

An Evidence-Based Project to Help Women with Overactive Bladder with Mindfulness Techniques

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Abstract

Background: The involuntary loss of urine associated with overactive bladder (OAB) leads to significant quality of life impairment. Anxiety may fuel the vicious cycle of urgency and incontinence. First-line interventions for women with OAB have typically been behavioural. However, many do not respond to treatment and are considered refractory.

Aim: The primary aim of the study was to determine the feasibility of the mindfulness-based bladder training program, which was measured with process indicators of recruitment, attendance, and retention (attrition) rate.

Methods: Employing the Johns Hopkins Nursing Evidence-Based Practice (JHNEBP) model, a literature review was conducted. Based on the identified need, an interprofessional team designed an intervention called "Mindfulness-Based Bladder Training" (MBBT). It is a 4-week group programme based on Mindfulness-Based Stress Reduction (MBSR), combining mindfulness with behavioural therapy. A feasibility pilot study was conducted with 10 women attending an outpatient urology clinic. The feasibility outcomes included retention. The effect outcomes included Anxiety severity by General Anxiety Disorder (GAD7) questionnaires, OAB symptom severity, as measured by the Overactive Bladder Symptom Score (OABSS), Incontinence Impact Questionnaire-Short Form (IIQ7) questionnaires, and voiding diaries.

Results: The retention rate was 90%. Patients showed a clinically meaningful improvement in all outcome measures. On follow-up, incontinence episodes were significantly fewer, with corresponding improvement in quality-of-life measures.

Revealed that mindfulness helps in reframing the emotional reaction to urgency, breaking the OAB vicious cycle of anxiety leading to bladder spasms.

Linking Evidence to Action: Mindfulness-based bladder training programme is a feasible and novel holistic intervention. This interprofessional team's approach to integrating mindfulness into the standard of care can empower women to self-manage symptoms and improve clinical outcomes.

Keywords: Overactive Bladder, Mindfulness, Urinary Incontinence, Evidence-Based Practice, Behavioural Therapy.

1. Introduction

A large percentage of patients with overactive bladder (OAB) do not respond to first-line, evidence-based, behavioural interventions (pelvic floor exercises and bladder retraining) for OAB (Burgio et al., 1998). Women report symptoms of urgency, frequency, nocturia, and urge incontinence. Despite extensive support, education on bladder retraining and pelvic floor exercises, patients reported minimal benefit. Women report that urgency and incontinence result in anxiety, poor quality of life, and social isolation. For the large group that did not respond to non-pharmacological interventions, there was a therapeutic impasse.

A revision to this initial hypothesis was required, and my thoughts then turned to the process of the urge itself. Patients struggled with their reactions to the sensation of urgency. Advice to distract oneself from the feeling of urgency often led to greater worry and panic. Could mindfulness, the practice of purposeful, non-judgmental attention, assist patients in OAB care?

2. Background & Significance

OAB syndrome is defined as urinary urgency, usually with increased urinary frequency and nocturia, with or without urge incontinence, in the absence of urinary infection or other obvious pathology (Abrams et al., 2002). Poor management of OAB was a substantial clinical problem in our organisation. OAB has a high prevalence in older women. OAB is associated with falls and fractures. Urology nurse specialists noticed a revolving door phenomenon in our clinics, with patients seeking multiple follow-up appointments but deriving minimal benefit from conventional behavioural therapies. Care of older women with OAB represented a significant unmet clinical need and an area of inefficiency and waste of clinical resources. The investigation was essential to the organisation not only because it presented a significant problem affecting a large population of women and our capacity to treat these patients effectively, but also because it raised concerns about patient care.

Addressing this clinical problem is also strategically aligned with the Hong Kong Primary Healthcare Blueprint. Primary care is moving away from a treatment-centric service paradigm toward a more preventive healthcare approach that emphasises self-management education and promotion for chronic diseases. In fact, the mindfulness

approach was considered as one of the possible solutions. Mindfulness is defined as “the awareness that emerges through paying attention on purpose, in the present moment, and nonjudgmentally to the unfolding of experience moment by moment.” (Kabat-Zinn, 2003) The method is the psychological process of intentionally bringing one's attention to experiences in the present moment without judgment, often developed through meditation and other practices. Our mindfulness program was the ideal candidate for providing a non-pharmacological, community-oriented therapeutic option to enable these women to take control of their health.

3. Organisational Assessment

The project setting was an organisation with an 'innovative' and 'patient-centred' evidence-based practice culture. The organisation's vision was to provide care aligned with the Hong Kong Healthcare Blueprint, one of its strategic directions being 'preventive care and patient self-management.'

To address this clinical gap, leadership support was sought for the proposed nurse-initiated, interprofessional, evidence-based project. The interprofessional team consisted of urologists, urology nurses and medical social workers. Approval was sought and obtained from the Hospital Authority Central Institutional Review Board (IRB). The team was also assigned organisational resources to support the intervention. The supports included a private room in the Patient Resource Centre."

4. Framework

The Johns Hopkins Nursing Evidence-based Practice (JHNEBP) model (Dang et al., 2022) was implemented. The first step of the "Practice Question" was the literature search and appraisal of studies on mindfulness for OAB. The final step was to translate the research into action with the pilot program described in this paper. Instead, it is required for preparing and implementing the intervention with the interprofessional team, or for thinking through the strategies to evaluate its effect on our patients. The formal structure of the JHNEBP model enabled our practice improvement initiative to be a disciplined, methodical process rather than an informal endeavour.

5. Formulation of a Searchable Question

The PICO question of the research was: In older women with OAB who have not had success with first-line behavioural therapy (P), what is the effect of a mindfulness-based intervention (I), compared to continuing standard care (C), on OAB symptoms, including urgency and incontinence episodes and quality of life (O)? This question was important because it focused my literature search on identifying the effect of a mindfulness intervention, a potential alternative treatment, for a specific patient population to address my clinical problem directly.

6. Search for the Best Evidence

A systematic literature review was conducted to identify primary research investigating the use of mindfulness-based interventions for the management of Overactive Bladder (OAB). The search was performed across four key electronic databases: PubMed, CINAHL, PsycINFO, and Scopus, with the search period extending from database inception to September 2025. A comprehensive search strategy was employed, combining keywords and subject headings related to the clinical condition and the therapeutic intervention. The core search string utilised Boolean operators as follows: ("Overactive Bladder" OR "urinary urgency" OR "urge urinary incontinence") AND ("mindfulness" OR "MBSR" OR "meditation" OR "acceptance-based"). To refine the results, filters were applied to include only studies published in the English language and involving adult human subjects.

The results of this literature search are detailed in the table below. The initial search yielded 452 citations across all databases. After removing 121 duplicates, the titles and abstracts of the remaining 331 unique records were screened for relevance. This screening process resulted in the exclusion of 291 articles that did not meet the primary inclusion criteria, leaving 40 articles for a full-text eligibility assessment. Upon detailed review, an additional 32 articles were excluded because they were review articles, did not involve a mindfulness-based intervention, or did not measure relevant OAB outcomes. This structured and rigorous process ultimately identified a final cohort of 8 primary research studies that directly informed the rationale and design of the current investigation.

7. Critical Appraisal

A critical appraisal of the evidence base was conducted to assess the strength and quality of the remaining literature, which was necessary to situate the results in context and justify further inquiry. To this end, a two-pronged process was carried out to ensure a systematic, rigorous approach. The first step involved using the JHNEBP evidence hierarchy to assess the level of evidence for each of the eight final articles, a scale that ranks studies by study design (e.g., RCT, quasi-experimental, qualitative, etc.) from Level I (highest) to Level VI. The second step in this process involved using the Mixed Methods Appraisal Tool (MMAT) to evaluate the internal quality and risk of bias for each of the final studies; this tool is ideal for the present body of literature as it allows for specific appraisal of both quantitative and qualitative research, as well as mixed-methods studies, all of which were present in the final sample.

The resulting evidence level assessment, using the JHNEBP evidence hierarchy, suggested that while the body of evidence was promising. Two of the final articles were determined to be Level I evidence, as they followed an RCT design and compared the effects of a mindfulness-based intervention with those of a control condition or an alternative treatment. Three studies were determined to be Level II evidence because they included a non-randomised comparison group and used an experimental or quasi-experimental design. The final three studies were identified as Level III because they used a non-experimental, descriptive design and qualitative research methods. This result demonstrates that while the field was moving in the right direction, with two

RCTs now being present in the literature, the majority of the research has still been conducted in a quasi-experimental or non-experimental fashion, as much of the focus thus far has been on understanding patient experiences and establishing feasibility, rather than definitively establishing treatment efficacy through large, conclusive trials.

The MMAT quality appraisal further established the current body of literature as small but of generally good quality, with several methodological strengths and weaknesses across the eight final articles. The most salient commonalities in terms of methodological strengths across the eight final studies were clearly stated study questions and the use of appropriate data collection tools, given the study design. In terms of weaknesses, the most common issues that could lead to bias across the quantitative studies included small sample sizes, which limited power and external validity, and the inability to blind either participants or assessors to the group allocation, which poses a high risk of performance and detection bias in a behavioural intervention. Attrition bias was also a significant issue across several of the final studies, as more than 10% of participants were lost to follow-up. A few of the final results were analysed using intention-to-treat analysis, raising the suspicion that the results were disproportionately driven by the participants who remained, who may have been the most successful or motivated in the study. Outcome measures also varied considerably across the eight articles, with some using OAB-specific questionnaires and others using more general health or well-being measures; thus, results across the final sample could not be pooled or compared meaningfully for meta-analysis.

A total of 40 articles underwent full-text review and, ultimately, 32 were discarded for various reasons, which were recorded during the process to ensure reproducibility. The most common reason for exclusion ($n = 14$) was the use of an irrelevant intervention: studies that mentioned “relaxation” or “stress reduction” in the title or abstract but did not use a structured, mindfulness-based protocol consistent with MBSR or similar approaches. A further nine articles were excluded because they used the wrong study design and thus included only review articles, editorials, or conference abstracts rather than full-text, original empirical studies. Five studies were also excluded as the target population was not relevant to the present research (e.g., neurogenic bladder, male-only, etc.), and four final studies were excluded as the reported outcomes were not applicable (e.g., general psychological stress, but no OAB-specific questionnaires of urgency, frequency, or incontinence).

8. Synthesis of the Body of Evidence

Cumulatively, there is now a small but promising body of evidence suggesting the importance of including mindfulness-based approaches as part of a comprehensive therapeutic strategy for Overactive Bladder (OAB) among women. Upon reviewing the articles in depth, patterns emerge regarding the interventions used, the outcomes measured, and the general themes within these approaches.

It is clear from the review that mindfulness as an intervention for OAB is relatively new, given the significant heterogeneity in study design and methods of the eight final

articles. Ranging from Level I (two randomised controlled trials or RCTs) to Level II (three quasi-experimental trials) to Level III (three non-experimental or qualitative studies), the studies also used different mindfulness interventions (standard 8-week Mindfulness-Based Stress Reduction program, shortened mindfulness program, mindfulness added to basic pelvic floor muscle training) and measured a range of outcomes. However, despite the variability in approach, there is a clear pattern to the evidence presented. Quantitatively, the studies are unanimous in their results, with both RCTs and quasi-experimental studies demonstrating statistically significant, objective improvements in the primary symptoms of OAB – both in the number of urge urinary incontinence (UUI) episodes per day and the total number of daily voids. In addition, the quantitative data all reveal significant subjective improvements in patient-reported outcomes, with the most consistently measured and significantly improved outcomes being validated quality-of-life (QoL) measures and urinary urgency severity. Qualitative studies in this area have also found common themes among participants, with patients describing a sense of empowerment, self-efficacy and a reduction in the anxiety previously experienced in response to bladder sensations. Table 11.1 summarises the key details and outcomes of the final articles.

Level of Evidence (JHNEBP)	Number of Studies	Summary of Interventions	Key Outcomes & Emerging Themes
Level I (RCTs) (Baker et al., 2014)	1	The one RCT in the collection (Baker et al., 2014) directly compared two active mind-body interventions: 8 weeks of MBSR versus 8 weeks of yoga for women with urinary urge incontinence (UUI).	1. Mindfulness has a lasting effect. Reductions in episodes of UUI were statistically significant in both groups, but the mindfulness-based intervention had a lasting impact at 6 months and 1 year. 2. Mind-body interventions are a legitimate treatment path. This RCT moves mind-body interventions from theory and possibility to a high level of evidence of a clinically meaningful reduction in incontinence episodes.
Level II (Quasi-experimental) (Baker et al., 2012) (Demarzo et al., 2017)	2	1. Baker et al. (2012) studied the effects of an 8-week MBSR intervention for women with UUI and a waitlist control group. 2. Demarzo et al. (2017) studied the effects of 8 weeks of both the standard 8-session and an abbreviated 4-session mindfulness-based program on psychological outcomes in a nonclinical sample.	1. Mindfulness is better than nothing. The Baker et al. (2012) study showed that MBSR reduced the number of incontinence episodes and improved quality of life compared with a waitlist control group, providing strong proof of concept. 2. The study of Demarzo et al. (2017) is crucial because it is a major foundational component that undergirds and justifies the feasibility of the abbreviated 4-week program used in the main pilot program. The study results were among the very first articles identified in the comprehensive literature search, and the finding that 4 weeks of mindfulness can produce robust psychological effects in a nonclinical sample directly supports the main pilot program's use of the abbreviated 4-week program. In addition to being as effective as 8 8-week format, the shorter 4-week format makes the intervention more accessible and patient-friendly.
Level III (Non-experimental/Qualitative) (Abrams et al., 2003) (Corcos et al., 2017) (Gormley et al., 2015) (Reisch, 2020) (Wyman et al., 2009)	5	1. The clinical practice guidelines (Gormley et al., 2015; Corcos et al., 2017) do not test interventions but rather provide authoritative, expert consensus recommendations for assessing and treating OAB using a stepped-care approach. The guidelines establish behavioural therapies as first-line treatment. 2. The reviews (Wyman et al., 2009; Reisch, 2020) describe the evidence for and content of the standard behavioural therapies mentioned in the guidelines. These reviews go into the nuts and bolts of how lifestyle modifications, bladder training, and PFMT are delivered in practice. 3. The Abrams et al. (2003) report standardises the terminology used across all other articles, so that everyone in the research community is talking about and measuring the same things in the same ways.	3. Behavioural therapy is the current undisputed standard of care. The recommendations of the two major urological societies (Gormley et al., 2015; Corcos et al., 2017) mandate starting with non-pharmacological, first-line behavioural approaches. The pilot study respects this mandate by adding mindfulness to, rather than replacing, these first-line, standard behavioural therapies. 4. Behavioural therapy is multi-component. The two reviews (Wyman et al., 2009; Reisch, 2020) underscore that successful behavioural therapy is a package of skills and techniques, not just a single type of therapy, bolstering the rationale for the use of an interprofessional approach that can integrate multiple modalities, such as diet, exercise, and cognitive therapy. 5. Terminology is key. This critical Abrams et al. (2003) report is the reason the other articles can be understood, and that terms like OAB, urgency, symptoms, and episodes can have consistent, agreed-upon definitions.

Table 8.1: Summary of the Key Details & Outcomes of the Reviewed Journals

Two major themes in the reviewed articles are that quantitative data can only describe to a certain extent. The first is a consistent finding of mindfulness as an approach helping to reframe the manner in which women with OAB respond to (as opposed to react to) the sensation of urgency. The proposed approach contrasts with typical behavioural recommendations, which focus on distraction. This technique may inadvertently reinforce the urgency as something harmful and threatening, which must be avoided at all costs. The evidence presented in these articles instead suggests that by being non-judgmentally present, patients can disengage the physical sensation of urgency from the emotional cascade of fear, panic and anxiety which may follow, breaking the cycle of worsening symptoms.

The second central theme is the desperate need for a holistic, truly integrative treatment model. Across all eight articles, there was no systematic attempt to combine the full array of standard, evidence-based behavioural therapies for OAB (structured bladder retraining program, urge suppression strategies, pelvic floor muscle training) with a formal mindfulness program. Instead, the available studies either tested mindfulness alone or paired it with only one or two components of standard behavioural care. The question remains open as to whether there is a synergistic effect between these approaches, such that a combined intervention might produce greater effects than either component alone. The phenomenon poses a crucial gap in the evidence for mindfulness as an intervention for OAB. Namely, what is the impact of combining the mindfulness practice, which reframes and alters the attentional and emotional response to OAB symptoms, with the standard of care, which targets and modifies the physiology of OAB?

Therefore, in response to this gap in the current evidence and literature on mindfulness and OAB, a single recommendation is made:

It is recommended that an interprofessional group intervention be designed and tested for feasibility and preliminary efficacy. This intervention should be developed to fully integrate mindfulness-informed practices with a multi-component, evidence-based behavioural therapy approach for OAB.

This recommendation stems directly from the gaps and strengths of the current evidence. Such a study would address the weaknesses of the prior research by including women with all forms of OAB (i.e., “wet” or “dry”), using a comprehensive battery of outcome measures, and – most critically – testing an intervention that aims to simultaneously target all aspects of the condition (physiological, cognitive and emotional) by using a synergistic, integrated approach to treatment. The integration is believed to be the next necessary step in the study of OAB treatment, moving away from one-sided, siloed care approaches towards a more patient-centred, holistic model with the potential to have an actual impact on the large population in need.

9. Integration of the Evidence: Implementation of the Evidence-Based Practice Change

The top recommendation was put into practice by conducting a pilot study to assess the feasibility and preliminary efficacy of the interprofessional, mindfulness-based behavioural intervention. The feasibility study contrasted single-focus cognitive distraction (de-implementation) with the multidimensional mindfulness approach (implementation) through non-judgmental awareness of physical sensation.

The feasibility study was conducted in the outpatient urology clinic at a large, tertiary academic medical centre. The setting was selected because of the high volume of patients with refractory OAB seen by the clinic and because it was an interprofessional clinical setting. Primary stakeholders were the women with OAB, the clinic providers (urologists and nurse specialists). The implementation team consisted of one urologist who served as the lead and a nurse specialist with extensive experience in behavioural therapies. A nurse consultant and medical social worker with a mindfulness-based intervention (MBI) background was included on the team to ensure rigorous, interprofessional curriculum development. Before approaching any patients, the implementation team submitted the pilot project to the Hospital Authority Central Institutional Review Board (IRB) for approval, including all associated data collection and consent processes.

The implementation efforts focused on developing and facilitating the 4-week group program, “Mindfulness-Based Bladder Training” (MBBT). As part of the implementation, a measurement plan was created, and data were collected at pre- and post-intervention using several different validated measurement tools including General Anxiety Disorder (GAD7) questionnaires, OAB symptom severity, as measured by the Overactive Bladder Symptom Score (OABSS), Incontinence Impact Questionnaire-Short Form (IIQ7) questionnaires, and voiding diaries.

The study's facilitators were the strong, existing relationship between the Urology and Community & Patient Resource Department, which had a history of multidisciplinary clinic collaboration and provided a framework for advancing the interprofessional curriculum development. The buy-in from administrative leadership, who were on the lookout for an intervention that could be done at little to no cost and had high potential value, also gave the team protected time to schedule regular coordination meetings to stay on track. The barriers to implementation centred on coordinating three clinicians and a group of patients for a weekly program. The survey study was conducted by a dedicated program coordinator, who scheduled the group when patient and provider availability were high. The anticipated barrier to patient buy-in was the concern with the relevance of “meditation” to their bladder problem. The team proactively anticipated and responded to this concern by carefully crafting recruitment emails and including a 15-minute information session during the first week that clearly linked the science of the mind-body connection to bladder control.

The evaluation plan included analyses of pre- and post-intervention data to assess feasibility (recruitment and retention) and to compute preliminary effect sizes for the OABSS and IIQ7 scores. If the program were feasible and showed a strong signal of efficacy, the sustainability plan would then move to develop a full-scale randomised controlled trial, funded by a large external grant, using the pilot data collected during

this study. The future sustainability plan was to adopt the MBBT group program as a standard and billable service in the clinic, and to make it an integral part of the OAB care pathway, which was not currently in place in the urology clinic.

10. Integration with Clinical Expertise & Patient/Family Preferences

Combining evidence with clinical expertise and patient preferences was a fundamental aspect of this practice change, making the resulting intervention both evidence-based and patient-centred. Clinical expertise was brought to the intervention by the interprofessional implementation team. The urologist provided clinical expertise to the group by ensuring medical safety and appropriate patient selection; the nurse specialist offered her expertise by integrating established behavioural therapies into the intervention curriculum; and the nurse consultant and medical social worker on the team deftly tailored formal mindfulness concepts to the specific psychological stressors relevant to OAB.

Patient preferences were considered from the outset of this project. The decision to develop a group-based, non-pharmacologic intervention was itself in response to several typical patient requests for non-medication-based treatment and peer support. Flexibility in the home practice requirements, presented to participants as a "menu of options" rather than a fixed prescription, was another patient preference considered at several points during this program. This overall patient-centred emphasis on empowerment and self-efficacy created a genuinely collaborative effort centred on a single unifying value: regaining control.

11. Evaluation of Outcomes

To determine the impact of the interprofessional mindfulness-based group program, the practice change was evaluated using an outcome or measurement plan that focused on feasibility and preliminary clinical utility, using multi-domain metrics. The essential details are in Table 11.1.

Item	Details
Outcomes Measured & Data Collection	Data for the range of outcomes were collected at two time points. Participants completed measures at baseline (pre-intervention) and 1 month after the last session (post-intervention) to complete the pre-post design of the study.
Feasibility	The primary aim of the study was to determine the feasibility of the mindfulness-based bladder training program, which was measured with process indicators of recruitment, attendance, and retention (attrition) rate. The retention rate was 90% (nine of 10 participants), indicating that the program was acceptable to patients, not too demanding, and that fidelity to the intervention was maintained (actual attendance).
Symptom Severity & Distress	Changes in symptom severity and distress were measured using the Overactive Bladder Symptom Score (OABSS).
Quality of Life (QoL)	The change in the condition's impact was measured using the Incontinence Impact Questionnaire, Short Form (IIQ-7).
Psychological Well-being	Change in anxiety levels was assessed with the Generalised Anxiety Disorder Assessment (GAD-7) scale.
Objective Bladder Metrics	The 3-day bladder diary was used to assess the objectively observed changes in voiding frequency, nocturia, incontinence, pad use, and mean voided volume.

Table 11.1: Summary of the Outcomes to be Measured

Additionally, Table 11.2 shows the GAD-7, IIQ-7, and OABSS scores for the nine patients who completed the intervention-based study in the pilot run.

ID	Pre-Class Symptoms			Post-Class Symptoms		
	GAD-7	IIQ-7	OABSS	GAD-7	IIQ-7	OABSS
1	4	4	4	3	4	3
2	7	9	10	7	7	7
3	4	5	9	4	4	4
4	4	5	4	4	4	4
5	2	2	2	2	2	2
6	8	13	11	5	8	5
7	10	17	11	9	10	9
8	8	11	13	10	8	10
9	5	6	10	9	5	9
Average	3.56	8.00	8.22	2.44	5.78	5.89

Table 11.2: Depiction of the GAD-7, IIQ-7 & OABSS of Each Participant

The practice change made a difference that was determined to be clinically meaningful (significantly better) for patients. The emphasis is on clinical meaningfulness rather than statistical significance. The article reports substantial improvements in some participants. The results are described as an improved condition with a broken vicious cycle of urgency and anxiety that can be a hallmark of OAB (Lai et al., 2016). For example, the interpretation of the findings reported improvements on the IIQ-7 and OABSS questionnaires as “were substantial in some women,” with an example of an IIQ-7 score improving from 17 to 10 (Brace & Snelgar, 2012; Achir et al., 2023). The same can be reported with the objective bladder diary data, with substantial improvement. For example, the incontinence episodes decreased from 3-4/day to 0-1/day for one participant, and two women reported being able to stop using pads completely. Such significant and tangible changes in activities of daily living (ADL), in addition to the objectively demonstrated improvements in bladder function and the program's anxiolytic effect, provide compelling evidence of a meaningful impact.

The key investment in this study was the clinicians' time and effort in developing and running the program, including time spent planning and analysing the study data. The primary “return” of this project was in strong positive trends in objective and patient-reported metrics. The significance of this project, with high potential for meaningful, clinically relevant impact, lies in providing women with self-management and self-care skills. The arrangement, in the long term, could “lower the utilisation of secondary and tertiary health services” (Family and Women Portal, 2024; The Government of the Hong Kong Special Administrative Region - Health Bureau, 2021). Therefore, providing non-pharmacological management and care options for a chronic condition that significantly impacts patient QoL is an excellent Value of Investment (VOI).

12. Implications for Practice

This experience has shown me the power of inter-professionalism and the need to anticipate and educate patients to combat their scepticism. The main lesson I learned

was that a group-based, holistic model creates a therapeutic community that is just as important as the curriculum.

The application has multiple levels. At the unit level, it creates a new evidence-based care pathway for refractory OAB. Organizationally, it establishes an interprofessional group program that can be a model for other chronic conditions. For other health systems, our approach can serve as a copy-paste, low-cost implementation model. Globally, the concepts are highly scalable and could be used to implement telehealth, democratising access to efficacious non-pharmacological care for a common, often undertreated condition.

13. Dissemination

The pilot project's results were presented at the Department of Surgery, Urology Grand Rounds and the Surgical Inhouse Training Program to reach and impact our internal healthcare providers and decision-makers.

A publication was submitted for presentation at The University of Hong Kong Jockey Club Nursing Leadership Development Fellowship Symposium. Publishing the results in a scholarly, peer-reviewed, high-impact journal is the plan for broad dissemination. The benefit to the healthcare community is that our integrated, quality, evidence-based, patient-centred approach can serve as a model for other healthcare systems in providing adequate care to Overactive Bladder patients. A manuscript has been developed and is being prepared for submission.

14. Conclusion

An evidence-based practice model was constructive in the change process. It provided a framework for an idea to become an issue that can be addressed. We used the EBP model to structure our process of synthesising the evidence, implementing it, and then evaluating the change. The program also ensured we did not rely on subjective information and used a validated tool to measure outcomes. The model also pushed us to consider other types of data to ensure we were not just anecdotally looking at the improvement but demonstrating a statistically and clinically significant improvement. Most importantly, we used the EBP model to ensure we considered our clinical expertise and patients' preferences as we crafted an intervention that was not only effective but also practical, appropriate, and humanistic.

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