Citation: Taylor, C., Mulligan, K. & McGraw, C. (2021). Barriers and enablers to the implementation of evidence-based practice in pressure ulcer prevention and management in an integrated community care setting: a qualitative study informed by the Theoretical Domains Framework. Health and Social Care in the Community, 29(3), pp. 766-779. doi: 10.1111/hsc.13322

Title Page

Title: Barriers and enablers to the implementation of evidence-based practice in pressure ulcer prevention and management in an integrated community care setting: a qualitative study informed by the Theoretical Domains Framework.

Authorship: (1) Carole Taylor, (2) Kathleen Mulligan, (3) Caroline McGraw

Corresponding author: Caroline McGraw, School of Health Sciences, City, University of London, Northampton Square, London, EC1V 0HB. Email: caroline.mcgraw.1@city.ac.uk.

Institutional affiliations: (1) East London NHS Foundation Trust; (2) Centre for Health Services Research, School of Health Sciences, City, University of London, and East London NHS Foundation Trust (3) Centre for Health Services Research, School of Health Sciences, City, University of London

Acknowledgement: The authors wish to thank all the nurses, occupational therapists and physiotherapists who took part in the study.

Conflict of Interest Statement: The authors declare they have no competing interests.

Funding Source: The first author conducted the study in partial fulfilment of a MSc Advanced Practice in Health and Social Care. Funding to undertake the Masters degree was provided by East London NHS Foundation Trust.

Data Availability: The data that support the findings of this study are available from the corresponding author upon reasonable request.

Main Document

Title: Barriers and enablers to the implementation of evidence-based practice in pressure ulcer prevention and management in an integrated community care setting: a qualitative study informed by the Theoretical Domains Framework

Abstract

Pressure ulcer reduction is a healthcare priority. Good clinical guidelines have the potential to transform pressure ulcer prevention and management practices. However, evidence suggests these guidelines are inconsistently utilised. The aim of this study was to explore health practitioners' perceived barriers and enablers to the implementation of evidence-based pressure ulcer prevention and management recommendations in an integrated community care setting.

The study used a qualitative exploratory design. It took place in a community Trust in London, England. Semi structured interviews were conducted with a purposive sample of registered nurses and allied healthcare professionals (AHPs). The Theoretical Domains Framework (TDF) informed both data collection and data analysis. Analysis followed a five-step process including deductive coding of the transcripts and inductive generation of specific belief statements. Nine nurses and four AHPs took part in the study.

Six TDF domains were identified as most relevant to the implementation of best practice in pressure ulcer prevention and management: Goals, Knowledge, Skills, Beliefs about capabilities, Environmental context and resources, and Social influences. All participants felt it was important to prevent pressure ulcers and were motivated to do so. Key enablers to the implementation of evidence-based practice included high levels of self-reported pressure ulcer knowledge and skills (nurses), responsive community equipment provision, the introduction of novel Pressure Ulcer Implementation Facilitator roles, and integrated team working. Barriers included self-reported deficits in knowledge and skills (AHPs), worries about inspecting intimate anatomical locations (AHPs), difficulties initiating conversations with patients about risk and behaviour change, high workloads, and clutter in the home. Family members and mobile working solutions were identified as both enablers and barriers.

Potential routes to addressing implementation challenges are identified and recommendations made for future research.

What is known about this topic?

- Good clinical guidelines have the potential to transform healthcare practices, improve patient outcomes and promote efficient use of resources
- There is widespread acknowledgement that translating guidelines into practice is often a slow process and that knowledge about best practice is inconsistently applied

- Pressure ulcer prevention and management guidelines are inconsistently utilised in community healthcare settings

What this paper adds

- Unique insight into the factors perceived by nurses and allied healthcare practitioners as influencing the implementation of evidence-based practice in community settings
- Identification of the key enablers and barriers to the implementation of evidence-based practice in pressure ulcer prevention and management in community settings
- Potential routes to addressing implementation challenges

Key words

- Pressure ulcer
- Evidence based practice
- Theoretical Domains Framework
- Integrated care
- Community nursing
- Allied healthcare professionals

Introduction

A pressure ulcer (PU) is defined as localised damage to the skin and/or underlying tissue, typically over a bony prominence, resulting from sustained pressure, which may present as intact skin or an open ulcer (NHS Improvement, 2018). The National PU Advisory Panel (NPUAP), European PU Advisory Panel (EPUAP) and Pan Pacific Pressure Injury

Alliance (PPPIA) (2014) classify ulcers into four levels of injury from category 1 (intact skin with localised non-blanchable redness) to 4 (full thickness tissue loss with exposed bone, tendon or muscle). They also identify unstageable injuries (full thickness tissue loss where the base of the ulcer is covered by slough and/or eschar) and deep tissue injuries (intact or non-intact skin with localised and persistent non-blanchable deep red, maroon, purple discolouration, where the wound may evolve rapidly to reveal the actual extent of the injury or resolve without tissue loss). PUs cause physical, social and psychological harm to patients (Gorecki et al., 2014) and reduced quality of life in both patients and family caregivers (Rodrigues et al., 2016). They also have important implications for healthcare providers in terms of treatment expenditure (Demarré et al., 2015), avoidable hospital admission, and delayed hospital discharge (Majeed et al., 2012).

There is a paucity of high-quality epidemiological studies of PUs in community settings (Hopkins and Worboys, 2015). However, a medical record review in New England in the United States (US) found the prevalence of adult patients admitted to hospital with a PU was 7.4% (Corbett et al., 2017). Meanwhile a medical record review in Italy found the prevalence of patients who were referred to a regional community palliative care team with a PU was 13.1% (Artico et al., 2017).

Good clinical guidelines have the potential to transform healthcare practices, improve patient outcomes and promote efficient use of resources. For the care of people with or at risk of PUs, these include international guidelines produced by NPUAP/EPUAP/PPPIA (2019) and national guidelines produced by the National Institute for Health and Care Excellence (NICE) (2014) for use in England and Wales, and the Institute for Healthcare Improvement (2011) for application in the US. A central feature of these guidelines is the SSKIN bundle (NHS Midlands and East, 2012), which comprises the essential elements of PU prevention: support surfaces, skin inspection, keep patients moving, incontinence/moisture, and nutrition/hydration. More recently, the model has been extended to ASSKING (NHS Improvement, 2018), which recognises the importance of risk assessment and giving information.

There is widespread acknowledgement that translating guidelines into clinical practice is often a slow process. Analysis of data from Safeguarding Adults Reviews in care homes (Manthorpe and Martineau, 2017a) and community settings (Manthorpe and Martineau, 2017b) suggest that PU prevention and management guidelines are inconsistently utilised. These studies identified problems with individual practice (such as failure to conduct risk assessments) as well as failings in multi-agency working.

Despite evidence to suggest guidelines are inconsistently utilised, there is a paucity of research exploring the drivers for variation in community PU care. One exception is a study by McGraw (2018), which explored the root causes of community-acquired PUs from the perspective of district nurses delivering healthcare to people in their own homes using the Model for Examining Safety and Quality Concerns in Home Healthcare (Henriksen et al., 2009). This study provided an insight into the unique dimensions of risk in community settings and the factors contributing to community-acquired ulcers, including: patient and provider characteristics, nature of home healthcare tasks, social and community environment, medical devices and new technology, and physical and external environment. However, the exclusive focus on district nurses limits the transferability of the findings to the wider community healthcare team. Furthermore, whilst the study was an early adopter of the aforementioned conceptual model, there are more contemporary models that describe the process of translating evidence into practice and the factors that influence implementation outcomes (Lynch et al., 2018). Therefore, further research is indicated to add to our understanding of risk in community settings and advance our ability to explain and/or predict how and why implementation succeeds or fails.

One contemporary model describing the process of translating evidence and the factors that influence outcomes is the Theoretical Domains Framework (TDF) (Cane, O'Connor and Mitchie, 2012). The TDF provides a lens through which to observe the cognitive, affective, social and environmental influences on behaviour (Aitken et al., 2017). It was derived from 33 theories of behaviour and behaviour change and classifies influences on behaviour into 14 domains (Table 1). The framework has been shown to be useful across healthcare settings, including out-of-hospital settings; for example, to identify the factors that influence community wound care (Gray et al., 2018) and the barriers and facilitators to preventing PUs in nursing home residents (Lavallée et al., 2018).

Using the TDF, the aim of present study was to explore practitioners' perceived barriers to and enablers of the implementation of evidence-based PU prevention and management recommendations in an integrated community care setting. The findings will inform strategies to enhance implementation in the service where the study is conducted and, more broadly, increase understanding of factors that are important to implementation of evidence-based PU care.

Methods

Design

This was a qualitative study in which the TDF informed data collection and data analysis.

Setting

The study took place in London, England. The setting was a community Trust, which delivered healthcare through locality-based extended primary care teams (PCTs), comprised of registered nurses, physiotherapists, occupational therapists, healthcare assistants and rehabilitation support workers. Each team worked from shared administrative offices.

The Trust had introduced a number of initiatives to reduce PU occurrence including: the appointment of skin care champions, voluntary roles for nurses with an expressed interest in PUs to motivate colleagues to improve practice; the recruitment of a number of dedicated PU improvement facilitators, whose substantive role was to support the development, implementation and maintenance of high quality, safe and sustainable PU care; and requiring those working in clinical roles to undertake annual PU training. The Trust was committed to maximising every clinician’s contribution to PU care. To that end, initiatives also included upskilling allied healthcare professionals (AHPs) in PU prevention. These initiatives were endorsed by local AHP leaders.

According to the Trust's Quality Accounts for 2017/18, there were 15 category 3 and 4 ulcers reported each month in 2014 but this number decreased to five each month in 2018. However, the Trust recognised the need to continually improve and ensure that best practice is delivered.

Sampling

Nurses are the largest group of healthcare professionals providing community care (NHS Digital, 2018) followed by AHPs (NHS England, 2017). Purposive sampling was used to select nurses and AHPs from the PCTs who had experience preventing and managing PUs amongst adults living at home. Within each team, the ratio of nurses to AHPs was 11 to 4.

Eligible participants included occupational therapists and physiotherapists (therapists) and registered nurses. Healthcare assistants and rehabilitation support workers were excluded as they do not have the same defined accountability and delegation responsibilities as registered practitioners.

In determining sample size, the guiding principle was data saturation. An *a priori* sample size for the first round of analysis was set at ten. After ten interviews, the point of data saturation was defined as being when three further consecutive interviews had been conducted with no new ideas emerging (Francis et al., 2010).

The study was undertaken in partial fulfilment of an MSc by the first author, who is a tissue viability (TV) specialist nurse in the organisation where the study took place. Whilst she had no line management responsibility for the intended sample population, to minimise the risk of bias, anyone who acted as a link between the PCTs and the TV service (such as skin care champions) was excluded from the sample.

The study was advertised by posters displayed in staff areas. The first author also presented the study at team meetings. During these presentations, she declared her position, and set out the purpose, methods and intended uses of the research and what participation would entail. Anyone who subsequently expressed an interest in taking part was emailed a participant information sheet. Participation was voluntary.

Ethical approval was obtained from the School of Health Sciences Research Ethics Committee at City, University of London (MSc/18-19/05). Governance approval was obtained from the Research and Development department in the participating NHS site.

Procedure

Data were collected in semi-structured interviews using a topic guide, which was informed by the research aim and the domains in the TDF. One to three questions were developed per domain. The guide was tested in pilot interviews with three practitioners sharing similar characteristics as the intended sample and amended following their feedback and the interviewer's reflections (Appendix 1). Pilot data were not included in the analysis.

Face-to-face interviews were conducted by the first author in a private room at participants' workplace at a time that was convenient to the participant. Informed consent was obtained in writing. Before the interview began, participants were asked to complete a brief demographic questionnaire. Data were collected during a four-month period up to February 2019. All interviews were audio recorded. Data saturation was deemed to have occurred after thirteen interviews.

Analysis

Audio recordings were transcribed verbatim. Analysis followed five steps:

1. Deductive coding of the transcripts, informed by the TDF. Quotes that related to barriers or enablers to PU care were coded into one or more of the TDF domains. To promote rigour, a proportion were independently coded by CT and KM, who then discussed any differences until consensus was reached. Acceptable reliability was said to be achieved when agreement reached 60% (Atkins et al., 2017). This was achieved after coding the third transcript. The remainder were then coded by CT.

2. Specific ‘belief statements’ were generated inductively. A belief statement is a statement that summarises a group of responses which have a similar underlying meaning. Belief statements were created using Microsoft® Excel by CT and reviewed by KM.

3. The most often cited barriers and enablers were calculated using the frequency with which participants mentioned each specific belief. This quantitating of qualitative data is widely used in TDF research and in the present study, contributed to the identification of the most relevant domains (Step 5).

4. Belief statements were coded back into the TDF domains to ensure accuracy. This was performed by an independent coder who was blinded

to the domain in which the statement had been devised and asked to appoint a TDF domain to each statement.

5. The most relevant domains were identified by concurrently considering (a) the frequency of the beliefs across all interviews, (b) the presence of conflicting beliefs (e.g. I know/don't know the guidelines) and (c) the likely salience of the belief in influencing participants' behaviour.

All participants were asked if they wanted to receive a copy of the final study report. Furthermore, on completion of the study, the first author presented the study findings to seven participants, who indicated the analysis reflected their views, feelings and experiences.

Findings

Thirteen interviews were conducted; interview duration varied between 25 and 35 minutes (mean 31 minutes). Participants included nine nurses and four therapists (two physiotherapists and two occupational therapists). There were eleven women and two men. Participants had been qualified for between 1 and 30 years (mean 9.5 years). All participants had worked in the community for more than one year and had completed PU training in the last year.

All 14 theoretical domains of the TDF were mentioned by at least five participants. Seven domains were mentioned by all participants: (i) Social/professional role and identity (ii) Beliefs about consequences (iii) Knowledge (iv) Skills (v) Environmental context and resources (vi) Social influences and (vii) Goals. The least frequently mentioned domains were Emotion, Intentions, and Behavioural regulation. A total of 41 specific belief statements were generated, ranging from one to ten per domain (Table 2).

This section focuses on the domains that were identified as most relevant to implementation of best practice in PU prevention and management. Three domains (Knowledge, Skills and Beliefs about capabilities) were closely linked and have been combined in the presentation of the findings.

Goals

All participants expressed how important they felt it was to prevent PUs and were highly motivated to do so. Prevention was regularly discussed at team meetings and several participants reported prioritising skin checks in their practice.

Social/professional role and identity

All participants considered the implementation of evidence-based practice (EBP) in PU prevention and management to be part of their role. However, the pressure related activities they undertook and the frequency with which they were undertaken differed according to their professional background.

Nurses indicated that PU care was a part of their everyday job (*It's a huge part of my day to day work… we have to do the prevention stuff every day* – Nurse.13). For these participants, pressure related activities included: escalating safeguarding concerns, completing incident report (datix) forms, categorising ulcers, performing wound care, seeking advice on complex wounds from TV colleagues, ensuring the provision of moving and handling equipment, facilitating the establishment of care packages that addressed PU prevention and management needs, and educating patients, family caregivers and paid carers. The ASSKING care model was widely used with a focus on assessing risk, providing support surfaces (from heel protectors to lateral turning systems), and regular skin inspection.

For therapists, pressure related activities included: skin inspection, assessing risk, escalating concerns about skin damage to nurses, providing support surfaces (primarily cushions), and completing datix forms. Two participants indicated that these activities would not ordinarily be the responsibility of a therapist (*'Not professionally in general, but … it is for this Trust'* – Therapist.7); however, they largely accepted the expansion of the AHP role to include PU activities.

Beliefs about consequences

All participants identified the consequences of either implementing or not implementing evidence in PU care. The predominant concern was patient wellbeing. Twelve participants reported that PUs were a significant source of physical, social and psychological burden to patients. The former included not only pain but complications such as infection with the potential for sepsis and death. Participants explained how quickly skin breakdown occurred and the need to be vigilant to signs of damage (*'They can happen so quickly it's a shock to us how rapidly… somebody can end up with a sore'* – Therapist.1). Implementing best practice was recognised as benefitting both the patient and the wider health system. Five participants referred to financial savings associated with evidence implementation (*'This will save money on dressings and our time* – Nurse.8).

Knowledge, Skills and Beliefs about capability

Few participants engaged directly with PU guidelines. For example, whilst six participants were aware that international and national guidelines existed, only two had read them. Six participants referred to the availability of local guidelines but found it quicker to ask a colleague for advice than it was to access the guidelines from the intranet (*'…they are there but to be honest I tend to ask a colleague if I am unsure'* - Nurse.12).

Therapists reported that their undergraduate training did not provide them with the skills for the extended role they were now expected to perform (*'They were great at Uni… but I don't think it did prepare me for working in the community and [PUs were] a really new thing to me…'* – Therapist.3). Nurses did not express similar concerns.

Despite different baseline levels of knowledge, participants from all backgrounds were satisfied with the provision of in-house training (*'There's always training available and classes in the trust on wound management and PU prevention'* – Nurse.9). However, self-assessment of current levels of knowledge, skills and capabilities varied. For example, nurses' self-assessment of their PU knowledge was generally high, as was their assessment of their skills and capabilities to undertake PU care; however, therapists were equivocal, with all four identifying both knowledge deficits and concerns about their ability to accurately categorise PUs (*‘I am not confident enough to say ‘yeah, that’s a whatever grade’* – Therapist.7).

Memory, attention and decision making

Five nurses reported automaticity in PU care (*‘I don’t really have to think about PU prevention because most of the patients I see are at risk and so now it’s just part of my routine practice* – Nurse.13). In contrast, three therapists felt their behaviour was not yet routine (*‘You can get distracted… side tracked … I still have to make a conscious decision or effort to remember to check PUs’* – Therapist.7). When behaviour was not automatic, therapists found memory prompts useful; these included crib cards and patient alerts (notifications about high-risk patients received via the computerised record system).

Environmental context and resources

Key consumable resources reported by participants to help prevent and manage PUs included support surfaces, moving and handling equipment, easy availability of wound dressings, and – to varying degrees - mobile working solutions. Time was also characterised as an important resource.

Prompt provision of support surfaces and moving and handling equipment was highlighted by participants as being critical to effective PU prevention and management. Two participants remarked how easy it was to acquire such equipment locally. However, according to one participant, putting large items (such as hoists) to use was less straightforward due to the presence of clutter (*‘… the patient’s home environment may get in the way* *of delivering best practice, I am thinking of cluttered homes, so no space for equipment'* – Nurse.10).

Not only was clutter a barrier to equipment provision, it also impacted on other aspects of care delivery; for example, it prevented one participant from checking the patient's skin (*'You know if there is clutter in the home it sometimes hinders an assessment … you know there may be no space to stand the patient'* – Therapist.6).

All participants talked about their heavy workloads and its impact on the time available to attend to PU prevention (*'Shortage of staff prevents us from carrying out the things we should be doing for PU prevention'* – Nurse.4). Whilst the data suggested care was rarely left undone, activities threatened with cancelation included joint home visits and attendance at training events. The former are appointments where professionals from different disciplines see the patient together in order broaden their assessment.

To increase productivity and improve integrated working, remote working solutions had been introduced. These included the provision of iPads with access to EMIS (Egton Medical Information Systems) Mobile, which allowed practitioners to securely review, share and upload patient notes at any time, and at any location. First contact assessment and wound assessment templates were available on EMIS. Five participants described using iPads to complete assessment documentation in patients' homes. One said these devices helped them work more efficiently (*I am not always having to rush back to the base to write my documentation, I* *can just do it wherever I am'* – Nurse.13). However, two believed they were a barrier to rapport during assessments, and two said that following their implementation, they felt there was an expectation that practitioners would spend more time in the field, which afforded them less time to troubleshoot with colleagues (*'We'll be more out there with our iPads and that'll make it harder for us to implement… good practice as there will be less face to face meetings'* – Nurse.5*).* Despite these concerns, remote working solutions included functions that individual practitioners found helpful, such as EMIS patient alerts. Another participant explained how they allowed them to be more responsive to queries from colleagues (*'Especially if one of my team ring me about a patient, because it means I have all their electronic medical records with me instead of having to wait until I am back at the office'* – Nurse.10).

Social influences

This domain generated the most discussion (10 belief statements from 13 participants). It identifies how social norms, families and other members of the clinical team either facilitated or hindered implementation of EBP.

With respect to social norms, the first challenge was related to skin inspection. In order to conduct a thorough inspection, patients had to be willing to expose their skin. Three therapists described how they or the patient were sometimes too embarrassed to allow the inspection (*'I am not always comfortable asking a lady if I can look at her bottom'* – Therapist.7). In contrast, nurses did not raise any concerns regarding either the provision of intimate care or acceptance of that care by the patient.

The second challenge was conversational etiquette, in particular difficulties initiating conversations with patients about the implications of them refusing to accept advice and equipment. Nine participants described patient non-adherence as a significant barrier to EBP (*'So people may not want to follow the recommended advice or accept the equipment'* – Nurse.10). However, three believed colleagues were reluctant to engage in conversations about the risks and consequences of non-adherence (*'Sometimes as nurses we don't want to have difficult conversations with patients like … 'if you have a PU and you don't let us treat it and then it gets infected, you could die''* – Nurse.2).

Family members were an important social influence. Participants sometimes found it difficult to engage families in prevention and management strategies. For example, four recalled occasions when the provision and use of support surfaces had become problematic (*'The son doesn't like the bed we had recommended for a patient'* – Nurse.5). In contrast, four participants described how effective partnerships with families reduced the likelihood of pressure damage and facilitated healing (*'Families can be a huge support actually, they're our eyes and ears when we're not there and … if you don't have that relationship it can be a huge issue'* – Nurse.12). For this reason, participants were anxious not to undermine the mutual trust upon which their relationship with family caregivers was dependent. For example, two participants recognised the need for sensitivity in order to avoid conveying any lack of confidence in the family's honesty or ability (*'I think sometimes the family say 'don't worry, there is no problem with the skin, we have checked [it] and it's all fine' and I don't feel comfortable overriding them and saying 'I need to check anyway''* – Nurse.13).

Participants emphasised the benefits of integrated multi-disciplinary team working for PU prevention and management. Seven participants described working cooperatively within the multi-disciplinary team context to achieve the best patient outcomes (*'I sat down with an [occupational therapist] the other day and worked out the risks'* – Nurse.2). This integration helped ensure the accessibility of team members ('*It's really good now that we all work as one big team… physios and our nursing colleagues all in one place so if ever there are issues… you can always check in'* – Nurse.11).

Participants identified two especially influential members of the team: PU improvement facilitators, and team leaders. All participants praised the former (*'PU nurses certainly have been a great influence… of how to do things… thoroughly and correctly* – Therapist.3). Eight participants referred to supportive team leaders. However, one therapist complained their concerns regarding the expansion of the therapy role to include skin inspection were not acknowledged (*'The way that it was explained to me originally was, 'well you're going to have to check people's bottoms' and that's not necessarily the best way to explain [it]'* - Therapist.3).

Optimism

Eight participants talked optimistically about the future and anticipated a time when, either as an individual or an organisation, they would achieve further improvements in patient outcomes (*‘We work in a good Trust [and] I am optimistic that as we learn more and more, we can get even better’* – Nurse.11). Two more participants expressed conditional optimism, contingent on either the receipt of additional training or further developments in team working.

Discussion

The purpose of this study was to explore and report the barriers and enablers perceived by practitioners as influencing the implementation of best practice in PU care in an integrated community care setting. The setting was a community Trust, which had a track record of reducing harm from PUs. In this context, enablers of best practice included a high level of motivation, which manifested in participants accepting responsibility for PU care. It also manifested in participants’ concern for both the physical, social and psychological wellbeing of the patient affected by PUs, and the financial cost of pressure ulceration. Similar findings were reported by Lavallée et al (2018) in their exploration of the barriers and facilitators to preventing PUs in nursing homes from the perspective of 25 participants (including nursing home participants, registered nurses, and TV nurses) in the North West of England; however, given that UK nursing home provision is largely privately funded, emphasis was on patient wellbeing rather than the financial cost to the wider NHS.

In the present study, implementation was also enabled by high levels of PU knowledge, skills and capabilities amongst nurses; the availability of aides-memoire for those in whom automaticity in PU activities had not been achieved; prompt provision of nursing equipment; integrated working and locating different professionals in shared offices; and the presence of PU improvement facilitators. Of particular note were the latter, whose contribution was recognised by all participants. Unlike more established skin care champion roles (Bergquist-Beringer et al., 2009), the role of the PU improvement facilitator is a novel one that has not previously been described in the literature. Whilst not without resource implications, they were reportedly central to influencing the implementation of EBP and may prove useful in other areas. As a result of these findings, the NHS Trust in which the study was conducted has introduced PU improvement facilitators into another of its community services.

Family members were both a barrier and a facilitator to EBP. On the one hand they could refuse equipment whilst on the other they acted as the eyes and ears of nurses between scheduled visits. The importance of family caregivers was also reported by McGraw (2018) who cited occasions when families neither recognised the significance of early skin changes nor escalated them to healthcare providers in a timely fashion. Little is known about the availability or effectiveness of lay carer education for PU prevention (O’Connor et al, 2015); however, the findings from the present study suggest there is a need to develop interventions to support family caregivers. In response to these findings, the Trust is exploring the feasibility of an educational app for family caregivers similar to the iCare

PU App, which is available in neighbouring boroughs (McKeown et al, 2020).

Key barriers to best practice included patient non-adherence and participants’ fear of violating social norms. The home environment differs to hospital settings (Ellenbecker et al., 2008). The home is indisputably under the jurisdiction of the patient. As such, patients are in complete control of all decisions regarding the implementation of their care and treatment. In the present study, participants reported that patients frequently exercised their autonomy in this respect. When their decisions had the potential to adversely affect their health and wellbeing, practitioners sometimes avoided initiating conversations about the possible consequences. Similarly, social rules and conventions relating to intimate anatomical locations got in the way of therapists undertaking skin inspections. These findings are congruent with those reported by McGraw (2018), whose participants described difficulties initiating conversations with patients about risk and behaviour change. In the same study, participants described how they and their colleagues often conducted themselves as guests in patients’ homes, which made any request to inspect the sacrum difficult. Together, these findings suggest that behavioural interventions which address the unease practitioners experience communicating difficult information and seeking permission to inspect pressure areas may be critical to optimal implementation of EBP.

Key barriers also included the home environment as participants described the presence of clutter as an obstacle to equipment provision, mobilisation and anatomical inspection. They did not describe patients whose behaviour necessarily met the diagnostic criteria for hoarding disorder but patients whose everyday possessions had accumulated. The hazards associated with clutter has been highlighted in other research; particularly research pertaining to falls (Postlethwaite, Kellett, and Mataix-Cols, 2019) and the occupational wellbeing of community nurses (Markkanen et al., 2017). In relation to PU care, McGraw (2018) identified clutter as a source of frustration; however, the present study is the first in which participants describe clutter as an obstacle to care delivery. The literature suggests removing clutter is not always straightforward or appreciated amongst older people. In terms of ease, older people may be less physically or cognitively able to engage in clutter removal. In terms of appreciation, items that professionals regard as clutter can be meaningful and ordered to the older person (Lutz, 2010). However, where clutter is a barrier to EBP, practitioners should ask patients and family members to initiate decluttering efforts. Where this is not possible, social services may be able to provide support such as signposting to cleaning contractors or other specialist schemes. One such scheme is the Attic Project in Wales, which recognises and confronts the emotional difficulties associated with decluttering and helps older people make space at home, whilst sharing memories about treasured possessions (Care and Repair, 2019).

Barriers less amenable to behavioural intervention at an individual or Trust level included the omission of PU content in undergraduate education for AHPs and high workloads. In the present study, therapists reported that their preregistration training had not prepared them to undertake PU care. This gap in undergraduate education has previously been reported. For example, Worsley et al (2016) used focus groups to explore the barriers and facilitators to AHP's participation in PU prevention in hospital settings; five physiotherapists and four occupational therapists took part in the study and all reported that they did not acquire PU knowledge as part of their basic pre-registration training. According to NHS England (2017), the effective and efficient deployment of AHPs is key to supporting integration and reducing duplication and fragmentation in community care. However, these findings suggest that gaps in undergraduate education need to be addressed. This would include learning related to the physiology of skin layers, a prerequisite to developing knowledge and skills in categorising PUs post registration. In response to the study findings, the Trust in which this research was conducted has included PU training as part of the induction programme for new AHPs and ongoing training and support to therapy teams.

Staff shortages and high workloads are pervasive across healthcare settings (Beech et al, 2019). In the present study, many participants argued that increased workloads affected their ability to effectively prioritise PU prevention activities. Similar findings were reported by Gray et al (2018) in their investigation of the factors that influence community wound care from the perspective of 46 clinical professionals who cared for patients with complex wounds. They found that in the context of increased demand and diminished resources, nursing roles were perceived as increasingly task orientated, meaning nurses focused on undertaking scheduled tasks rather than proactively identifying new or changing needs. Whereas, in the present study, despite concerns regarding workloads, the

Trust had successfully reduced PU incidence. Some participants attributed this success to the provision of mobile working solutions, which enabled them to better manage their workloads and implement EBP by working smarter not harder. However, further research is needed to examine more closely the relationship between mobile working and the implementation of EBP.

Strengths and limitations

The study had several strengths. The findings support earlier research exploring the factors that contribute to pressure ulceration in community settings. In addition, it captures the views of both nurses and therapists. By applying the TDF it provides a theory-based understanding of the context and behaviours involved in PU care in integrated teams in community settings. However, the study was not without limitations. Participants were self-selecting. Therefore, their views might not have been representative; those who volunteered might have been more motivated to implement best practice than those who did not. Interviews also run the risk of introducing bias, where participants strive to conform to what they believe is socially acceptable, in this instance because the interviewer was a TV specialist nurse. Furthermore, only four AHPs took part in the study. Whilst the number recruited reflected their representation in the workplace, the inclusion of additional therapists might have provided more detailed insight into their perspectives. Notwithstanding this limitation, data from AHPs largely reflected other research in the field, which increases the trustworthiness of our findings.

Conclusion

This study provides new insights into the factors perceived by practitioners as influencing the implementation of best practice in PU prevention and management in an integrated community care setting. Potential routes to addressing implementation challenges include enhancing undergraduate education for AHPs, establishing novel PU improvement facilitator roles, supporting practitioners communicating difficult information and, offering assistance with decluttering. Further research is also recommended to explore the support needs of family carers, and the impact of mobile working solutions on the implementation of EBP.

References

Aitken, L., Francis, J., Islam, R., O'Connor, D., Patey, A., Ivers, N., Foy, R., Duncan, E., Colquhoun, H., Grimshaw, J., Lawton, R., and Michie, S. (2017) A guide to using the Theoretical Domains Framework of behaviour change to investigate implementation problems, Implementation Science, doi: https://doi.org/10.1186/s13012-017-0605-9

Artico, M., Dante, A., and D'Angelo, D. (2017) Prevalence, incidence and associated factors of pressure ulcers in home palliative care patients: A retrospective chart review, Palliative Medicine, doi: https://doi.org/10.1177/0269216317737671

Beech, J., Bottey, S., Charlesworth, A., Evans, H., Gershlick, B., Hemmings, N., Imison, C., Kahtan, P., McKenna, H., Murray, R., & Palmer, B. (2019) Closing the gap: Key areas for action on the health and care workforce. Available at:

https://www.kingsfund.org.uk/sites/default/files/2019-03/closing-the-gap-health-care-workforce-full-report.pdf

Bergquist-Beringer, S., Derganc, K., and Dunton, N. (2009) Embracing the use of skin care champions, Nursing Management, doi: 10.1097/01.NUMA.0000365465.01722.4b

Cane, J., O'Connor, D., and Michie, S. (2012) Validation of the theoretical domains framework for use in behaviour change and implementation science, Implementation Science, doi: https://doi.org/10.1186/1748-5908-7-37

Care and Repair (2019) The Attic Project: Helping people to make space and reminisce. Available at: https://www.careandrepair.org.uk/files/7215/7856/9892/Attic_Project_Impact_Report.pdf

Corbett, L., Funk, M., Fortunato, G., and O'Sullivan, D. (2017) Pressure injury in a community population: A descriptive study, Journal of Wound, Ostomy and Continence Nursing, doi: 10.1097/WON.0000000000000320

Demarré, L., Van Lancker, A., Van Hecke, A., Verhaeghe, S., Grydonck, M., Lemey, J., Annemans, L., Beekman, D. (2015) The cost of prevention and treatment of pressure ulcers: A systematic review. International Journal of Nursing Studies, doi: 10.1016/j.ijnurstu.2015.06.006

Ellenbecker, C., Samia, L., Cushman, M., and Alster, K. (2008) Patient Safety and Quality in Home Health Care, in Hughes, G. (ed) Patient Safety and Quality: An Evidence Based Handbook for Nurses. Rockville (MD): Agency for Healthcare Research and Quality

Francis, J., Johnston, M., Robertson, C., Glidewell, L., Entwistle, V., Eccles, M., & Grimshaw, J. (2010) What is an adequate sample size? Operationalising data saturation for theory-based interview studies. Psychology and Health, doi: 10.1080/08870440903194015

Gorecki, C., Nixon, J., Lamping, D., Alavi, Y., and Brown, J. (2014) Patient-reported outcome measures for chronic wounds with particular reference to pressure ulcer research: A systematic review, International Journal of Nursing Studies, doi: https://doi.org/10.1016/j.ijnurstu.2013.03.004

Gray, T., Wilson, P., Dumville, J., and Cullum (2018) What factors influence community wound care in the UK? A focus group study using the Theoretical Domains Framework, BMJ Open, doi: 10.1136/bmjopen-2018-024859

Guest, J., Ayoub, N. McIlwraith, T., Uchegbu, I., Gerrish, A., Weidlich, D., Vowden, K., and Vowden, P. (2016) Health economic burden that different wound types impose on the UK's National Health Service. International Wound Journal, doi: 10.1111/iwj.12603

Henriksen, K., Joseph, A., and Zayas-Caban, T. (2009) The human factors of home health care: a conceptual model for examining safety and quality concerns, Journal of Patient Safety, doi: 10.1097/PTS.0b013e3181bd1c2a

Hopkins, A., and Worboys, F. (2015) Establishing community wound prevalence within an inner London borough: Exploring the complexities, Journal of Tissue Viability, doi: https://0-doi-org.wam.city.ac.uk/10.1016/j.jtv.2015.01.004

Institute for Healthcare Improvement (2011) How-to Guide: Prevent Pressure Ulcers. Available at: http://www.ihi.org/resources/Pages/Tools/HowtoGuidePreventPressureUlcers.aspx

Lavallée, J., Gray, T., Dumville, J., and Cullum, N. (2018) Barriers and facilitators to preventing pressure ulcers in nursing home residents: A qualitative analysis informed by the Theoretical Domains Framework, International Journal of Nursing Studies, 82: 79 – 89

Lutz, P. (2010) Clutter moves in old age homecare, in Schillmeier, M., and Domenech, M (editors) New Technologies and Emerging Spaces of Care. London: Routledge

Lynch, E., Mudge, A., Knowles, S., Kitson, A., Hunter, S., Harvey, G. (2018) There is nothing so practical as a good theory: a pragmatic guide for selecting theoretical approaches for implementation projects, BMC Health Services Research, doi: https://doi.org/10.1186/s12913-018-3671-z

Majeed, M., Williams, D., Pollock, R., Amir, F., Liam, M., Foong, K., and Whitaker, C. (2012) Delay in discharge and its impact on unnecessary hospital bed occupancy, BMC Health Services Research, doi: 10.1186/1472-6963-12-410

Manthorpe, J., and Martineau, S. (2017a) Pressure points: Learning from Serious Case Reviews of failures of care and pressure ulcer problems in care homes, The Journal of Adult Protection, doi: https://doi.org/10.1108/JAP-11-2016-0029

Manthorpe, J., and Martineau, S. (2017b) Home pressures: Failures of care and pressure ulcer problems in the community – the findings of serious case reviews, The Journal of Adult Protection, doi: https://doi.org/10.1108/JAP-03-2017-0013

Markkanen, P., Galligan, C., and Quinn, M. (2017) Safety risks among home infusion nurses and other home health care providers, Journal of Infusion Nursing, doi: 10.1097/NAN.0000000000000227

McGraw, C. (2018) Nurses' perceptions of the root causes of community-acquired pressure ulcers: Application of the Model for Examining Safety and Quality Concerns in Home Healthcare, Journal of Clinical Nursing, doi: 10.1111/jocn.14652

McKeown, E., McGraw, C., Holder, P., Hirani, S. (2020) Carers and pressure ulcers: A pilot study examining the acceptability and impact of an educational app. London: City, University of London

National Institute for Health and Care Excellence (2014) Pressure ulcers: prevention and management [CG179]. Available at: https://www.nice.org.uk/guidance/cg179

National Pressure Ulcer Advisory Panel, European Pressure Ulcer Advisory Panel, and Pan Pacific Pressure Injury Alliance (2014) Prevention and Treatment of Pressure Ulcers: Quick Reference Guide. Available online: https://www.epuap.org/wp-content/uploads/2016/10/quick-reference-guide-digital-npuap-epuap-pppia-jan2016.pdf

National Pressure Ulcer Advisory Panel, European Pressure Ulcer Advisory Panel, and Pan Pacific Pressure Injury Alliance (2019) Prevention and Treatment of Pressure Ulcers/Injuries: Clinical Practice Guideline, The International Guideline. Available at: https://guidelinesales.com/

NHS Digital (2018) NHS Workforce Statistics – September 2018. Available at: https://digital.nhs.uk/data-and-information/publications/statistical/nhs-workforce-statistics/september-2018

NHS England (2017) AHPs into Action: Using AHPs to transform health, care and wellbeing. Available at: https://www.england.nhs.uk/publication/ahps-into-action/

NHS Improvement (2018) Pressure ulcer core curriculum. Available at: https://improvement.nhs.uk/resources/pressure-ulcer-core-curriculum/

NHS Midlands and East (2012) Stop the pressure pathway. Available at: http://nhs.stopthepressure.co.uk/

NHS Scotland (2017) The Prevention and Management of Pressure Ulcers. Available at: https://www.nes.scot.nhs.uk/media/3978822/pressure_ulcers_reference_book_dec_2017_-_final.pdf

O'Connor, T., Moore, Z., Dumville, J., and Patton, D. (2015) Patient and lay carer education for preventing pressure ulceration in at-risk populations, Cochrane Systematic Review – Intervention – Protocol, doi: https://doi.org/10.1002/14651858.CD012006

Postlethwaite, A., Kellett, S., and Mataix-Cols, D (2019) Prevalence of hoarding disorder: A systematic review and meta-analysis, Journal of Affective Disorders, doi: https://doi.org/10.1016/j.jad.2019.06.004

Worsley, P., Clarkson, P., Bader, D., and Schoonhoven (2017) Identifying barriers and facilitators to participation in pressure ulcer prevention in allied healthcare professionals: a mixed methods evaluation, Physiotherapy, doi: 10.1016/j.physio.2016.02.005

Table 1: Theoretical Domains Framework (Cane, O'Connor and Michie, 2012)

Domain (definition)	**Constructs**
1. Knowledge (an awareness of the existence of something)	Knowledge (including knowledge of condition/scientific rationale) Procedural knowledge Knowledge of task environment
2. Skills (an ability or proficiency acquired through practice)	Skills Skills development Competence Ability Interpersonal skills Practice Skills assessment
3. Social/professional role and identify (a coherent set of behaviours and displayed personal qualities of an individual in a social or work setting)	Professional identity Professional role Social identity Identity Professional boundaries Professional confidence Group identity Leadership Organisational commitment
4. Beliefs about capabilities (acceptance of the truth, reality or validity about an ability, talent or facility that a person can put to constructive use)	Self-confidence Perceived competence Self-efficacy Perceived behavioural control Beliefs Self-esteem Empowerment Professional confidence
5. Optimism (the confidence that things will happen for the best	Optimism Pessimism

or that desired goals will be attained)	Unrealistic optimism Identity
6. Beliefs about consequences (acceptance of the truth, reality, or validity about outcomes of a behaviour in a given situation)	Beliefs Outcome expectancies Anticipated regret Consequents
7. Reinforcement (increasing the probability of a response by arranging a dependent relationship, or contingency, between the response and a given stimulus)	Rewards (proximal/distal, valued/not valued, probable/improbable) Incentives Punishment Consequents Reinforcement Contingencies Sanctions
8. Intentions (a conscious decision to perform a behaviour or a resolve to act in a certain way)	Stability of intentions Stages of change model Transtheoretical model and stages of change
9. Goals (mental representations of outcomes or end states that an individual wants to achieve)	Goals (distal/proximal) Goal priority Goal/target setting Goals (autonomous/controlled) Action planning Implementation intention
10. Memory, attention and decision processes (the ability to retain information, focus selectively on aspects of the environment and choose between two or more alternatives)	Memory Attention Attention control Decision making Cognitive overload/tiredness
11. Environmental context and resources (any circumstance of a person's situation or environment that discourages or encourages the development of skills and abilities, independence, social competence and adaptive behaviour)	Environmental stressors Resources/material resources Organisational culture/climate Salient events/critical incidents Person x environment interaction Barriers and facilitators
12. Social influences (those interpersonal processes that can cause individuals to change their thoughts, feelings or behaviours)	Social pressure Social norms Group conformity Social comparisons Group norms Social support Power Intergroup conflict

	Alienation Group identity Modelling
13. Emotion (a complex reaction pattern, involving experiential, behavioural, and physiological elements, by which the individual attempts to deal with a personally significant matter or event)	Fear Anxiety Affect Stress Depression Positive/negative affect Burn-out
14. Behavioural regulation (anything aimed at managing or changing objectively observed or measured actions)	Self-monitoring Breaking habit Action planning

Table 2: Belief Statements

Domain	Specific Belief	Sample Quote	No of participants
Knowledge (13)	I know we have guidelines to help guide practice, but I don't always use them	*I don't know how familiar I am with guidelines I just go with what I know. I know there are guidelines on the Intranet if I need them, but I haven't had to use them. I never really look at guidelines because there is so much support around that there is always someone to ask if I am not sure. There is loads of information.*	10
	I am familiar with guidelines for pressure ulcer prevention and management	*I am very familiar with them I know how to access them on the intranet and would go to them if I need to look something up that I was not sure about. Also, there is always the NICE guidelines and then there is the NMC code we need to work to.*	3
	My knowledge of pressure ulcers is limited	Yet we're still not one hundred percent on pressure ulcers and what we're looking for and is that right.	3
	I have a knowledge of pressure ulcer prevention and management	*I would say I have a good understanding of how to treat and manage pressure ulcers. I also know what we should be implementing prevention wise.*	4
Skills (13)	My pre-registration training did not prepare me for pressure ulcer prevention and management	*The only issue for me is if I am asked what grade it and that is becomes a grey area for me because I am not confident enough to say yeah that's a whatever grade, but I know it's something that needs to be*	4

Table 2: Belief Statements			
Domain	**Specific Belief**	**Sample Quote**	**No of participants**
		looked at by a nurse.	
	There is regular training to keep us updated	*There's always training available and classes in the trust on wound management and pressure ulcer prevention.*	10
	I have the skills for pressure ulcer prevention and management	*I know how to utilise the Waterlow and I know how to use the SSKIN bundle and I know about the need for proper care plans in place etc.*	11
Beliefs about Capabilities (10)	I am confident about pressure ulcer prevention and or management	*It's about having the confidence to sometimes have difficult conversations when the patient is resisting.*	8
	I sometimes find it difficult to carry out best practice	*But then I find that we get so much to concentrate on that it becomes you know a huge task to cover.*	6
Beliefs about Consequences (13)	If I don't implement best practice for pressure ulcer prevention and management patients will be suffer	*Patient deterioration. I mean pressure ulcers I think are underestimated. If that becomes infected, you're at huge risk of sepsis and dying. Yeah, it's serious, it's a big deal we just have to get it right.*	12
	If I implement pressure ulcer prevention it will benefit patients and the healthcare system	Well if you implement best practice when they are at risk then you shouldn't end up with a patient getting a pressure ulcer.	13

Table 2: Belief Statements

Domain	**Specific Belief**	**Sample Quote**	**No of participants**
Reinforcement (11)	I think we get motivated when good practice is recognised	Recognise good practice and give praise is a great motivator.	4
	I may have to account for my actions or omissions	Well we are nurses and have a duty of care, and if patients do become harmed in our care as a result of a pressure ulcer then we may be called to account.	4
	When we discuss pressure ulcer management in group meetings it encourages good practice	*“he RAG meetings as well which is great implementation, the safety huddle – great implementation to help deliver best practice.*	7
Memory Attention and Decision Process (11)	I adapt my practice in pressure ulcer prevention and management dependent on my patients needs	*But with some patients that I can clearly see are very, very, very low risk and it’s unlikely, I would still ask them (if i could check the skin) but it was more as a kind of “are you aware of pressure sores?” “do you know what they are?” kind of thing and, you know “do you notice anything on your skin.*	3
	Pressure ulcer prevention is automatic to me	*Nothing ever discourages me I always do this as a matter of routine (pressure ulcer prevention).*	6
	I don’t always think about pressure ulcer prevention all of the time	*Pressure ulcer prevention I think it’s still not automatic to be honest.*	4
Environmental	Low staffing levels make it difficult	*The existence of trained staff and having enough staff*	6

Table 2: Belief Statements			
Domain	**Specific Belief**	**Sample Quote**	**No of participants**
Context and Resources (13)	to deliver best practice	*to carry out best practice can sometimes be an issue.*	
	There is not enough time to do all the things I want to do to ensure delivery of best practice for pressure ulcer prevention and management	*Time is a big factor we have long lists and then have to do all our documentation and there never seems to be enough hours in the day sometimes.*	9
	I find that the electronic systems and remote working may hinder best practice in pressure ulcer prevention and management	*I don't often use the iPad at the moment to complete the initial template on EMIS because it quite lengthy and it's difficult to do both at the same time (talk and type).*	4
	Having access to electronic systems helps me to deliver best practice in pressure ulcer prevention	*Also, the iPads for mobile working are really useful. Especially if one of my team rings me about a patient, because it means I have all of their electronic medical records and with me instead of having to wait until I am back at the office to look things up.*	5
	We have access to equipment for the pressure ulcer prevention and management	*The equipment that helps I just, I know that pressure relieving mattresses, cushions, that's something that I implement quite a lot anyway.*	7
	There are external influences that may affect deliver of best practice	*Sometimes manual handling can be a struggle or a barrier because if you go into a patient's house on your*	7

Table 2: Belief Statements

Domain	**Specific Belief**	**Sample Quote**	**No of participants**
	in pressure ulcer prevention and management	*own and you can't move the patient then you can't check all of the skin.*	
	The Trust has put in place several measures to help us deliver best practice in pressure ulcer prevention and management	*We had the Qi project which brought about a lot of change. It was lots of little things that were introduced that helped us to make changes.*	10
Social Influences (13)	There is very good support from the Pressure Ulcer Improvement Facilitators (PUIF)	*And of course, the PUIF who is always around and again is a huge influence in making sure we are doing things by the book.*	13
	Team leaders support delivery of best practice	*Our team leader knows it is a big thing that has to be done and she is always encouraging us all to check the skin at each visit if the patient is at risk.*	7
	There is sometimes a lack of support	*So, and the way that it was explained to me originally which was "well, you're going to have to check people's bottoms" and that's not necessarily the best way to explain the importance and stuff.*	2
	There is collaborative working within the MDT teams	*I sat down with an OT the other day and worked out the risks.*	7
	Healthcare assistants and rehab	*We have rehab support workers who are unqualified*	5

Table 2: Belief Statements			
Domain	**Specific Belief**	**Sample Quote**	**No of participants**
	support workers play an important part in delivering best practice in pressure ulcer prevention and management	*staff who actually see the patients more than we do.*	
	Patient non-compliance has an effect on my implementation of best practice recommendations	*Also, when the patient is non-complaint is a big problem, but we still have to try to get them to comply we shouldn't be discouraged but sometimes we are.*	7
	It is important to foster a good working relationship with the patient to be able to have meaningful conversations about prevention and management	*I think that's the big thing we don't do, we don't talk with patients about risk because we have understanding that they you know we ask, 'can I check your bottom'? 'No thank you' then we just accept that's fine, but we need to disseminate risks to them.*	3
	I sometimes encounter gender and cultural sensitivity when I try to implement best practice if it involves looking at intermate areas	*Sometimes there are certain types of patients that I don't do because it's not appropriate so for example an elderly Muslim lady it might not be appropriate for me as a young man to be asking if I can look at her bottom.*	4
	Family members or carers can hinder implementation of best practice	*So, I got a referral this week saying the son doesn't like the bed we had recommended for a patient who was ninety-three and very high risk.*	10

Table 2: Belief Statements

Domain	**Specific Belief**	**Sample Quote**	**No of participants**
	Family and carers can help with pressure ulcer prevention	*I would say the family, in my experience, are normally quite supportive. I haven't really come across any negative influences, I haven't really come across it where the family have tried to hinder anything.*	5
Behavioural Regulation (9)	I use a plan/tool to help me deliver best practice in pressure ulcer and management	*So, I use [A]SSKIN[G] all the time.*	9
Intentions (7)	I will always act to try and prevent pressure ulcers	*Let's do the best practice we possibly can - I'd definitely encourage it.*	7
Social/Professional role and Identity (13)	I see pressure ulcer prevention as part of my role	*So yes, it's a big part of my job and also not just my own practice but ensuring that my team as well are aware of their responsibilities.*	13
	My role is extending to include pressure ulcer prevention	*I think any health professional, you know, it's our responsibility is the health and wellbeing of patients. It's still a new concept to me, it's odd because it seems really familiar for everyone else but for me this is quite a new thing, I don't think we ever discussed it in university even so … and I know that roles are merging a bit more, you know, nursing roles and a lot of the kind of… but it's something that I guess I still*	4

Table 2: Belief Statements

Domain	**Specific Belief**	**Sample Quote**	**No of participants**
		view as not a traditional OT role but maybe that's something that I just have to kind of get use to as we are encouraged to adopt a holistic approach.	
Optimism (10)	I am optimistic we can get even better at preventing pressure ulcers	*I am quite optimistic about implementing pressure ulcer prevention generally.*	10
Emotion (5	I have feelings of regret and worry if my patient develops a pressure ulcer	*And there is the worry that if something has gone wrong you may have to go before the NMC because you have forgotten something.*	5
Goals (13)	Pressure ulcer prevention is very important	*Like I said it is very important for me in my practice to check the skin integrity.*	13

Appendix 1: Topic Guide

Social and professional role
• How much of your work involves pressure ulcer prevention and management?

• What aspects of pressure ulcer prevention and management do you see as part of your role?
Knowledge
• Can you tell me how familiar you are with guidelines on pressure ulcer prevention and management? • Can you tell me how you might use the guidelines to inform your practice? • How well do you think the guidelines help you in pressure ulcer prevention and management?
Skills
• What skills/training do you need to be able to deliver best practice for pressure ulcer prevention and management?
Beliefs about capabilities
• Can you tell me of any difficulties you experience or anything that makes it easy for you to apply best practice in pressure ulcer prevention and management?
Beliefs about consequences
• What do you feel are the benefits of implementing best practice to patients who are at risk or who have a pressure ulcer? • What do you think might happen if you do not routinely implement evidence-based practice?
Reinforcement
• What encourages or discourages you from routinely implementing best practice?

- Can you explain how learning from incidents may affect your practice?
- Can you tell me about any processes that may be in place to help you share best practice in pressure ulcer prevention?

Goals

- Considering all the things you have to do when you are looking after a patient, can you explain how important it is to you to deliver best practice in pressure ulcer prevention and management?

Memory, attention and decision processes

- How would you routinely deliver best practice in pressure ulcer prevention and management (is it something you routinely do or do you make a deliberate decision about each patient)?
- Is it something you need to take time to think about?

Environmental context and resources

- What factors in your working environment facilitate or hinder you in delivering best practice in pressure ulcer prevention and management?

Social influences

- In what ways does the patient/carer/family influence your implementation of best practice in pressure ulcer prevention and management?

• How would other members of your team influence how you deliver best practice in pressure ulcer prevention and management?
Emotion
• Can you tell me if you have concerns or worries about pressure ulcer prevention and management? • Can you tell me of any occasion(s) when you worry about a patient developing a pressure ulcer?
Behavioural regulation
• What are your specific plans/procedures/ways of working for how and when you implement pressure ulcer prevention and management? Are there things that help to prompt you to do it? • If you wanted to bring about changes in your own practice (individual/team setting/practice setting) in the way you implement best practice to prevent and manage pressure ulcers, what would be some ways you might do this?
Intentions
• How do you think you will routinely implement best practice in the future? Is it something you feel you have to do?
Optimism
• How optimistic are you that in the future you will be able to deliver best practice despite any difficulties experienced?