

Role understanding of the interprofessional team in promoting movement for pressure ulcer prevention: An ethnographic study

Johanna Dreier^a, Sandra Staudacher-Preite^b , Hannah Bosshart^a, Sabine Hübsch^a, Peter Suter^a, Eva-Maria Panfil^{a,*}

^a University Hospital Basel, Petersgraben 4, 4031, Basel, Switzerland

^b Institute of Nursing Science (INS), Department of Public Health, Faculty of Medicine, University of Basel, Bernoullistrasse 28, 4056, Switzerland

ARTICLE INFO

Keywords:

Pressure ulcer
Prevention
Movement
Interprofessional relations
Qualitative research

ABSTRACT

Background: Interprofessional movement promotion is a key measure for preventing pressure ulcers. Although international guidelines emphasize the importance of interprofessional collaboration, it remains unclear what specific roles different professional groups assume in movement promotion and how they collaborate in clinical practice. Therefore, this study aimed to investigate the implementation of interprofessional movement promotion as well as the understanding, roles, and expectations of the involved healthcare professionals.

Methods: As part of qualitative rapid ethnography, we observed the clinical practice of pressure ulcer prevention in an acute care hospital by using an observation guide, informal interviews, field notes, and memos. Using purposive sampling, we included patients at risk of pressure ulcers and the health professionals caring for them, including nurses, physiotherapists, and physicians. The data analysis was based on interpretive description.

Results: We observed 8 patients at risk of decubitus ulcers with relatives and 52 professionals from nursing, physiotherapy, and the medical profession during 30 observation sequences and a total of 80 h. We found uncertainties in the understanding of roles, responsibility for managing and controlling the process of movement promotion, and the involvement of patients and relatives. The involved professionals are convinced of the importance of interprofessional collaboration, but we did not observe corresponding implementation in practice.

Conclusion: The implementation of interprofessional movement promotion for pressure ulcer prevention in acute-care hospitals requires a binding, cross-hospital concept that defines the team composition, roles, and suitable communication channels to promote exchange.

1. Introduction

A pressure sore, also known as a bedsore or pressure ulcer, is a localized injury to the skin and/or its sub-tissue caused by pressure or pressure in combination with shear forces. These pressure injuries usually occur over bony structures, but can also be caused by medical devices [1]. The development of pressure ulcers is favored by a complex interplay of various risk factors [2], including reduced mobility and activity, reduced sensory perception, increased skin moisture, a poor nutritional status, and concomitant diseases such as diabetes mellitus [1]. The occurrence of pressure ulcers can lead to considerable restrictions in the independence of affected patients, accompanied by pain, social isolation, and impaired quality of life [3]. Pressure ulcers also lead to high healthcare costs [1]: \$2.8–11.6 billion per year in the USA and the Netherlands [4–6], although there are no comparable data

available for Switzerland.

In most cases, pressure ulcers can be prevented by nursing measures [1]. For this reason, their incidence is considered to be an indicator of the quality of care [7]. In European acute care hospitals, the incidence is up to 12 % [1]. In Swiss hospitals, it is 3.9 % [7], which indicates a high quality of healthcare. Preventive measures are aimed at reducing the risk factors. Causal measures include pressure relief through positioning and movement; the use of pressure-distributing aids such as alternating pressure mattresses, soft positioning pads, and pillows [1]; as well as promoting movement [1]. Movement promotion in the hospital is also carried out by physiotherapists. In many cases, they are involved with patients at risk of developing pressure ulcers. Effective interprofessional collaboration (IPC) is therefore highly relevant to promote a patient's movement skills.

IPC is playing an increasingly important role in healthcare, as it can

* Corresponding author. University Hospital Basel, Spitalstr. 22, 4031 Basel, Switzerland.

E-mail address: eva-maria.panfil@usb.ch (E.-M. Panfil).

<https://doi.org/10.1016/j.jtv.2025.100936>

Received 4 March 2025; Received in revised form 23 May 2025; Accepted 2 July 2025

Available online 5 July 2025

0965-206X/© 2025 The Authors. Published by Elsevier Ltd on behalf of Society of Tissue Viability. This is an open access article under the CC BY license (<http://creativecommons.org/licenses/by/4.0/>).

improve clinical outcomes, reduce costs, and increase job satisfaction for healthcare professionals [8]. The World Health Organization (WHO) defines interprofessionalism as “teaching and practice that occurs when professionals from at least two professions work together and learn from each other, in the spirit of effective collaboration that improves health outcomes” [9]. The essential competences for IPC include knowledge of the roles and responsibilities of the various professions, the ability to work together in a team, clear and effective communication, collaboration in the interests of the patient, and an understanding of the interprofessional healthcare system. The implementation of these competences requires close cooperation and respectful interaction between the various professions in the healthcare system [10].

Although the international guideline on pressure ulcer prevention emphasizes the need for IPC [1], the explicit role of each professional group involved in the promotion of movement to prevent pressure ulcers and how these groups act interprofessionally remain unclear. Against this background, this research project aimed to investigate the understanding of roles and expectations regarding the promotion of movement in an interprofessional team. In addition, we investigated which interprofessional promotion of physical activity is actually implemented in everyday clinical practice and what ideas and expectations the various participants in an interprofessional team have regarding their understanding of their role in promoting physical activity.

2. Materials and methods

We have followed the consolidated criteria for reporting qualitative research (COREQ) reporting guideline [11] to present our method.

2.1. Study design

We used rapid ethnography as the study design [12]. The aim of this qualitative research methodology is to quickly gain insights into social phenomena or cultural practices. It helps identify patterns, themes, or key findings in everyday cultures through observations and interviews in a natural setting.

2.2. Setting and participants

We conducted the study in the medical and surgical departments of a university hospital in Switzerland. The medical department has 25 beds with a nurse-to-patient ratio that ranges from 1/6 to 1/12, and sometimes even 1/25, depending on the shift. The surgical department has 38 beds with a nurse-to-patient ratio that ranges from 1/8 to 1/19, depending on the shift. According to the managers, there is a constant staff shortage in both departments, which is why temporary staff members are often deployed.

Pressure ulcer prevention is based on the internal nursing evidence-based guideline, which uses the Braden scale for risk assessment [13]. The concept of kinesthetics is used to promote movement [14] and the prescription of physiotherapy measures.

We selected the patients by using purposive sampling. The inclusion criteria were a Braden scale score ≤ 18 points, at risk of developing pressure sores (according to experts), and the ability to understand and speak German. JD contacted the patients personally to ask them to participate in the study, and none of them dropped out. We included all professional groups (nursing, physicians, and physiotherapy) involved in the care of the patients without any fixed inclusion or exclusion criteria.

Lean management was introduced at the university hospital in 2014 to optimize patient-related processes [15]. This includes the “huddle,” a short, structured team meeting in the ward corridor to exchange information, to make arrangements, and to clarify any questions that arise. A patient board, a whiteboard that hangs visibly on the wall opposite the patient, enables a transparent and up-to-date presentation of treatment progress and goals. The individual departments at the university

hospital have the opportunity to decide for themselves which tools they would like to use and in what form. There is currently no overarching concept of IPC in this university hospital.

2.3. Research team

The research team consisted of: EMP (an expert in pressure ulcers and wounds and experienced in qualitative research and IPC), SST (an expert in ethnography and qualitative research), PS (an expert in physiotherapy), SH (an expert in kinesthetics), and HB and JD (female nurses). All research members (except SST) were employees of the university hospital.

2.4. Data collection

We had planned for a total of 30 half-day observations. They were carried out at different times and in consultation with the patients. The duration and times were chosen so that a whole day per patient could be mapped. During the observations, short, unstructured conversations (up to 10 min) took place with the patients, relatives, or professionals. JD conducted the observations and informal interviews. The participating patients did not know JD and had no information about her. JD had worked as a nurse for over 10 years and had participated in training on the pressure ulcer prevention guideline.

2.5. Observation

We used an observation guide that we had created within our research team. This included the location, the people present, activity, interaction, communication, emotions, the role of the observer, and possible questions/content of the informal conversations.

We took field notes and prepared memos during the observations and documented informal conversations. These were transcribed electronically. We also collected socio-demographic and clinical data on the patients (current diagnosis, relevant secondary diagnoses, length of hospitalization, preexisting pressure ulcers, body mass index, and current measures for pressure ulcer prevention) from the hospital's internal documentation system.

To characterize the sample, all participating professionals completed a short questionnaire together with JD (it took approximately 2 min to complete). The questionnaire covered age, professional group, professional experience and previous knowledge of pressure ulcer prevention, and IPC.

2.6. Data analysis

The data analysis was based on the iterative analytical process of interpretive description (ID) according to Sally Thorne (2016) and the ethnographic orientation (natural setting and inductive approach) [16]. We carried out the following steps using the MAXQDA Plus 2022 software (version 22.2.1): reading and coding of observations, iterative development of themes and subthemes and their relationship, and conceptualization of relationships. Memos supported the interpretation.

2.7. Guarantee of the qualitative quality criteria

We have taken various measures to guarantee the quality criteria of our qualitative research [17]. Rigor was ensured by a detailed description of the survey method, the context and, the data analysis. Auditability and plausibility were ensured by documenting all work steps and discussing them in the research team. Positionality was ensured by reflecting on the observer's perspective to consider possible effects on the results. In addition, the results were compared with other relevant studies in order to strengthen their validity.

2.8. Ethics

This study did not require authorization from the responsible Swiss ethics committee as it does not fall under the Human Research Act (Req-2022-01062). All patients, their relatives, and professionals involved in their care were informed about the study in writing and participated voluntarily. They had the right to withdraw from the study at any time. Potential negative effects (no harm to the participants) and the effort for the participants were considered to be low. Data processing was carried out under strict confidentiality, with participants being pseudonymized by code numbers to protect their privacy.

3. Results

Four patients in each of the medical and surgical departments of the university hospital, their relatives, and the medical staff were observed for 30 observation sequences and a total of 80 h. Six of the patients were female and two were male. The admission diagnoses included anemia, hemothorax, bacteremia, polytrauma, and various fractures. The average length of hospitalization of the patients was 18.5 days. According to the Braden scale, two patients had a low risk of pressure sores, five had a general risk, and one patient had a high risk. Most of the patients were at risk of pressure ulcers due to reduced activity and mobility as well as the presence of friction and shear forces. [Table 1](#) presents additional information on the patients.

In addition to the patients, the following professionals were observed: 44 nurses, 5 doctors, and 3 physiotherapists. Over 45 % of the professionals stated that they had participated in training and further education in the area of pressure ulcer prevention, 15 % in training and further education in the area of IPC.

The observations resulted in two main topics for IPC in relation to the promotion of movement in patients at risk of decubitus ([Fig. 1](#)): (1) unclear understanding of roles and lack of coordination in IPC and (2) limited proactive interprofessional communication and insufficient use of existing communication channels. The two topics were, in turn, divided into several sub-topics. These two thematic areas and their sub-themes are explained in more detail below and illustrated with two exemplary patient cases (Mrs. D and Mrs. W; see [Supplement 1](#)).

3.1. Unclear understanding of roles and lack of coordination in interprofessional collaboration

This topic area shows that there are uncertainties in the team members' understanding of their roles, particularly with regard to the involvement of patients and relatives, and that there is a lack of clarity as to which professional group takes the lead role in promoting movement for pressure ulcer prevention. This topic area is comprises two sub-topics, which are described in detail below.

3.1.1. Unclear understanding of one's own role and unclear understanding of other roles in the interprofessional team

The surveyed professional groups saw themselves as part of the interprofessional team. It became clear that the professional groups may have an uncertain understanding of their own role as well as the role of the other professional groups in the interprofessional team.

In the nursing profession, the carers were observed to have the most contact with patients. Therefore, their role was central to IPC. However, the observations and the interviews conducted showed a discrepancy between the statements made by the carers involved and the actual implementation in everyday clinical practice. This describes the following situation:

Mrs. D's carers said that it was their job to regularly support the patient's position. The plan to promote Mrs. D's movement included getting up/ sitting up in bed regularly, three times a day and exercises in bed by the

carers. It was observed that Mrs. D was not mobilized to eat in the morning and no exercises were carried out with her in bed.

In the interviews, almost all carers stated that promoting patient resources was one of their main tasks. However, the observations showed that patient resources were not specifically promoted by the nursing staff. In discussions with the nursing staff, it became clear that it was their task to give patients precise instructions on how to promote movement as part of pressure ulcer prevention. However, it was noted during the observations that the patients received little information from the nursing staff on this topic.

The nursing staff also stated that the use of kinesthetics to promote movement was one of their tasks. However, the use of kinesthetics was not observed in any of the sequences. The nursing staff promoted movement, but not according to the principles of kinesthetics, as the following field note shows.

A nursing staff member and a healthcare professional tried to lift Mrs. W up in bed with the help of a sheet under her buttocks. The two nursing staff tried to mobilize Mrs. W upwards in bed by pulling on a sheet (which was under her buttocks) and under her armpits.

Other nursing tasks included implementing the doctor's instructions for mobilization (mobilization to the edge of the bed and adherence to bed rest), carrying out skin checks, and encouraging patients to move. The performance of these tasks was partially observed.

In the occupational physiotherapy group, from the nurses' perspective, physiotherapy indirectly supported the implementation of movement promotion and thus contributed to pressure ulcer prevention. The physiotherapists also perceived their therapies as indirectly supporting pressure ulcer prevention. This view could not be convincingly observed in practice, as the following example shows. A physiotherapist performed strength exercises on Mrs. D using a bed bike and a TheraBand. This improved Mrs. D's mobility and ability to move. This type of therapy was not seen as part of pressure ulcer prevention by the other professional groups involved, as shown by the following response from one of Mrs. W's doctors: "Physiotherapy has nothing to do with pressure ulcer prevention and movement promotion."

There were various examples that demonstrated the different views among physicians regarding their role in the promotion of movement for pressure ulcer prevention. In the case of Mrs. K, one doctor described her role as a "supervisory body" for the implementation of pressure ulcer prevention: "I have to see that the patient's mobilization really takes place. I can't do it myself. That's why I see my role more as a supervisory body." On the other hand, one of Mrs. W's doctors described how he had no role at all in promoting movement for pressure ulcer prevention and was not involved at all.

In addition, some doctors mentioned that it was their task to explain the importance of physiotherapy to the patients and to discuss the skin condition with the nursing staff. These tasks were not observed during any medical rounds. In discussions with the carers, there was disagreement as to whether the medical profession was perceived as part of the interprofessional team. The role of the medical profession was interpreted differently by the other professional groups, sometimes as being indirectly involved, sometimes not at all, but never as being directly involved.

Finally, none of the surveyed professional groups saw patients and their relatives as part of the IPC. This was illustrated by the following observation: A nurse who was responsible for Mrs. D's care answered the question of who was involved in promoting movement for pressure ulcer prevention as follows: "All nurses, physiotherapists, and doctors." It was also noted during the observations that relatives were not included in IPC to promote movement, for example, in personal hygiene.

3.1.2. Uncertainty about which professional group takes the lead within the interprofessional team

Based on the observations, it was unclear who should take over the

Table 1
Characteristics of the eight patients observed in the medical and surgical departments.

	Mrs. A	Mrs. D	Mr. C	Mrs. E	Mrs. H	Mr. F	Mrs. K	Mrs. W
Age (years)	91	30	81	76	82	69	83	54
Department	Medicine	Medicine	Medicine	Medicine	Surgery	Surgery	Surgery	Surgery
Referral diagnosis	Aggravated hyperchromic normocytic hyporegenerative Anemia	Hemothorax on the left, mixed intoxication	Ulcer crurum popliteal fossa bilateral	Bacteremia with <i>Staphylococcus aureus</i>	Right hip total endoprosthesis replacement	Tochanteric right femoral fracture	Polytrauma with hemorrhagic shock after being run over by a car, fracture of the humerus on both sides, Weber C fracture on the right, hemorrhage of the sartorius muscle on the right	Acute immobilizing right lumbospondylogenic pain syndrome with spinal canal stenosis
Relevant secondary diagnoses	Chronic renal insufficiency, mitral valve insufficiency, atrial fibrillation	Acute pulmonary edema, pneumonia, paraparesis legs on both sides, suspected right foot pressure ulcer	Chronic perianal eczema, cardiac insufficiency, chronic lower leg edema	Cardiac decompensation, moderate anemia, polymyalgia rheumatica	Chronic right total hip prosthesis infection with grade 4 decubitus, Parkinson's syndrome, pain-related deconditioning	Pertrochanteric left femur fracture, multiple fractures after bicycle accidents	Right-sided arm paralysis, dermatitis on the sacrum	Alcohol toxic liver cirrhosis, multisubstance abuse, multifactorial gait disorder
Body mass index (kg/m²)	23.4	19.9	33.0	21.7	Not documented	22.3	Not documented	34.3
Length of hospitalization (days)	26	22	13	28	11	8	27	13
Previously existing pressure ulcer	No	No	Gluteal pressure ulcer, healed	Primary pressure ulcer, lower left leg, healed	Hip, healed	No	No	No
At risk of decubitus according to experts	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Braden scale (total)	18	17	18	19	15	23	12	15
Sensorimotor sensory disturbances	4	4	4	4	4	4	4	4
Moisture	4	4	4	4	3	4	3	3
Activity	2	3	2	3	1	4	2	2
Mobility	2	3	4	3	2	4	1	2
Nutrition	4	2	4	3	4	4	1	2
Friction and shear forces	2	1	1	2	1	3	1	2
Current measures for pressure ulcer prevention	Regular positioning of the extremities	Regular positioning of the extremities	Alternating pressure mattress	Regular positioning of the extremities	None	None	Alternating pressure mattress	None

Classification of the Braden scale: >18 points, low risk; 15–18 points, general risk; 13–14 points, medium risk; 10–12 points, high risk; <9 points, very high risk.

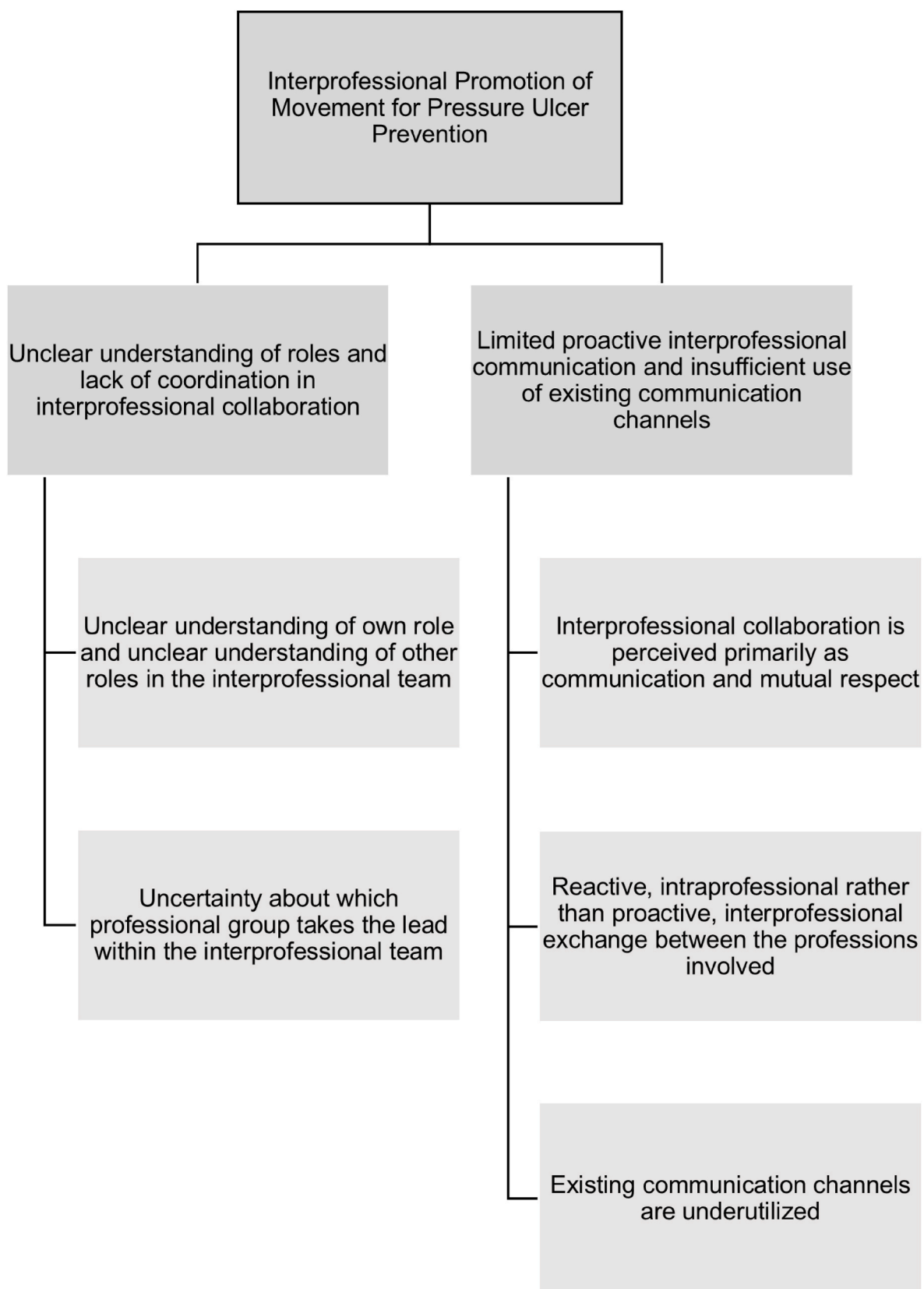


Fig. 1. Presentation of the results.

process control for the promotion of movement. The doctors and physiotherapists believed that nursing should take the lead in promoting movement for pressure ulcer prevention. Mrs. W's attending physician said: "Nursing is mainly responsible for implementing the promotion of movement."

Additional important information was provided by the observation of a complex mobilization of Mrs. D by several carers together with the physiotherapists.

After the mobilization, Mrs. D was asked who she thought had taken the lead in promoting this movement. Mrs. D replied that she had taken the lead. The nurse in charge, who was also involved in the mobilization, said that she had taken the lead. It was observed that the physiotherapist had taken the lead in the previous mobilization and instructed all carers and Mrs. D on what to do and actively pursued its implementation.

In other observed cases, the responsibility for mobility promotion was given to people who happened to be available (such as interns) and often had little experience or knowledge of the patients or pressure ulcer prevention.

3.2. Limited proactive interprofessional communication and insufficient use of existing communication channels

This topic area shows that IPC is defined by communication, mutual respect, and teamwork with clear agreements and timely feedback. The exchange between professionals was mostly reactive rather than proactive, and communication often took place within individual professional groups rather than across professions. In addition, existing communication tools such as the patient board and the hospital's internal documentation system were rarely used for interprofessional exchange, and medical rounds did not consider the promotion of physical activity. This topic area includes three sub-topics, which are described in detail below.

3.2.1. Interprofessional collaboration is perceived primarily as communication and mutual respect

In discussions with the professionals, they were asked about their understanding of IPC in the promotion of movement for pressure ulcer prevention. Communication was frequently mentioned, in particular the provision of timely feedback. Nurses, physiotherapists, and doctors emphasized the need for consultation between professionals. One nurse reported the following understanding of IPC after caring for Mrs. D: "Good communication. Respect for all professionals. Ability to work in a team, which means being able to compromise, being helpful, understanding the other person and being there for each other."

3.2.2. Reactive, intraprofessional rather than proactive, interprofessional exchange between the professions involved

In most of the situations observed, there was no or only a reactive exchange between the professionals.

In the surgical ward, a proactive exchange was observed in a few situations, particularly between physiotherapy and nursing. The physiotherapists initiated contact with the nursing staff to arrange appointments for therapy sessions with the patients. In most other situations, there was a reactive exchange, which was often triggered by a lack of medical instructions or information about movement promotion. Where necessary, the exchange between doctors and physiotherapists took place by telephone. One of Mrs. D's doctors replied to the question of when exactly an exchange would take place between him and the physiotherapist: "Over the phone. And only if necessary. So if there's nothing, we're not in contact."

In the medical department, the physiotherapists usually visited the patients for therapy without consulting the nursing staff.

In most of the observed situations, there was an intraprofessional exchange. Interprofessional dialogue between physiotherapists, doctors, and nurses was only spontaneous and situational. As a result, not all

professionals had the necessary information to promote movement. One of Mrs. D's doctors said about the exchange with other specialists: "There is no common vessel or similar for this." He (the doctor) had most exchanges with other doctors.

Another situation with Mrs. W outlines that there was a lack of exchange between the professionals and the patients regarding their exercise promotion:

It was observed that two carers came to Mrs. W to mobilize her. Mrs. W stated that she did not understand why the carers always came in pairs, as she only needed support from one person.

In most of the observations and informal discussions, it became clear that the nursing staff regularly communicated and exchanged information during fixed huddle times without the involvement of other professional groups.

3.2.3. Existing communication channels are underutilized

During the observations, the patient board, internal hospital documentation system, and daily ward rounds were not used interprofessionally to exchange information on the promotion of physical activity. There was a patient board in the patient rooms, the use of which varied depending on the department. On the surgical ward, there was a separate section for mobilization, in which mainly activities prescribed by doctors were documented. In the medical department, however, mobilization was documented sporadically, without a separate section for this topic. The patient board on the surgical ward was generally more up-to-date with regard to mobilization compared with the medical ward.

A health specialist (defined as someone who reports to the nursing staff, and takes on tasks relating to care, nutrition, and administration) for Mrs. K said the following: "We (the nursing staff) are responsible for managing the patient board. Other professional groups tend to use it less. Sometimes physiotherapy writes something down on it."

Physiotherapy documented its therapies in the clinic's internal documentation system, but this documentation was hardly considered by other professionals. Doctors and nursing staff took part in the daily ward round without the involvement of other professional groups. The promotion of movement for pressure ulcer prevention was not an integral part of these rounds.

4. Discussion

To our knowledge, this is the first qualitative study on IPC regarding the promotion of movement for pressure ulcer prevention. We examined a sample of eight patients who are representative cases (existing pressure ulcer risk, limited mobility, and chronic diseases) in the clinical context of pressure ulcer prevention [1]. The results indicate that the nursing, medical, and physiotherapy professional groups we observed have an inadequate understanding of their role in pressure ulcer prevention in the interprofessional team and do not make appropriate use of the existing communication channels.

4.1. Clear role responsibilities and communication are crucial for effective Interprofessional Education Collaborative

For IPC to occur, the professional groups involved must have the necessary competences, such as role responsibilities, interprofessional communication, teamwork and values of interprofessional practice, which are described in the Interprofessional Education Collaborative (IPEC) Framework [10]. As the professionals involved were in regular dialogue and had respectful conversations, it can be assumed that they have the skills for team-oriented collaboration. However, we found evidence of a lack of clarity regarding their own role and the role of other professional groups, which indicates a lack of the key competences described in the IPEC Framework.

4.2. Difficulties in interprofessional collaboration between professionals and patients/relatives

Although various frameworks describe patients and their relatives as part of the interprofessional team [9,18], we found evidence that this is not recognized by the professional groups involved. This could, in turn, be a reason why patients had little involvement in the process of physical activity promotion. The patients were also unclear about the roles of the interprofessional team, although professionals are obliged to communicate their role clearly [19,20]. For IPC to be successful, professionals and patients must be in a cooperative relationship in which the patients feel part of the team and are the center of attention [21].

4.3. The limited role of the medical profession and the unknown importance of physiotherapy in promoting physical activity for pressure ulcer prevention

In this study, the role of the medical profession was perceived as indirect involvement in exercise promotion for pressure ulcer prevention. Koenders et al. [22] emphasized the limited but nevertheless important role of the medical profession in physical activity promotion, as it is responsible for medical safety. In addition to issuing physiotherapy prescriptions, their task is to motivate patients to exercise. Due to high workloads, it is often not possible for doctors to encourage patients to be physically active, even though this would be important [22, 23]. Therefore, doctors should be aware that it is their responsibility to motivate patients to promote physical activity.

We found evidence that physiotherapy plays a role in pressure ulcer prevention by providing muscle-strengthening therapies to support the promotion of movement. Physiotherapy also includes the promotion of mobilization [24]. Not all stakeholders were aware of the role of physiotherapy in promoting movement for pressure ulcer prevention.

4.4. Process responsibility and role perception in the promotion of movement

We observed that physicians and physiotherapists see nursing as the lead in promoting movement for pressure ulcer prevention. Despite international guidelines [1], which assign the lead to nursing, this role was not recognized in everyday clinical practice. This may have been because nurses were not aware of the importance of their role. Effective collaboration requires clear responsibilities for leading and managing a process.

4.5. Lack of application of kinesthetics in everyday clinical practice

In German-speaking countries, carers often use the concept of kinesthetics to promote movement. This involves consciously perceiving, analyzing, and controlling a patient's movements to strengthen their self-control and body awareness [14,25]. Targeted support for movement can promote a patient's existing abilities and reduce pain during mobilization and physical strain on carers. Although the concept of kinesthetics is known among nursing staff, we were unable to observe this in everyday clinical practice. In addition, there is only limited evidence on the effectiveness of kinesthetics [26], and it requires individualized adaptation to each patient's situation [27]. The detailed results on kinesthetics will be described in a separate publication.

4.6. Existing communication channels and joint decision-making in the interprofessional team

According to the IPEC framework, effective communication tools and techniques as well as information systems are necessary for IPC [10]. We found that existing communication vehicles such as the patient board, the hospital's internal communication system, and the daily ward round, were not sufficiently utilized. The question arises as to whether

the communication channels are ineffective or whether interprofessional exchange is not considered to be necessary. According to the IPEC Framework, joint decision-making is also one of the interprofessional competences. Decision-making cannot take place if there is no regular interprofessional dialogue. It is important to define the use of existing communication channels in everyday clinical practice to ensure a continuous interprofessional exchange.

4.7. Lack of guidelines for interprofessional collaboration

The WHO emphasizes structural requirements for IPC [9], including institutional support mechanisms, work culture mechanisms, and environmental mechanisms. There are no explicit institutional standards for IPC at this university hospital. The lack of guidelines makes implementation difficult.

4.8. Strengths and weaknesses

A strength of this study is that we worked reflexively to carefully describe the context, data collection, and data analysis. The research method (rapid ethnography) was particularly suited to exploring the perspectives of different professionals and understanding interprofessional physical activity promotion. All data were collected by JD, a nurse, which may have led to observer bias. To avoid this, we discussed and reviewed all steps within the research team, which increased the internal validity of this study.

The results of this study may vary in terms of external validity and transferability to other hospitals, as ethnographic studies are fundamentally context dependent [17,28]. The observation times were chosen in consultation with the patients to minimize the impact on everyday clinical practice. As a result, relatives were only seen with one patient and, in some cases, no ward rounds could be observed. The same physiotherapist was involved with all four patients on the surgical ward, while different physiotherapists were involved on the medical ward.

Due to the chosen methodology, snapshots were recorded, so it is unclear what happened before or after the observations. However, as the results are consistent with the literature [29] and we did not collect contradictory evidence, the present findings can be confirmed.

Due to the chosen method, not all aspects of IPC could be observed, such as conflict resolution, positive working relationships, active listening, and exchange of ideas [10]. We did not observe other professional groups such as occupational therapy and nutritional counseling in this study, so their role is unclear.

5. Conclusion

We found that there are uncertainties regarding the understanding of the roles, responsibility for management, and control of the process as well as the involvement of patients and relatives in the promotion of movement for pressure ulcer prevention. The exchange between professionals is mostly reactive and specific to each professional group. Communication tools for interprofessional exchange are not sufficiently utilized, and medical rounds do not consider movement promotion. The professionals involved are convinced of the importance of IPC [9], but its implementation was not observed in practice.

Based on the findings, we can provide several recommendations for practice. A binding, cross-hospital concept for IPC is required for effective interprofessional movement promotion for pressure ulcer prevention. Among other things, this should include the promotion of movement as a fixed item on the medical ward round agenda. The interprofessional team and the exercise plan should be noted on the patient board. A shared medium such as a huddle can promote interprofessional dialogue. Moreover, a clear definition of the roles for all employees is also important for implementation.

In the future, our observations should be investigated in other settings. The main questions concern the perception of process control and

the application of kinesthetics in movement promotion.

Key messages

Interprofessional collaboration plays a crucial role in movement promotion for pressure ulcer prevention; however, the clinical practice remains unclear. We observed professionals from nursing, physiotherapy, and the medical profession working together to promote movement in patients at risk of developing pressure sores in an acute hospital. We found uncertainties in the understanding of roles, responsibility for managing and controlling the process of movement promotion, and the involvement of patients and relatives. The involved professionals are convinced of the importance of interprofessional collaboration, but we did not observe corresponding implementation in practice. To ensure effective movement promotion, a standardized, hospital-wide framework is needed to define team composition, clarify roles, and establish appropriate communication channels.

Ethics approval and consent to participate

No authorization from the Swiss Ethics Committee was required for this study as it was not covered by the Human Research Act (Req-2022-01062).

Funding

This research did not receive any specific grant from funding agencies in the public, commercial or not-for-profit sectors.

Conflict of interest

The authors declare that there are no conflicts of interest related to this study. They have no financial, institutional, or personal relationships that could have influenced the research, analysis, or conclusions presented in this study. Furthermore, there are no other competing interests that may pose a conflict.

Acknowledgment

Our greatest thanks go to the participants for their trust and openness. We would also like to thank the interprofessional specialist staff of the department for recruiting the patients.

Appendix A. Supplementary data

Supplementary data to this article can be found online at <https://doi.org/10.1016/j.jtv.2025.100936>.

References

- [1] Haesler E, editor. European pressure ulcer advisory panel national pressure injury advisory panel and pan Pacific pressure injury alliance. Prevention and treatment of pressure ulcers/injuries: clinical practice guideline; 2019 (EPUAP/NPIAP/PPPIA).
- [2] Coleman S, Gorecki C, Nelson EA, Closs SJ, Defloor T, Halfens R, Farrin A, Brown J, Schoonhoven L, Nixon J. Patient risk factors for pressure ulcer development: systematic review. *Int J Nurs Stud* 2013;50(7):9741003.
- [3] German network for quality development in nursing. In: Büscher A, Blumenberg P, Krebs M, Moers M, Stehling H, Stomberg D, editors. Expert standard decubitus prophylaxis in nursing care. 2nd update 2017. Osnabrück: Osnabrück University of Applied Sciences, Faculty of Business, Economics and Social Sciences; 2017.
- [4] Padula WV, Mishra MK, Makic MBF, Sullivan PW. Improving the quality of pressure ulcer care with prevention: a cost-effectiveness analysis. *Med Care* 2011; 385–92.
- [5] Young DL, Shen JJ, Estocado N, Landers MR. Financial impact of improved pressure ulcer staging in the acute hospital with use of a new tool, the NEI wound assessment tool. *Adv Skin Wound Care* 2012;25(4):158–66.
- [6] Padula WV, Pronovost PJ, Makic MBF, Wald HL, Moran D, Mishra MK, Meltzer DO. Value of hospital resources for effective pressure injury prevention: a cost-effectiveness analysis. *BMJ Qual Saf* 2019;28(2):132–41.
- [7] National Association for Quality Development in Hospitals and Clinics. Constant decubitus and fall rates in Swiss hospitals [internet] [cited 7 June 2023], https://www.anq.ch/wp-content/uploads/2020/09/ANQakut_Sturz_Dekubitus_MM_Ergebnisse_2019.pdf; 2020.
- [8] Federal Office of Public Health (Switzerland). Interprofessionalism in healthcare [Internet] [cited 3 Mar 2023], <https://www.bag.admin.ch/bag/de/home/strategie-und-politik/nationale-gesundheitspolitik/foerderprogramme-der-fachkraefteinitiative-plus/foerderprogramme-interprofessionality.html>; 2017.
- [9] World Health Organization. Framework for action on interprofessional education and collaborative practice. Geneva: World Health Organization; 2010.
- [10] Interprofessional Education Collaborative. Core competencies for interprofessional collaborative practice: 2016 update. Washington, DC: Interprofessional Education Collaborative; 2016.
- [11] Tong A, Sainsbury P, Craig J. Consolidated criteria for reporting qualitative research (COREQ): a 32-item checklist for interviews and focus groups. *Int J Qual Health Care* 2007;19(6):349–57.
- [12] Vindrola-Padros C. Rapid ethnographies: a practical guide. Cambridge: Cambridge University Press; 2021.
- [13] Bergstrom N, Braden BJ, Laguzza A, Holman V. The braden scale for predicting pressure sore risk. *Nurs Res* 1987;36(4):205–10.
- [14] Citron Ina. Kinesthetics – communicative movement learning. third ed. Thieme; 2011 [cited 27 January 2024]. Available from: [Internet]. <https://www.orellfuessli.ch/shop/home/artikeldetails/A1031752126>.
- [15] Graban M. Lean hospitals: improving quality, patient safety, and employee engagement. third ed. Boca Raton: Productivity Press; 2016.
- [16] Thorne S. Interpretive description: qualitative research for applied practice. 2nd ed. Routledge; 2016.
- [17] Lincoln YS, Guba EG. Naturalistic inquiry. Sage; 1985.
- [18] Canadian Interprofessional Health Collaborative. A national interprofessional competency framework. CIHC CPIS; 2010.
- [19] Hewitt G, Sims S, Greenwood N, Jones F, Ross F, Harris R. Interprofessional teamwork in stroke care: is it visible or important to patients and carers? *J Interprof Care* 2015;29(4):331–9.
- [20] Lamb BW, Jalil RT, Shah S, Brown K, Allchorne P, Vincent C, Green JSA, Sevdalis N. Cancer patients' perspectives on multidisciplinary team working: an exploratory focus group study. *Urol Nurs* 2014;34(2):83.
- [21] Didier A, Dzemaili S, Perrenoud B, Campbell J, Gachoud D, Serex M, Staffioni-Donadini L, Franco L, Benaroyo L, Maya ZS. Patients' perspectives on interprofessional collaboration between health care professionals during hospitalisation: a qualitative systematic review. *JBIM Evid Synth* 2020;18(6):1208.
- [22] Koenders N, Marcellis L, Nijhuis-van der Sanden MW, Satink T, Hoogeboom TJ. Multifaceted interventions are required to improve physical activity behaviour in hospital care: a meta-ethnographic synthesis of qualitative research. *J Physiother* 2021;67(2):115–23.
- [23] So C, Pierluissi E. Attitudes and expectations regarding exercise in the hospital of hospitalised older adults: a qualitative study. *J Am Geriatr Soc* 2012;60(4):713–8.
- [24] Guhan M, Hastings J, Garber SL. Therapists' roles in pressure ulcer management in persons with spinal cord injury. *J Spinal Cord Med* 2009;32(5):560–5.
- [25] Christen L, Scheidegger J, Grossenbacher G, Christen S, Oehninger R. Experiences and results of standardised observations of conventional and kinaesthetic care in a radiation oncology department. *Nursing* 2005;18(1):25–37.
- [26] Maurer C, Gatteringer H, Mayer H. The problem of implementing kinaesthetics in long-term inpatient care facilities - a multiple case study. *Pflege* 2020;34(1):13–21.
- [27] Jensen HI, Rasmussen AH, Breier A, Frederiksen GV. Use of kinaesthetic in patient mobilisation: an evaluation study. *Open J Nurs Med Care* 2019;1(April):12–20.
- [28] Sandelowski M. The problem of rigour in qualitative research. *ANS Adv Nurs Sci* 1986;8(3):27–37.
- [29] Wu Z, Song B, Liu Y, Zhai Y, Chen S, Lin F. Barriers and facilitators to pressure injury prevention in hospitals: a mixed methods systematic review. *J Tissue Viability* 2023;32(3):355–64.