.2)

There is a significant correlation found between knowledge and attitude items of urinary incontinence (table 5).

Table 6: Correlations Between Knowledge and Attitude Items

		Knowledge score	Attitude score
Knowledge score	Pearson Correlation	1	-.159*
	Sig. (2-tailed)		.046
	N	157	157
Attitude score	Pearson Correlation	-.159*	1
	Sig. (2-tailed)	.046	
	N	157	157

Table 7 provides the information that there is a significant correlation between knowledge and practice items of urinary incontinency.

Table 7: Correlations Between Knowledge and Practice Items

		Knowledge score	Practice Score
Knowledge score	Pearson Correlation	1	.165*
	Sig. (2-tailed)		.039
	N	157	157
Practice Score	Pearson Correlation	.165*	1
	Sig. (2-tailed)	.039	
	N	157	157

DISCUSSIONS AND CONCLUSION

Discussions

The research questions addressed in this article were developed instruments and had reliable and valid measures of nurses' knowledge, attitude, practice and obstacles in previous studies. The urinary incontinence knowledge table was established by the researchers' existing literature.

A cross-sectional descriptive study was conducted in Turkey comprising 304 health care professionals (HCPs) to addressed knowledge, attitudes, and behaviors regarding execution and teaching of pelvic floor muscle exercise, 18 nurses were found with lowermost level of knowledge of UI among HCP which they gained in nursing schools. Another 6 months randomized controlled study in UK has prevailed that urinary incontinence treatment-based training for licensed nurses 25(N = 295) after nursing school education have found significantly reduce the episodes of urinary incontinence. The results of this study were almost the same as those gathered in other countries. It was concluded from this study that the desired level of knowledge is not enough for nurse to make them able to provide satisfactory care to the patients with UI. It is necessary to have adequate knowledge when nurses are playing role as trainer or consultant in different practice fields (Caliskan, Gulnar, Aydogan, Bayram, & Yagci, 2019).

An optimistic attitude is necessary to put knowledge into practice as knowledge without help of attitude is not adequate for positive behavior. Practice short fall is a gap between knowledge and practice which suppress positive attitudes towards UI (Kelly & Byrne, 2006). However, many cross-sectional studies have shown that many nurses have very low knowledge of prevention, treatment and management of UI (Keilman & Dunn, 2010).

Conclusion

It is concluded that nurses have good knowledge, positive attitude but wrong practices that require special training or workshops to managing and treating incontinence more efficiently. This helps to bring significant improvement in urinary incontinence care and helps to lower the heath care cost. Such clinical guidelines need to be made within the organizations to manage a significant proportion of patients with urinary incontinence. In Pakistan there is lack knowledge and communication skills lowers providing continence care. There is evidence in many countries like US, India and UK that clients appreciate the good communication skills provided by nurses, therefore they endorse that a continence nurse specialist should deliver basic continence care. A combined public health movement is required to build the profile of urinary continence care in Lahore, Pakistan. The part of community centered support is important but also difficult to apply. Urinary incontinence campaign can help increase awareness in primary health care workers who are in a perfect place to take on the role of case detection. Moreover, specific training or workshops in incontinence may improve the numbers successfully seeking help for urinary incontinence.

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