11th EAUN Meeting – sharing insights, unveiling opportunities

Nurses' meeting successful despite volcano eruption

Barcelona
16-20 April 2010

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15 April, evening: On the television - pictures of an ash cloud coming to Europe... Airplanes are staying on the ground. Hopefully tomorrow this will be over....

16 April: All airfields in Europe are closing or already closed. Ulli Haase (board member) calls me, she tells me that Bente Thoft (chair EAUN) is stranded in the Netherlands. After some phone calls we can join a bus to Barcelona sponsored by Astellas. So at 5.30 pm we start our 'Barcelona adventure'.

17 April: Twenty hours later we arrive in Barcelona (around 2.00 pm), just in time for Bente to open the EAUN Meeting.

Of the 400 nurses expected, between 100 and 200 arrived. Unfortunately, also some speakers didn't arrive. For the board, this was a very challenging situation. Some presentations were cancelled, some were taken over by colleagues, and some programme elements were re-arranged. But everybody was very understanding and basically almost the whole programme was presented.

EAU Secretary General P.A. Abrahamsson

At 15.15 Bente Thoft and Per-Anders Abrahamsson (Secretary General EAU) opened the EAUN Meeting. After the opening the new evidence-based guideline "Good Practice in Healthcare: Continent Urinary Diversion" was introduced. All delegates received a free copy. The board of the EAUN was very proud to announce that the guideline which was published last year - "Incontinent Urostomy" - is accepted by the National Clearing House. The board expressed their hope that this guideline will also be accepted. For the next publication the practice-based guideline "Urethral Catheterisation", section "Male Catheterisation" will be updated as an evidence-based guideline. The board requested members to apply to join this working group (more information is available on the EAUN website).

The Hollister-sponsored workshop "The ins and outs of intermittent catheterization" by D. Newman was very informative. Presented with a focus on US-based practices, the lecture pointed to a lot of similarities with Europe, but also differences. The latter were mostly about insurance and the way nurse practitioners are working in the USA.

Opening day reception

At the end of the day there was a wonderful welcome reception partly sponsored by AMGEN where nurses could meet and enjoy the Spanish sangria and lovely food.

W. De Blok

18 April
After the well-appreciated ESU-course on "Erectile dysfunction" which was held in the morning, W. De Blok replaced H. Van Muilekom to present the state-of-the-art lecture "New developments in urological cancer care including the nursing aspects". Here are some of the highlights from this lecture:

- Prostate cancer: the prostate pointer, which can be helpful in decision-making for the urologist and patient.
- The number of performed laparoscopic procedures has increased from 9% (2003) to 43% (2007). But both in open as well as laparoscopic procedures, the two major nursing challenges remain: ED and incontinence.
- Testicular cancer: many long-term effects like secondary malignancy, infertility, libido,etc.. Here too, there are many challenges for nursing interventions! The risk of developing second malignancy is 30%. In the first 2 years in 50% of cases the sperm is normal, after 5 years this is observed in 80%.
- Penile cancer: is uncommon, mostly in older men (> 60 years). After amputation, sometimes a perianal urostomy is necessary.
- Bladder cancer: The audience participated in the discussion on the need of an evidence-based guideline about instillation. Currently everybody does it in their own way and there are no standard recommendations available for nurses.

Sietske De Vries wins the 1st EAUN Urology Nursing Quiz

The first EAUN Urology Nursing Quiz took place with questions about urology, Barcelona and soccer. At the end four delegates had only one wrong answer. The final winner was selected by lottery. The prize – a free registration for the EAUN Meeting next year in Vienna - was won by Sietske De Vries from Amsterdam.

EAUN Chair Bente Thoft

The workshop *"Nursing tools for patients instruction on prostate cancer"* also new some replaced speakers and I would like to share some important take home messages from 'Prostate cancer: nursing and supportive care':

- High supportive care needs during therapy is predictive of unmet needs afterwards
- Treatment with radiotherapy or hormone therapy is a significant predictor of unmet needs
- Resources should be targeted to those who need them most
- Assessment is crucial
- Promote health and focus on prevention
- Need to develop supportive care strategies to reduce burden of illness

In the same workshop the presentation: *'The role of the nurse in diagnostic and bone health'* discussed that it is important to establish whether the bone-disease is due to androgen therapy or due to bone-metastasis. Important is the assessment of risk factors, such as medical history, life-style history and fall risk. Non-pharmacological treatment options include: advice about alcohol decrease, to stop smoking and on diet (calcium and vitamin D supplementation)

The next presentation: *"Hormone treatment and possible nursing interventions"* described hormonal therapy and side-effects, the need for monitoring effects and the complications. Treatment options are androgen deprivation or medical castration. The nurse is a part of a prostate team and nursing interventions are lined up to relieve side effects, treat, monitor effect, ensure QoL, prevent adverse events and research.

In the following lecture *"Patient perspective and patient education"*, L. Denis talked about the optimal medical treatment, patient-centred care, holistic approach, quality of life and equality. The organisation Europa UOMO is in partnership with many other organisations, including the EAUN. The next meeting is in Warsaw in 2010 and the EAUN is also invited.

Winning poster

A poster which discussed *"Parameters important for patient recovery undergoing radical retropubic prostatectomy"* (P10-s) drew some interesting conclusions: Urinary continence following radical prostatectomy seems to be the cornerstone in the process of regaining pre-operative social and functional capacity. Patient-reported continence 6 months following surgery strongly correlates to the results from pad tests. In other words pad tests can be omitted in patients stating continence.

An oral presentation about *"Profile of urology nurses in Turkey"* (O10-s) gave an overview of urology nurses working in Turkey. The Turkish urology nurses organisation is very young but it already has 130 members. There are many different education levels and nurses are not active in participating in scientific research. Urology nurses have to be supported in education and research by taking their expectations from the association into consideration.

"Nursing trainee ward for urological patients" (O5-s) described a project on an oncological ward, where nursing students learn about some of the most important issues, while practising in an authentic environment. Four students are coached by two nurses from the ward. The reason to start this project is the fact that in the near future the shortage of nurses is expected to increase. Importantly, research shows that students often continue to work in their final internship department.

"Assesment of nurses' support programme for self-removal of urethral stents with external strings by patients at their home guide by telephone assistance" (O9-p). Nurses' support programme for self-removal of stents by patients at their home significantly improves patients' understanding and acceptance. Considering the positive results of this study, the authors are in the process of establishing specific nurses' support programmes for other urological interventions.

19 April
We started with the EAUN general Assembly. After that the sponsored session by Astra Tech on *"Urological management of Spina Bifida during childhood and adolescence – what happens when entering adulthood"* was presented. Important issues were to convey good urological management, clean intermittent catheterisation training and education; to discuss that CIC changed the survival of Spina bifida patients reaching adulthood and to realise the importance of bladder management follow-up regardless of age.

The state-of-the-art lecture *"Quality of life (QoL) after cystectomy"* described how a cystectomy can influence the individual QoL. The objectives are to pay attention to a wide range of symptoms that may occur after a cystectomy and to how we can improve the care in order to support the affected individuals.

There are different measures of QoL: Generic (e.g. SF-36), Symptom-specific (e.g. IPSS), Cancer-specific (e.g. EORTC), Tumour group-specific (e.g. eTACT-B1), Treatment-specific. QoL differs in individual patients. The investigator did research in 190 patients with non-continent urostomy, 82 with a continent cuteneous reservoir, and 180 with an orthothopic bladder.

EAUN Board

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She used the VAS-scale, and asked the QoL questions in the last year. She assessed various parameters including anxiety, self-esteem and incontinence. In conclusion it was said that the number and grade of the symptoms influence the QoL, and not the type of diversions.

Then, a Vantas-sponsored presentation was delivered to the audience *"Vantas: a new era for prostate cancer management"*. Vantas is an implant for patients with advanced prostate cancer. It is implanted in the upper arm with a trochart, and before implantation some anesthesia is given. In some countries nurse practitioners perform this implantation, (removal and the replacement), which can be done in 2-7 minutes. Testosterone suppression is maintained for one year and is well tolerated.

The state-of-the-art lecture of J. Albaugh on *'Managing erectile dysfunction and quality of life'* was very interesting. Working as a nurse practitioner in this field he has the possibility to do a lot of conservative treatments, educate and do research.

In the workshop *"Ensuring continence in difficult cases"* two difficult cases were presented: *"Nursing care of post-ileal neobladder incontinence"* and *"Lluis 1-Cancer 0"*. Both were well-presented cases.
Next year this workshop will be open to all urological cases.

Prizes
Because only one author of an EAUN Nursing Research Project was present, the board decided that for an honest assessment the decision who won the award should be based on the research plan assessment, which had taken place by the jury before the meeting.

- The EAUN Nursing Research Project award went to E. Grainger (Denmark) et al. for *"Adherence to fast-track programmes within urology nursing care 2008-2010"*;
- The Poster prize went to L. Grunchy (Denmark) et al for *"Parameters important for patient recovery undergoing radical retropubic prostatectomy"* (P10-s);
- The Oral presentation prizes went to A. Ozbas (Turkey) et al. for *"Profile of urology nurses in Turkey"* and C. Ferrero (Italy) et al. for *"Realisation of a pediatric pathway in an adult urological division: a bet for nurse"*.

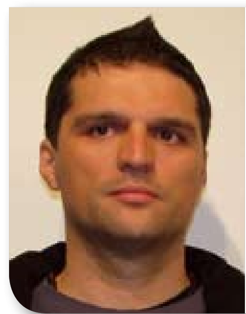
After the closing words by the board, there was the possibility for 20 nurses to visit the Fundacio Puigvert hospital, which was informative and exciting.

Last but not least, Ulli, Bente and Hanny sincerely thank Astellas, the Netherlands for the opportunity to travel to Barcelona with a bus arranged by the company.

Enthusiasm for the award winners

Realising a paediatric pathway in an Adult Urological Division

Providing a child-friendly environment provides challenges for the nurse



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Valle d'Aosta is a small mountain region in north-western Italy, with a population of about 120,000 inhabitants (about 15% in paediatric age). The paediatric surgical pathologies are generally treated by surgeons involved in the adult specialties. Specifically in Aosta, excluding neonathal surgery, the paediatric urology represents almost 80% of pediatric surgical pathology.

In 2008 we organised a specific team with a paediatric surgeon expert in urology, a paediatric anaesthesis, two anaesthesists with interest in paediatrics, two urological nurses, a midwife and a paediatric nurse. The challenge in our job was to build of a pathway for paediatric work within the division for adults, whilst maintaining a high level of assistance.

Our experience
The main problem in our hospital and in our Adult Division was the absence of a paediatric approach and mentality. Since our previous experiences both include paediatric nursing and midwife experiences) we adapted our behaviour with regards to parents and children in a paediatric direction. The presence of a paediatric urologist and an intern in Strasbourg (Prof. Becmeur, HUS Strasbourg, France) helped us. However, we faced many initial practical problems which remain up to this day.

Our problem or the initial question which we asked was 'where?'

The first step was to organise a rudimental outpatient activity in the urology ward. We actually use the waiting room and the areas utilised for endoscopy, which are close by but divided by the ward. We created a waiting room that is suitable for children, placed some toys, colour books and balloons. We realised that the time spent waiting may be an equally important issue as the check-up itself. The waiting time, in fact, may be used by the child to become acquainted with the environment.

The second problem is: when. We always scheduled the visits in the late afternoon or in the evening, at first for practical reasons. It eventually became the best solution for various reasons, such as: providing a calmer situation for parents (after the end of a working day), less stress for children, hospital activities are less intense compared with the morning activities, a proper day-time to see some pathologies such as hydrocele or hernia.

The third problem is: what.
The nursing part consists of various aspects, both psychological and practical. The first step is the initial contact and the relation with the nurse who informs the parents about the visit, the intervention and the other practical issues. During the visit, the nurse assists the doctor, helping the child to undress and, in particular, distracting the child during the visit while the doctor explains to the parents all the information they need to know.

Proper planning
Moreover, the main purpose of our project is to organise a supportive net for the child and parents, with the constant presence of the same contact persons, during the pathway, from the first visit to the end of the follow-up. We defined it as "FIL ROUGE". We believe that this principle may provide great results, in both human and professional aspects, and enable a correct risk management. We believe that the complex child-parents contact should always include "a friendly and familiar face."

The fourth problem is: how. Proper planning of all the activities and an updated database are also fundamental. We usually perform the blood analysis and electrocardiograph (ECG) in children less than three years old and in accordance with the anaesthesiologists, while the ECG is only done in children older than three years. Performing the blood analysis in our division also allowed us not to overload the paediatric ward with other work.

And in accordance with our hospital slogan *"The Hospital Without Pain,"* we decided to perform painless blood tests by applying local aaesthetics (EMLA), which are always done in the presence of two nurses. Meanwhile, the ECG becomes an important bonding moment when the nurse creates a close and friendly relation with a child.

Other activities include the positioning of a bladder catheter with a paediatric urologist, accompanying the child during diagnostic exams (voiding cystoscintigraphy, kidney scintigraphy, ultrasound, magnetic resonance, etc...), reassuring both the child and the parents in adult environments such as in the Radiology or Nuclear Medicine Divisions.

The challenges
Amongst the main difficulties or challenges are: paediatric mentality, avoiding an adult mentality or attitude when dealing with children, providing all the necessary equipment, experience in paediatric venous accesses, coordination with other hospital services and complex bureaucracy.

Regarding intervention, we decided to guarantee, whenever possible, a hospitalisation in the Paediatric Division, and actively promoting a cooperation with paediatricians in that delicate phase. The child enters the operating room in his own clothes, and a parent can accompany the child in the pre-operatory room. In some selected occasions, a parent can enter the operatory room during the induction time if it helps the child. Furthermore, the child can always bring a favorite toy or "doudou" to make the experience less traumatic.

Results
The following are the summary of the results after one year:

Skills: complete autonomy of all four nurses in venipuncture in children younger than three years. Two nurses are always present during venipuncture. (7-8 / month)

Outpatient: Five ambulatory/month (60-70 children), separated by the Urological Ward with a nurse present. Project "Ambulatory of fantasy"

Day Hospital: active participation during the diagnostic exams (blockage of child, catheter management, etc...) and during interdisciplinary clinical meetings. (four children/month)

Operation Room: a nurse present during the peri-operative phase. Two scopes: make the parents comfortable or at ease (by showing a "friendly familiar face") and continue the training in venous accesses. Two lists/month dedicated to children (1 for children < 3 years) with hospitalisation in the Paediatric Ward.

Territory: contacts between nurses and family and between nurses and paediatricians before the urological visit.

Update: One stage in Strasbourg; two congresses in Aosta; three international publications; attendance in three paediatric urological courses in Turin; attendance in two international congresses (EAU Barcelona 2010, SFCP Paris 2010).

EAUN Chair Mrs. Bente Thoft Jensen hands over the award to Mr. Trajkov (middle) and Mrs. Ferrero (right) for the oral abstract on the realisation of a paediatric pathway.

A feasible project
A paediatric urological activity is feasible in a peripheral hospital, and provides a more patient-friendly environment whilst incurring minimal costs. The main advantages for urological nurses include the widening of their skills and mentality, overcoming the fear to face or address the complex parents-child relationship, professional satisfaction and achieving paediatric experience. Furthermore, there is the potential to integrate the technical skills of an Adult Urological Division (endoscopy, laser, robot, urological experience) with a pathway or approach that is "children-sized." In creating this activity with high standards, we offer the possibility to many families not to consider or go to other regions.

We believe in this model which may, in the future, represent a far-sighted way of treating paediatric pathology in a district hospital. Quality does not only come from great numbers and great experience, but also from goodwill, enthusiasm and a thirst for knowledge. In a period of crisis, the opportunity of integrating adult and paediatric activity in a single division, whilst maintaining the international standards of nursing and medical care is, in our opinion, a road to follow and pursue.

EAUN Award winners

Prize for the Best EAUN Oral Presentation (Scientific Research)
N.K. Kanan, A.O. Ozbas, E.A. Aslan, Istanbul (TR)
For the paper: *"Profile of urology nurses in Turkey"*

Prize for the Best EAUN Oral Presentation (Scientific Research)
Z. Trajkov, C.F. Ferrero, D.D.C.D. Da Costa Duarte, E.C. Cecchelli, M.T. Trabucatto, C.V. Villanova, P.D. Denarier, P.P. Pierini, E.B. Baldassarre, Aosta (IT)
For the paper: *"Realization of a pediatric pathway in an adult urological division: a bet for nurse"*

Prize for the Best EAUN Poster Presentation (Scientific Research)
L. Gruschy, S.T. Nielsen, M.B. Andersen, Copenhagen (DK)
For the poster: *"Parameters important for patient recovery undergoing radical retropubic prostatectomy"*
Prizes supported by an unrestricted educational grant from Amgen (Europe) GmbH

Prize for the Best EAUN Nursing Research Project
E. Grainger, B.T. Jensen, W.A.K. Sahl, Århus & Hinnerup (DK)
For the project plan: *"Adherence to fast-track programmes within urology nursing care 2008-2010"*
Prize supported by an unrestricted educational grant from Ferring Pharmaceuticals

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Working for the EAUN's Guidelines Group

Challenges and hard work bring rewards for guideline members

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I am a clinical nurse specialist working in a large private hospital in northern England, and in 2008 I responded to an emailed invitation from the national association of urology nurses. The invitation was about the work by an international group which was developing guidelines for European nurses on the subject of incontinent urostomies.

I replied with a brief resume that showed why I could be of assistance. But I honestly wasn't expecting my application to be accepted as I thought the response would be huge and there would obviously be a lot more experienced nurses out there who would be better! I never had experience with a guideline group at this level although a lot of my previous tasks concerned guidelines development for the company I worked for.

A few weeks later I received an email from the EAUN inviting me to participate. The guideline group was also asked to research the topic and submit any relevant literature to the first meeting in Amsterdam. During the meeting the guideline members from across Europe were introduced and agreed on the content and process for guidelines development. Although I remember it as an exceptionally long day with a lot of hard work, the experience was also fun!

Our discussions of different practices across Europe were very lively at times. Agreeing on common standards of practice to be recommended throughout Europe proved challenging. By the end of the day we were all assigned sections of the proposed content and to write 'expert' information and guideline recommendations. This was the first EAUN guideline to be evidence-based and it proved to be quite a challenge by itself as a lot of the available research material was of a low academic standard.

The second meeting took place in December 2008 – a chance for us to be festive- although of course there was a lot of work to do! The work continued even at home until early 2009 when all our efforts finally ended in the publication of the new guideline, and to be presented for the first time at the EAUN Annual Conference.

Following the success of the first guideline, the same group was asked to produce a second guideline on continent urostomies. The process remained the same – a lot of preparation were done at home followed by two meetings in Amsterdam to fine-tune the draft document.

Most of the original group members returned for the second guideline group with the addition of two new members. Since we worked together before the process was easier. We certainly seemed to progress at a faster rate, and the second guideline was ready in time for the scheduled launching at the EAUN Annual Conference in Barcelona.

I thoroughly enjoyed my experience working with the EAUN, particularly the video conference call in early 2010 was certainly a new experience for most of us! My advice to anyone who reads this and have the interest to participate in something similar is – go for it!

There is a lot of work involved which are most often done in your own time, but it is certainly a rewarding and valuable experience. Many nurses do not receive the opportunity to work at an international level and produce this level of guideline, so if you have the knowledge, experience and enthusiasm, give it a try.

The EAUN Research Competition

Preliminary results of the winning research on post-TURP incontinence

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In 2008, I participated in the first research competition at the EAUN Annual Congress held in Milan. I experienced stage-fright during my presentation, and looking back my winning the prize made the experience all the more memorable.

Back at home it took me a lot of time to specify the research plan, work out all the methodology and submit the application to the ethical committee. Finally, in November 2008 I started the data collection to address the following research questions:

- How many patients treated by TURP in the Department of Urology were discharged home, post-operatively experiencing dribbling of urine?
- How do patients experience this early post-operative incontinence after TURP during the first month at home and after hospital discharge?
- Were these patients given adequate information by the nursing staff to deal with possible short-term incontinence following their discharge?

Study background

The International Continence Society defines urinary incontinence as "the complaint of any involuntary leakage of urine" (Abrams, et al., 2002). Although it is well-known in clinical practice that patients could be incontinent for a period early after TURP, there is limited available data about early incontinence rates in these patients during the first days and weeks at home following hospital discharge. This is probably due to the fact that outcome variables of medical and surgical treatments are usually long-term evaluations.

The background and the motivation for the study are based on the results of a pilot study with 32 patients. In this pilot study the aim was to evaluate nursing interventions regarding early post-operative incontinence following TURP. It showed that 50% of the interviewed patients reported urinary incontinence following TURP within the first weeks at home. It also showed that nurses did not sufficiently recognise the incontinence problems of these patients during their stay in the hospital.

Although it is the nurses' responsibility to educate patients on how to handle this problem at home, only 20% of the incontinent men received information from the nursing staff.

The results of this small pilot study motivated the nursing team of the Department of Urology and myself to initiate further steps. On a practical level, nurses were sensitised to early incontinence post-TURP, and patient information about pelvic floor muscle training and incontinence products were prepared and are available since September 2009. In addition, the larger study described here was planned.

Methodology

In this study a mixed methods approach was used. Thus, the study combined a descriptive design to assess the prevalence, symptoms and quality of life of early post-operative incontinence and a qualitative content analysis to explore more deeply the experiences of patients suffering from early incontinence.

Sample and setting

During one year, all men discharged post-TURP were considered for study participation. According to the power calculation, a sample of at least 59 men was needed. The sample size was estimated based on the literature (Rassweiler et al., 2006, Rigatti et al., 2006) that reported 30-44% of incontinence and the internal evaluation (50%, n = 16) of any form of incontinence.

An expected proportion of 40% and a total width of the confidence interval of 0.25 with a confidence level of 95% was fixed (Hulley, et al., 2001). Patients were included if they understood and spoke German and gave verbal informed consent. Cognitively impaired patients and those without telephone were excluded.

Study procedure

Patients were contacted by telephone during the first two weeks after discharge and informed consent was obtained. A structured interview was conducted with patients who agreed to participate. All telephone calls were made by the same study nurse of the department.

To assess symptoms and quality of life scores, the standardised and validated International Consultation of Incontinence Questionnaire short Form (ICIQ-SF) was used. This questionnaire was developed by an expert committee established by the International Consultation on Incontinence and is part of the guideline on urinary incontinence edited by the European Association of Urology (EAU, 2009). The questionnaire is recommended for investigation of urinary incontinence.

Questions about symptoms and quality of life are rated with scores. The higher the score, the worse urine leakage is and the higher the interference with quality of daily life. Quantitative data from structured telephone interviews were analysed using descriptive statistics. To assess the experience of nursing interventions, interview questions from the pilot study were used. I had developed these questions and they were all well understood by participants and all interviews worked well in the pilot study.

At the end of the structured interview, incontinent patients were asked if they would be willing to participate in a second interview and report to me their experiences. Men who agreed got written information about the second part of the study. When they sent back the signed consent form, I contacted them and performed the second interview.

An interview guideline with open-ended questions was used for the collection of the qualitative data. Interviews were tape-recorded, transcribed verbatim and analysed using qualitative content analysis as described by Morse & Field (1998).

Preliminary results

From November 2008 to October 2009, 110 eligible men were discharged from the Department of Urology post-TURP. With the 94 men who agreed to participate, a structured interview was performed. Only six men agreed to participate in the second interview. Most men stated that they recovered rapidly from early post-operative incontinence, that incontinence was not very bothersome for them and that they could already clarify their questions with the nurse during the first interview.

At the moment we are analysing data. Preliminary results show that:

- Urinary incontinence, defined as "the complaint of any involuntary leakage of urine" (International Continence Society) occurs in up to 30% of the men early after TURP and one third of them stated that this incontinence negatively impacted their daily life.
- During telephone interviews, patients asked questions about dribbling urine, blood in the urine and how to handle problems.
- Sensitising nurses was successful: significantly more patients got adequate information on how to handle incontinence problems at home.

Unfortunately, I could not attend the EAUN Annual Meeting held in Barcelona but I'm looking forward to present additional results such as quantitative and qualitative data at the next meeting in 2011.

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New evidence-based Good Practice in Health Care 'Continent Urinary Diversion'

The new publication was introduced in Barcelona and made available to all participants at no cost. All EAUN members that were not able to join us in Barcelona will receive a copy in the mail in the coming weeks!

We thank AstraTech for their support.

Male catheterisation.. still a taboo practice for nurses?

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The role of females catheterising males was widely discussed in the English nursing literature in the 1990s, but there is little reported about Australian nursing practice. This study was designed to determine the attitudes and practices of nurses in Victoria surrounding male catheterisation in the 2000s.

Anonymous, self-administered questionnaires were distributed to a convenience sample of nurses in all departments at a major public teaching hospital and in a surgical and medical ward of a large private hospital, both in Melbourne. Neither hospital has a dedicated urology ward. The questionnaires were also completed by ANZUNS members attending an annual meeting.

388 of 520 questionnaires distributed were returned. 11.5% of respondents were male, 87.6% female. Of the total, 44.4% have not catheterised a male patient. The most common reason for not doing do was that hospital policy did not allow it (33.3%). 21% stated they had never received appropriate training. 4% were concerned about the potential for complications. Of those nurses who do catheterise males the majority (56.9%) were taught "on the job", with only 33% receiving formal training.

Almost half of the respondents in this survey do not catheterise male patients. This is despite policies at both hospitals surveyed allowing nurses who have gained appropriate experience to perform this procedure. There appears to be a lack of opportunities for graduate nurses to learn male catheterisation technique in the hospital setting, and colleges teach female, but not always male, catheterisation. It appears that traditional taboos are alive and well in nursing in Victoria.

European Association of Urology Nurses