EAUN: Networking beyond borders

High regard for EAUN projects from European and overseas participants

At the EAUN meetings nurses from across Europe gather to discuss topics of current interest and develop collaborative networks throughout the wide range of issues not only related to clinical practice and specialised healthcare but also professional development.

In this article, we collected the views and assessment of some of the EAUN meeting participants. Their opinions and insights about the organisation, programme, activities and future prospects of urological nursing are really remarkable, providing us with pointers on how further refine and improve future EAUN activities.

A multi-faceted organisation

I am a nurse practitioner working for almost 25 years at a urology department in the Netherlands and I have seen the growth of the EAUN organisation. In the early years, I once attended the annual congress when it was still a one-day programme with only about 100 nurses in attendance.

Today, the EAUN meeting is a three-day event with parallel sessions, hands-on training courses, medical lectures and workshops. Thus, there is a wide range of topics to choose from depending on a participant’s interests. And for Dutch nurses the congress is accredited, which is important. The social programme included a Nurses’ Evening which proved to be really fun this year, including dancing at the end! All these benefits for a reasonable fee!

However, these benefits and activities are only one of the many goals and services provided by the EAUN. Over the years the EAUN also develops and publishes guidelines, which were practice-based before, but are now evidence-based for the last four years. As of now, five of these guidelines were already published, and I am proud that I have contributed in preparing three of these guidelines.

As an international organisation, the EAUN is involved and collaborates with many other nurses groups around the world. I am impressed not only by the efficient and professional organisation of the congress but also the goal of the EAUN to provide an effective platform for a research project, including granting a prize to the best project.

The EAUN also provides group membership for national nurse organisations. In the Netherlands, the active collaboration between nurses and the association of continuity nurses have this membership, which can boost interest on their organisation and highlight the active links between urological nurses and other nurses. The urological nurse organisation has translated the EAUN guidelines for indwelling catheters, and the continence nurse organisation will translate the intermittent catheterisation guideline.

I expect the EAUN to grow stronger but they would need input and support from all of us, since we are the members we are the core of the organisation. I also find it inspiring to work with colleagues from other countries since we have a lot in common, and we can also learn a lot from each other!

Beyond borders

The EAUN congress offers a unique chance for European nurses to discuss current topics with their colleagues from other countries, and personally I find it very exciting to discover the interests, for example, of nurses in Denmark are similar to the interests of nurses from other European countries. Networking among nurses across borders also begins in an international meeting like the EAUN congress which provides not only timely updates on urological diseases, but also presenting the latest services of medical companies. It helps that the medical congress as well as the nurses’ congress is held at the same time and place, enabling both nurses and doctors to discuss urology and learn practical insights we can use in our own practice.

In 2008 in Milan about 250 nurses from all over Europe participated, and this year the number has increased to more than 400 nurses. The EAUN has organised very interesting sessions such as the EAUN Market Place Workshop, which made possible intensive discussions on nursing issues that affect all nurses across Europe.

Presentations during the Difficult Cases session were also interesting, and I would strongly recommend that nurses contribute more actively to this session. Indeed, the EAUN has done much more to achieve a higher quality to the annual EAUN meeting, which contributes to the development of urological nursing in Europe.

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Urological nursing organisation

Urological nursing organisations are a relatively recent development, with the Society of Urological Nurses & Associates (SUANA) being among the pioneers when it was created in the late 1980s. In the mid-1990s, the British Association of Urological Nurses and Australia & New Zealand Urological Nurses Society (ANZUNS) were established, and followed in 2000 by the European Association of Urological Nurses (EAUN).

Today, there are at least 22 urological nursing organisations worldwide, and most of these groups have well established links with their urological societies and benefit from these links such as support for annual scientific meetings.

One of the challenges for nurses has been to forge active links between societies. Ms. Bente Thoft Jensen, in her capacity as EAUN chairperson, attended the ANZUNS meeting in Australia in 2010 and this visit raised the EAUN’s profile among ANZUNS members. Several ANZUNS members have since joined EAUN and travelled to Europe to attend the annual meetings. These meetings are well-run and cover diverse topics.

EAUN is admired by other nursing organisations as it has been highly productive in its ‘relatively brief history with the establishment of the Fellowship Programme and the development of nursing guidelines in several languages, to mention some of its more high profile achievements. Distance aside (I) the EAUN is a very valuable urological nursing organisation.

Excellent conference

As part of the Global Alliance of Urology Nurses representing the Society of Urological Nurses and Associates, I met representatives from the EAUN around 2008 as we began to forge relationships between our organisations for networking and knowledge sharing. I have been privileged to watch the EAUN grow into a thriving dynamic organisation. The organisation has strived to create an excellent conference for urology nurses each year and I was fortunate to attend two of those conferences. I enjoyed the knowledgeable expert speakers and presentations at each meeting, but especially this last meeting in Milan which featured an excellent debate on prostate cancer testing, nursing solutions in difficult cases, marketplace presentations on embarrassing issues in urology and many other excellent topics.

One of the EAUN’s greatest contributions are the evidenced-based clinical guidelines which offer excellent research-based information on several topics for urology nurses. I look forward to seeing more guidelines in the future. I have been very impressed with the EAUN leaders and their spirit of collaboration and networking.

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It is wonderful to see the EAUN’s growth, yet to know its members and strengthen my links with nurses from around the world to enhance our ability to offer excellent care. I certainly look forward to participating in future EAUN meetings.

Guidelines as reference point

I have not attended every EAUN congress, but the meetings I have attended in the last five to six years have gone bigger and better every year.

Moreover, the EAUN’s achievements have not remained unnoticed particularly its guidelines series which are evidence-based, and which can serve as a really good resource or reference point when local nursing groups are developing their guidelines in their own country or hospital.

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The EAUN has also witnessed a growth in its ranks due to its strategy of group membership. For instance, the number of Finnish members has grown explosively compared to five years ago. Nurses are also more skilled in the English language and have gained more confidence in publicly expressing their views during meetings. For members of Urhot, the Finnish association of nurses in urology, their group membership with the EAUN has raised the profile of the EAUN.

A unique role that the EAUN serves is its capacity to offer a platform where urological nurses can meet and orient themselves to other ways of nursing practice. Specialised nursing practice can differ from one country to another and the EAUN has made it possible for us to compare and be more aware of our own approaches and methods. At the end of the EAUN congress in Milan last March, I recall what one of my Finnish colleagues said: “Now I can go home and be proud of my work.”

I hope that more nurses from Finland would actively participate in the abstract sessions and inform their overseas colleagues about their work. I also hope that the EAUN will continue to develop since it is important for us to achieve excellence in our practice of urological nursing. And I believe that aside from focusing on research, which is a good thing, we should also not neglect to further improve basic nursing practices, two areas which should attract more attention and emphasis in abstracts sessions and presentations.

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EAUN launches “Catheterisation: Urethral Intermittent in Adults” Guidelines
Evidence-based guidelines to help nurses in catheterisation procedures

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A nurse practitioner in urology
Challenges to a clinical research nurse in phase 3 clinical trials

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A clinical trials nurse is a registered nurse who utilises knowledge of ethics, regulatory and data management aspects of clinical trials, in combination with clinical training and the traditional nursing skills of observation, assessment, patient education and advocacy to care for patients of clinical trials. Their role involves adjusting their mind-set from a focus on a patient’s individual experience of their disease and treatment, to one that includes how that experience affects the outcomes of a clinical trial protocol, and the future of a potential therapy for the disease involved.

Astute observation of each clinical trial participant and synthesis of the observations across the cohort will enable identification of commonalities that may identify an important medication side effect. Phase three clinical trials investigate a new treatment against the best existing (standard) treatment. Such clinical trials normally involve hundreds of people across multiple research sites. Clinical trials in nurses in phase three studies record and report all adverse events and administer care with a commitment to the individual patient’s outcome, and to the research question underlying the treatment. Clinical research nurses strive to advocate for their patients while ensuring the integrity of the clinical research.

Patients choose to participate in clinical trials for varied reasons. Some like the way a trial protocol allows them to potentially avoid surgery and perhaps more effective treatments than those currently available to them outside of a clinical trial. Others find the thought of more treatment and rigorous testing a helpful way to improve their quality of life. Clinical research nurses share the same dilemmas. I would be interested to hear what the EAUN urology / research nurse colleagues have discovered about prostate cancer patients’ decision making.

As long as the nurse practitioner is performing intermittent catheterisation. Furthermore, nurses should consider possible ways they can help to prevent catheterisation to prevent cross-infection (LE b1b GR A).

Regarding urethral dilation in adults, a Cochrane review from 2010 concluded that there is insufficient data to determine if urethral dilation, endoscopic urethrotomy or urethrotomy is the best technique for urethral strictures. No evidence was found for frequency of dilation.

Low-level evidence indicates that no higher level evidence was found in the literature when writing the guidelines, but cannot be regarded as an indication of the importance of the recommendation for daily practice.

The guideline can be downloaded for free at http://www.uroweb.org/nurses/nurses-guidelines/, guidelines will be available on the EAUN website.

We would like to thank Coloplast, Hollister Incorporated and Wellspect HealthCare for providing sponsorship grants, making possible the publication of this independent guideline.

Evidence-based guidelines to help nurses in catheterisation procedures

The EAUN has launched its third International EAUN Annual Meeting held in Milan last March its fifth evidence-based guidelines, with urethral intermittent catheterisation and dilation in adults as topic.

The new guidelines contain 12 chapters ranging from methodology to indications, complications, equipment to infection prevention, etc. The document contains 32 photos and figures showing many catheters, catheter sets and help devices, 4 diagrams and 2 flowcharts. The appendices include various catheterisation procedures and a checklist for patient information as well as an example of a voiding diary and a medical travel document.

It is a very practical document that aims to help nurses assess evidence-based management and use participation means they are doing something positive about their health and taking an active role in their treatment. The nursing role in this process can be very supportive, providing knowledge, support, education and patients, and their families, with the longer, more regular appointments allowing for more relaxed interactions and continuity of care.

Dual Since 2001 I have had the dual role of Urological Clinical Trials Nurse and Urinary Catheterisation Nurse Practitioner at the Waitemata District Health Board, and both positions have provided me with an immense amount of job satisfaction. In New Zealand, Nurse Practitioners (NP) is a legal title for a nurse who has completed advanced education (mechanistic in a Bachelor of Health). NPs have met the Nursing Council’s requirements to assess, diagnose and manage health conditions. This is achieved through a continuous learning process and demonstrated excellence in the relevant scope of practice.

...With pharmaceutical clinical trials, sponsors vary considerably in what tasks they will allow nurses practitioners to do....

NPs practice both independently and collaboratively to promote health, prevent disease and manage people’s health needs. They provide a wide range of patient assessment and treatments including ordering, conducting and interpreting medical tests, making diagnoses and implementing a plan of care in a holistic way, all with the goal of helping manage patient’s health needs. Leadership, integration of research, development of nursing practice and policy are also components of the NP role.

I started my nursing career 24 years ago as a registered comprehensive nurse in the urology and renal ward. Early years of practice and post-graduate study (completing a Bachelor of Health) prepared me for my first two senior nursing roles in urology as a clinical nurse educator and as a clinical nurse specialist. The opportunity to learn the skills of a urology clinical trials nurse came later, and as my other senior nursing roles, was due to opportunity rather than career planning. My passion for urological and advancing evidence-based guidelines to guide their clinical practice. As defined by Osborne, evidence-based practice is the “...integration of the latest, highest level scientific research into the daily nursing practice, with regard to theoretical knowledge, nursing experience, the ideas of the patient and available resources.” Whenever possible the guideline text is based on evidence and in cases where evidence is missing, the recommendation is anchored on best practices.

The working process for this guideline was similar to other evidence-based guidelines issued in previous years, with a systematic literature search done in the summer of 2011. The guideline group meetings were held in Amsterdam, while a follow-up meeting was held with only the attendance of the chair and vice-chair. Six video conferences were also held with the guideline members to finalise the text. A blinded review was then conducted with the participation of several nurses, urologists in various countries and a patient outside the EU representative.

One of the main questions addressed in this guideline is: “Is there any evidence for intermittent catheterisation and urethral dilation for nursing interventions in different care situations such as inpatient, care of patients outside of a clinical trial, and in home care?” The first challenge we encountered was the fact that in the literature there are various definitions of the different techniques, and there is, at times, a lack of clarity in what is exactly meant by a certain technique. Moreover, the interventions were not always non-concordant with each other.

Therapeutic catheterisation is only used in operating theatres and in diagnostic situations. Sterile technique implies that all materials are sterile and catheterisation is performed with sterile gloves, gloves, etc., that is, in full operating theatre conditions. Thus, the group decided to use these definitions of aseptic and sterile technique:

Sterile technique: Complete sterile technique is only used in operating theatres and in diagnostic situations. Sterile technique implies that all materials are sterile and catheterisation is performed with sterile gloves, gloves, etc., that is, in full operating theatre conditions.

Aseptic technique: Implies the use of sterile catheter, disinfection or cleansing of the genitals, sterile gloves or use of tweezers to make sure the catheter remains sterile, and the use of sterile lubricant if the catheter is not pre-lubricated.

The need for an updated definition of techniques used in intermittent catheterisation is a result of integrating the best available research and clinician expertise.

What the literature search also showed was that there is a lack of high-quality evidence regarding the choice of catheter, frequency of catheterisation and single- versus reusable catheters. However, we found evidence for infection prevention.

The literature search also showed no evidence (LE b1, GR A) to recommend cranberry supplements to prevent or treat UTI in patients performing intermittent catheterisation. Furthermore, nurses should consider possible ways they can help to prevent catheterisation to prevent cross-infection (LE b1 GR A).

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Nursing solutions for difficult cases

**EAUN session on special nursing interventions elicits enthusiastic responses**

At the 14th International EAUN Meeting held in Milan in March this year, the session on Nursing Solutions for Difficult Cases attracted positive comments from many of the participants expressing their appreciation for the interesting practical problem raised by the speakers.

Due to the enthusiastic response, the Difficult Cases session has become a regular feature in the EAUN’s annual conference, informing urology nursing specialists of effective interventions and special handling procedures. After the lectures, the speakers and the audience also had the opportunity to discuss specific aspects.

### DC13-01 Alcohol intake and Radical Cystectomy - how can we approach a safer patient outcome?

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1. **What was the problem you experienced in this patient?**

When a patient is cleared for surgery - radical cystectomy - they will have counselling with a consultant and a nurse and is informed about the risks and possible complications postoperatively. This includes: infections; postoperative bleeding; thrombosis; delayed bowel function; death while in hospital and in the postoperative period.

The consultant has an obligation to ask the patient about conditions that will influence on the total outcome; this includes the preoperative intake of alcohol. It is known that a high alcohol intake (> 3 units per day) is a risk factor for overall complications, even death.

A female patient age 56, with a long medical record of bladder papillomas, now has bladder cancer. She was cleared and accepted Radical Cystectomy as the treatment. She did not hide the fact that her alcohol intake was higher than recommended: more than 50% units a week. Nobody in the team reacted.

Preoperatively the patient increased her alcohol intake. The operation was cancelled the day before, because the patient had symptoms of withdrawal. The consultant found it too risky to do the surgery due to the risk of complications, especially delirium. The patient was discharged to treatment for her alcohol abuse.

A month later she had the Radical cystectomy. In the postoperative period the patient often felt sterilised - the staff questioned her about withdrawal symptoms whenever she was feeling different sensations in her body. This was very humiliating and offered a lot of tension between the patient and the staff. She was discharged after 8 days. Unfortunately, she had a severe relapse later.

2. **Which nursing intervention did you provide?**

The nurses and the team could have displayed a more holistic approach: social, physical and emotional. The patient herself with help of the home care nurses.

3. **Which materials did you choose to help the patient?**

- PolyPosisColi, pulmonary embolism after chemotherapy now has TNM2 urothelial cell bladder cancer, for which the patient had a Bricker-urryna diversion with complications and a new ileostomy. Complications led to a large abdominal wound, with the ileostomy in the middle and impossible wound care. Surgery is not possible because of the poor physical condition. General anaesthesia is not possible because of pulmonary embolism, high risk to get new fistulas because of chemo and adhesions. This is why the patient is given conservative treatment. Problems:
  - Long stay in hospital with very intensive (wound) treatment and nursing care.
  - Very difficult wound- and stoma care.
  - Hyper granulation after pinch grafting.
  - Necrosis after using wrong material by home care nurses, which was not communicated with our specialised ostomy/wound care team.

4. **Clinical nurse specialist performed pinch grafting but 556 was not possible because of the poor physical condition. After the pinch grafting the wound started to overgrow itself, this is called hyper granulation. We treated this with a silver nitrate pen**

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### DC13-02 Complicated ostomy and wound care after cystectomy and Bricker deviation (with complex comorbidity)

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**Fig. 2: Pinch grafting**

1. **What were the problems you experienced in this patient?**

A patient with complex comorbidity (APR, Fam. PolyPosisColi, pulmonary embolism after chemotherapy) now has TNM2 urothelial cell bladder cancer, for which the patient had a Bricker-urryna diversion with complications and a new ileostomy. Complications led to a large abdominal wound, with the ileostomy in the middle and impossible wound care. Surgery is not possible because of the poor physical condition. General anaesthesia is not possible because of pulmonary embolism, high risk to get new fistulas because of chemo and adhesions. This is why the patient is given conservative treatment. Problems:

a. Long stay in hospital with very intensive (wound) treatment and nursing care.

b. Very difficult wound- and stoma care.

c. Hyper granulation after pinch grafting.

d. Necrosis after using wrong material by home care nurses, which was not communicated with our specialised ostomy/wound care team.

2. **Which nursing interventions did you provide?**

a. Use of special protocol for ‘long stay patients’:

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  - b. Very difficult wound- and stoma care.
  - c. Hyper granulation after pinch grafting.
  - d. Necrosis after using wrong material by home care nurses, which was not communicated with our specialised ostomy/wound care team.

b. Use of different types of wound managers (Convatec, Coloplast) and stoma care materials to avoid leakage and skin problems. The ostomy/ wound care was very intense: 12 hours a day!

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**Fig. 1: Wound manager**

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### Fig. 3: Impressive growth with some hypergranulation after 3 weeks of pinch grafting

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**EAU around the world**

The EAU Board have been involved in or attended the following activities throughout the world recently:

- **June 2013**
  - EAU Satellite Educational Meeting, Århus, Denmark
  - European Men’s Health Forum Roundtable Brussels, Belgium

- **May 2013**
  - 3rd POST EAUN Meeting, Ede, Netherlands
  - EAUN Board meeting, Noordwijk, Netherlands

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Is your National Society organising a meeting and would you like the EAUN to be present? Contact our chair at k.fitpatrick@eaun.org