Implementation and impact of a lifting cushion for care home residents who have fallen

ABSTRACT

Introduction

Falls are a global public health problem and the second leading cause of death from unintentional injury. Globally, approximately 30-50% of people living in nursing or residential care homes fall each year. Falls have an impact on quality of life and morbidity. Prevention of falls is gold standard care. When falls do occur implementation of safe strategies to help the person rise are required. Structured risk assessment and use of a 'lifting' cushion are one such strategy.

Aims

To evaluate the impact of the lifting cushion on management of falls and assess barriers and facilitators to staff use of the lifting cushion in 18 care homes.

Methods

Two phase study involving i) capturing quantitative pre and post cushion implementation data with comparison of means testing and ii) theoretically underpinned qualitative semi-structured interviews to explore barriers and facilitators to cushion implementation with inductive and deductive data analysis.

Results

The cushion was used a total of 32 times out of 567 post-implementation recorded falls (6% of all falls). Barriers and facilitators to cushion use aligned to the Theoretical Domains Framework included: knowledge, skills and confidence, emotion, beliefs about safety and decision processes, environmental context and resources and social influences.

Conclusion

The lifting cushion was poorly adopted. Identified barriers to adoption would not be addressed using routine train and cascade processes. We identified facilitators that could be enhanced to promote uptake. Theoretically underpinned implementation strategies, tailored to assessed determinants are known to be more effective, however this approach has rarely been used in care homes. We have demonstrated a structured approach to implementation of cushion use, this may be transferable to other care home practices.

SUMMARY STATEMENT OF IMPLICATIONS FOR PRACTICE

What does this research add to existing knowledge in gerontology?

- Traditional 'teach and cascade' approaches to implementing evidence-based practice in care homes are not optimal.
- Staff can accurately identify barriers and facilitators to implementation of lifting cushion use in care home practice.
- Facilitators to cushion implementation include senior and influential staff "buy in", inclusion in policy, comprehensive training and ease of cushion use.

What are the implications of this new knowledge for nursing care with older people?

- Residents in care homes should benefit from implementation of person-centred evidence-based practice.
- Use of theoretically informed implementation strategies would enhance adoption of person-centred evidence-based practice in care homes.

How could the findings be used to influence policy or practice or research or education?

- Traditional 'teach and cascade' approaches to changing care home practice should be superseded by theoretically informed implementation strategies to enhance adoption.
- Further research should investigate optimal use of theoretically informed implementation strategies in different care home contexts and for other practices.

INTRODUCTION

Falls are a global public health problem and the second leading cause of unintentional injury death; adults over the age of 60 are likeliest to die following a fall (World Health Organisation, 2021a). The global care home population is unknown, in the United Kingdom it is estimated at 410,000 people (Office for National Statistics, 2023). Most direct care is delivered by Health Care Assistants (HCA) who are not required to have a degree or professional qualification. However, many care home providers require HCAs to complete a care certificate and have relevant care experience (Aicken et al., 2021). People living in nursing homes (care homes with registered nursing staff) or residential homes (care homes without registered nursing staff) are at high risk of falling. Globally, approximately 30-50% of people living in nursing or residential care homes fall each year, 40% of whom are expected to experience recurrent falls (World Health Organisation, 2021b). Risk of falling is associated with physical frailty (Shaw et al., 2019), cognitive impairment (Booth et al., 2015) and certain medications (Desborough et al., 2020). Care home residents are around three times as likely to fall compared with community-dwelling older people equating to approximately 1.5 falls per person per year. Falls have an impact on morbidity and quality of life, often being associated with fractures, head injuries, abrasions, lacerations, reduced mobility, loss of confidence, fear of falling and reduced independence (Logan et al., 2021). Falls are a common reason for emergency ambulance calls to be made, often resulting in residents attending emergency departments.

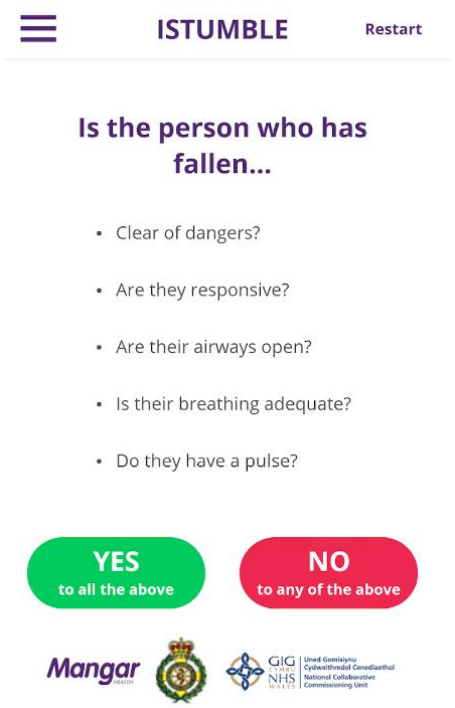
Prevention of falls is gold standard; however it is important to develop best practice for when a fall occurs. Little attention has been given to falls management to date, although there is some guidance (Agency for Healthcare Research and Quality). Care home staff are the first to respond to resident falls. In the United Kingdom (UK), care homes (with or without nursing) have a “no-lifting” policy. In some homes this is interpreted as not moving the resident at all, in others supporting self-rising or using approved equipment. Aids are available to help safely move residents post-fall, commonly including hoist devices. Lifting cushions are increasingly being supplied to care homes but there is limited evidence about i) impact of and ii) barriers and facilitators to using these devices in practice. Simply making equipment available does not result in adoption. Implementation of evidence into practice is known to be a slow process with estimates of a mean rate of 17 years (Morris et al., 2011), with no recent evidence of acceleration (Proctor et al., 2022). In one UK metropolitan borough, it was estimated that ambulances were called in response to resident falls between four and 12 times per month by each care home. In most instances the action was to “see and treat”, that is, assess and manage the resident in-situ with few being conveyed to hospital. This approach can be detrimental for residents as they are unnecessarily waiting for long periods of time for ambulances to arrive. This leads to “long lie” complications including pressure ulcers (Blackburn et

al., 2022). To address these issues, the service commissioners initiated a roll-out of lifting cushions in residential homes. Either independently or with the help of staff, fallen residents can shuffle or be rolled onto the inflatable cushion, which then raises them to a seated position ready to stand (figure 1).

In preparation for implementation and before this study commenced, selected staff members from each home attended formal training in use of the publicly available assessment app' "ISTUMBLE" (example page illustrated in figure 2) and the lifting cushion. ISTUMBLE is not explicitly evidence based although it has commonalities with the evidence-based AHRQ tool cited above. Lifting cushions are increasingly being supplied to care homes but there is limited evidence about impact. Training was cascaded to colleagues prior to adoption in practice. Senior staff in each home indicated when sufficient staff were competent in using the app' and cushion. The expectation was routine cushion use and reduction of ambulance calls would result in better resident experience and cost efficiency.

Figure 1: illustration of the cushion

Figure 2: ISTUMBLE App' (reproduced with permission of winncare.uk)



There are "no magic bullets" to expedite adoption of evidence into practice, however, this typically involves healthcare practitioners changing their behaviours. As such we know that behaviour change theory is effective in understanding and supporting this process (Michie et al., 2005). The Theoretical Domains Framework (TDF) (Michie et al., 2005) is a synthesis of all published models of behaviour and behaviour change and consists of 11 domains (*knowledge, skills, beliefs about consequences, professional role, beliefs about capabilities, social influences, environmental context and resources, motivation and goals, memory attention and decision making, emotion* and *action planning*) allowing a comprehensive means of identifying and understanding all possible determinants of behaviour. Doing so supports the identification of strategies likeliest to support change. The process has been extensively used in health care (Dyson and Cowdell, 2021, Cowdell and Dyson, 2019).

Aims

1. To evaluate the impact of the lifting cushion on management of falls,
2. Assess barriers and facilitators to staff use of the lifting cushion in 18 care homes.

METHODS

Design

The study was conducted in two phases:

Phase 1 involved capturing quantitative pre and post cushion implementation data,

Phase 2 consisted of theoretically underpinned (by the TDF) qualitative semi-structured interviews to explore barriers and facilitators to cushion implementation.

Phase 1

Participants

Eighteen care homes in the study locality were identified to provide a maximum variation sample according to i) the Care Quality Commission (CQC) score (independent regulator of health and social care in England), ii) size of care home (according to bed numbers) and a mix of iii) care and nursing homes.

Procedure

Care homes were identified by commissioners and recruited by the study team. Training was completed as described above. The point that senior staff indicated readiness to use the cushion was considered and recorded as the date of implementation. Data were retrospectively collected for 15 weeks pre and post implementation (between January and August 2023). In the pre and post implementation period data were collected using a bespoke template from resident records and included falls, means of support to rise and ambulance calls. In the post implementation period cushion use was also captured.

Data analysis

Data were transferred into Microsoft Excel and SPSS. Pre- and post-intervention data were subjected to; i) comparisons of means testing (independent t-tests, with $p \leq 0.05$ as our indicator of statistical significance) to indicate difference between the two time periods and ii) annotated, run charts were used to offer a more nuanced understanding of changes pre- and post-intervention.

Phase 2

Participants

Participants were a maximum variation sample of staff according to the degree of cushion use in the home, role and seniority. We anticipated recruiting 15 participants, however following the eleventh interview it was evident that we had reached the point of theoretical data saturation (Francis et al., 2010).

Procedure

Invitation fliers and participant information sheets were given to managers for distribution to staff. If interested, staff contacted the researcher (RH) directly. As care home staff are generally not familiar with research, to mitigate power differentials, they were offered the opportunity to be interviewed

in pairs. The interview guide was refined as required after each interview to maximise depth of understanding. RH, (postdoctoral female researcher) conducted interviews face-to-face in a private room in care homes at a time convenient to participants between January and August 2023. Interviews were audio-recorded and transcribed verbatim.

Data analysis

Transcriptions were transferred to NVivo (v12) and analysed firstly deductively, with relevant data mapped against TDF domains (higher level themes). Where there were no data mapped, domains were discarded. Where data overlapped two domains these were combined. Following this, data were analysed inductively using a six-step process (i) familiarisation, ii) coding, iii) generating, iv) reviewing and v) refining themes and vi) producing the report) (Braun and Clarke, 2006). Initial inductive coding (sub-themes) was undertaken independently by JD and RH and discussed with the full team to produce a final convergent coding framework and subsequent final themes.

Ethics

The study was approved by a University Research Ethics Committee (ref: 10382) and the National Health Service, Health Research Authority (ref: 315861). Quantitative data were extracted from anonymised records and qualitative data were anonymised at the point of analysis using pseudonyms to protect the confidentiality of staff, residents and homes.

RESULTS

Characteristics of included homes

The characteristics of participant homes are summarised in Table 1. Across the sample, the total bed capacity was 929 and average occupancy during the study period was 743 (80%). Within individual homes the number of residents ranged from 15 to 65. Six homes adopted the cushion during the study period. There were 10 residential and eight nursing homes. The nature of care in each home, their CQC rating, and the number of available beds (clustered to preserve anonymity) is reported below.

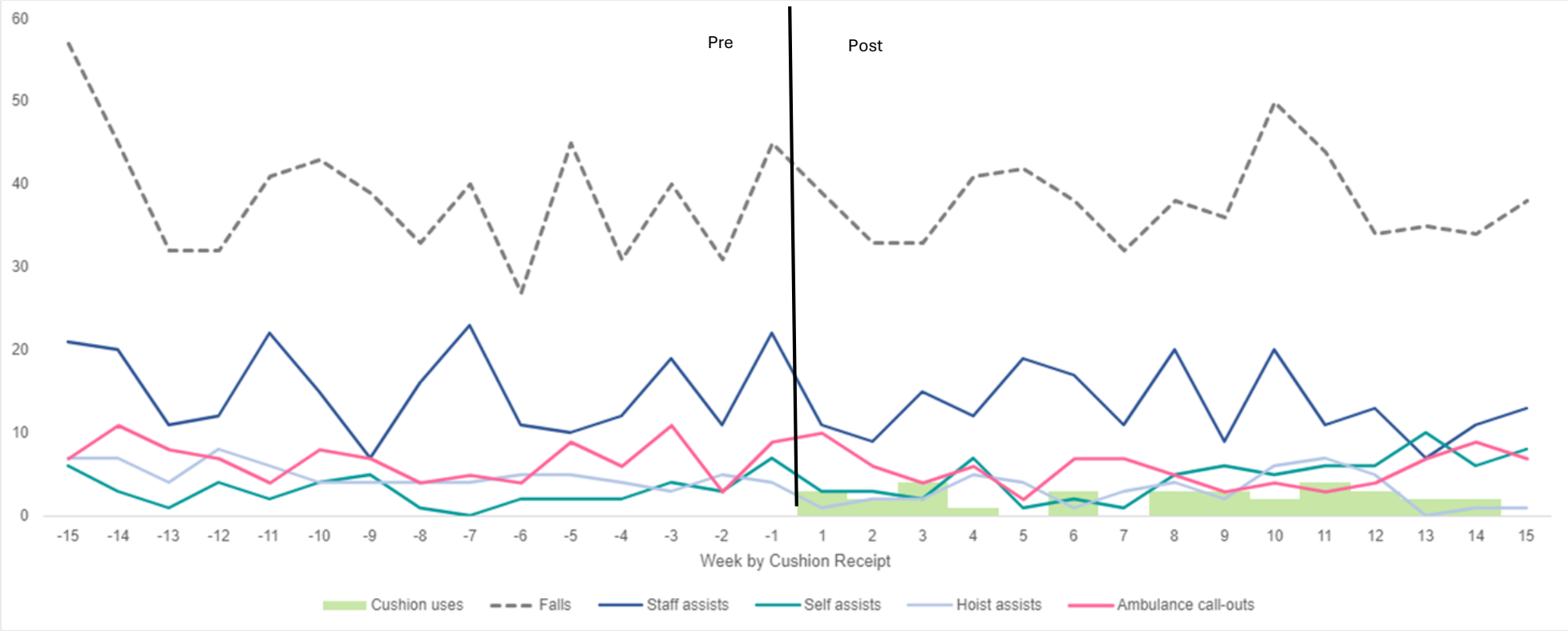
Table 1: Characteristics of included homes

ID	Nursing/ Residential	CQC rating	Number of beds	Cushion adoption information
1	Residential	Good	31-60	Adopted
2	Residential	Good	91-120	Not adopted
3	Residential	Good	61-90	Not adopted
4	Residential	Good	61-90	Adopted not recorded
5	Residential	Requires improvement	31-60	Adopted
6	Residential	Requires improvement	1-30	Adopted
7	Residential	Good	1-30	Adopted
8	Nursing	Good	1-30	Adopted
9	Nursing	Outstanding	61-90	Adopted
10	Nursing	Good	31-60	Not adopted
11	Nursing	Good	1-30	Not adopted
12	Residential	Good	61-90	Adopted not recorded
13	Nursing	Good	31-60	Not adopted
14	Residential	Good	31-60	Not adopted
15	Residential	Good	31-60	Adopted
16	Nursing	Good	31-60	Not adopted
17	Nursing	Requires improvement	61-90	Adopted
18	Nursing	Outstanding	61-90	Not adopted

Quantitative

Figure 3 presents a week-by-week run chart demonstrating pre- and post-cushion data aggregated across all homes relating to falls, self, hoist and staff assists and ambulance calls. Cushion use is illustrated with green bars post implementation (weeks 16 to 30).

Figure 3: Run chart of pre- and post-implementation data



Ambulance calls fell from 103 (mean 6.9 per week) to 84 (mean 5.6) across all homes, representing 19 fewer calls in the post- compared with the pre-implementation period. The cushion was used a total of 32 times out of 567 post-implementation recorded falls (6% of all falls). Hoist use fell from 74 (mean 4.9) to 44 (mean 2.9), staff assists decreased from 232 (mean 3.1) to 198 (mean 4.7) and self assists increased from 46 (mean 3.1) to 71 (mean 4.7). All pre- and post-implementation data, including statistically significant differences are reported in table 2. Of the 18 participating homes, only six adopted and recorded use of the lifting cushion in practice.

Table 2: Pre- and post- falls management data

	Pre-intervention mean (number)	Post-intervention mean (number)	Statistical significance of difference (t-test)
Falls	38.7 (581)	37.8 (567)	
Ambulance calls	6.9 (103)	5.6 (84)	p=0.859 (non-significant decrease)
Self-assists	3.1 (46)	4.7 (71)	p=0.003 (increase)
Staff-assists	15.5 (232)	13.2 (198)	p=0.073 (non-significant increase)
Hoist-assists	4.9 (74)	2.9 (44)	p=0.05 (decrease)
Cushion use		2.13 (32)	

Qualitative

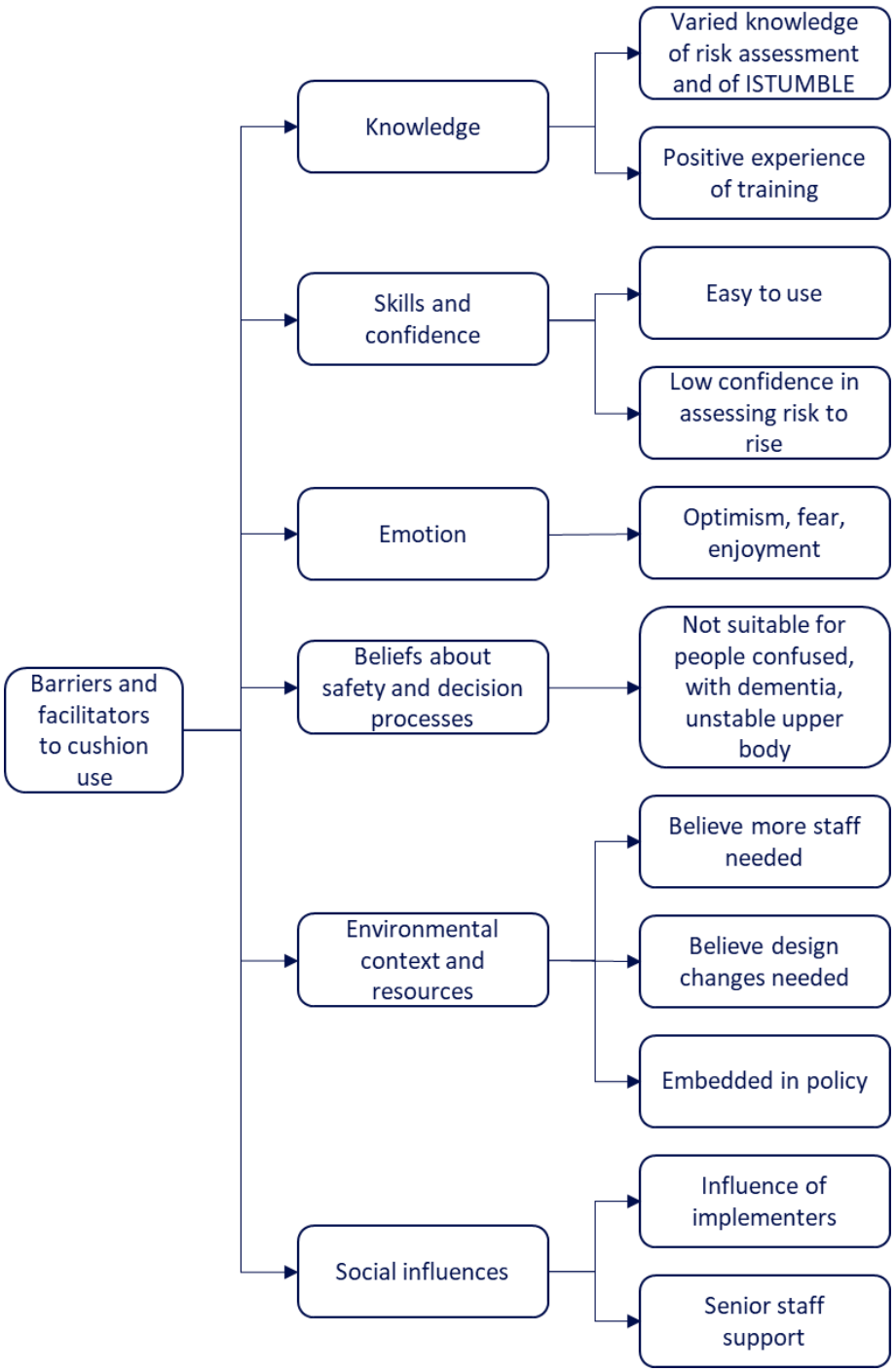
There were eleven participants, six working in homes with nursing and five without. Six participants worked in homes where the cushion had been adopted. Table 3 presents participant and home characteristics. Where participants were interviewed in pairs this is indicated with superscript numbers. Interviews ranged from 20 to 43 minutes (mean 31).

Table 3: Characteristics of participants and workplace

Participant			**Residential home**	
Pseudonym	**Role**	**Experience (years)**	**Nursing status**	**Cushion adoption**
Jessica	Senior carer	3	With nursing	Adopted
Gareth	Deputy Manager	8	With nursing	Not adopted
Linda	Senior carer	35	With nursing	Adopted
Sharon[1]	Senior carer	17	With nursing	Not adopted
Christine[1]	Team leader	29	With nursing	Not adopted
Lewis[2]	Care assistant	3	Without nursing	Adopted
Sara[2]	Care assistant	3	Without nursing	Adopted
Kim	Team leader	25	With nursing	Adopted
Nicole	Deputy manager	20	Without nursing	Adopted
Sam[3]	Senior Carer	5	Without nursing	Not adopted
Caitlin[3]	Senior carer	4	Without nursing	Not adopted

Analysis resulted in six themes (domains of the TDF) and eleven sub-themes (figure 4). Each are presented in turn.

Figure 4: Themes and subthemes



Theme 1: Knowledge

Participants had ***varied knowledge about assessing risks*** associated with rising. While some said they were not "allowed" to move a resident following a fall or would defer responsibility to registered nurses, others were informed through their in-house training: *"…don't touch them, don't move them. Just make sure they're okay, make sure they're comfortable and away from danger. And then we'll get the nurse, the nurse will check them over"* (Jessica). At formal pre-implementation training participants reported being introduced to ISTUMBLE, however, only four had seen it used in practice, two of whom worked in the same home. In all cases, participants reported that only senior members of staff used the app'. Sometimes there was a perception that: *"The seniors, I think, have now got the app pictured in their head. So, they don't always use the app, but they're more confident now on judging a resident if it's safe to use the lifting cushion and how to use it"* (Nicole). In other cases, the app' was downloaded to staff devices but had "never" been used; one senior carer, who received in-housing training on the lifting cushion, said they 'had not heard of it'.

Participants considered the ***training informative and useful***. However, training sessions did not necessarily result in the effective adoption of the intervention: *"the training was fine, it's just, us"* (Christine). In some homes, training was positively cascaded to others. This was particularly the case if the person attending training worked at a senior level and felt empowered to make decisions and arrange further on-site training: *"I would say about ninety-five per cent of the staff in the building, regardless of their job role, they are trained on it"* (Linda).

Theme 2: Skills and confidence

The ***ease of use*** of cushion was a facilitator for all, with participants explaining how easy it was to operate, for example, "*yes, it's easy to see . . . where to plug in the sides . . . so, that's what I like about it, and it's easy"* (Sara) and *"very easy. So straightforward"* (Jessica). Even those who had not adopted the cushion and had only seen it used in training agreed with the simplicity of the device. The cushion was considered simpler than assisting a resident without equipment or with the hoist: *"you're on the floor trying to get them up and that, this is just completely different. Usually, you're struggling.* [With the cushion you can] *just can slide it under, press the button and they . . . rise up"* (Linda). Participants were less confident about ***assessing a resident*** who had fallen: *"it's quite nerve-wracking, it's like you're making decisions based on that person's health and how they are in that moment, it can be quite nerve - especially when it's a serious fall, that's quite scary"* (Sam). However, the use of ISTUMBLE increased confidence: *"The* [app' gives] *the seniors more of a confidence as well, knowing that they're doing the right procedures because it's just following, yes, no"* (Nicole).

Theme 3: Emotion

Some participants were ***optimistic*** when they tried the lifting cushion for themselves or with residents. Others viewed it positively compared with their experience of being hoisted or using the hoist. Conversely, some staff were apprehensive and reported feeling unsafe, wobbly, nervous, or ***afraid*** of falling from the device. These feelings were projected onto residents: *"I felt a bit unsteady on it to start off . . . that was with me knowing what was going on and how the machine was working. I did think that would have an effect on our type of residents"* (Gareth). When using the cushion, some participant reported residents "***enjoyed***" being assisted with the device. The cushion was seen as a more dignified than other methods and prevented the need for poor practice such as "drag lifting": *"when it's just that cushion that lifts up, it's really calm, relaxed, they can get themselves together"* (Jessica). A sense of reassurance for both staff and residents was achieved through holding training sessions with residents present: *"We've actually done the training on the floor* [work environment]*, so that the residents can see the staff using it, so they become more familiar"* (Kim). Nearly all participants described the cushion as noisy and believed that this was off-putting.

Theme 4: Beliefs about safety and decision processes

Staff sometimes decided not to use the cushion as they believed it was not suitable for residents' needs: *"It wouldn't suit our residents that have fallen"* (Christine). This included people with ***limited capacity, living with dementia or with poor upper body strength***. For example: *"if they've got full-blown dementia, they can't follow instruction. I just feel that it's just not safe enough for a dementia resident, that's what I feel"* (Sharon). Even when the cushion had been adopted, it was not considered suitable for all; *"for the residents we've got, it's really good, but as I say, I've worked in challenging behaviour and if one of those has got on the floor, there's no way you would be getting them on that cushion"* (Linda). One participant offered a different view: *"*[We] *are really strong advocates for people with dementia; we don't see it as a condition that ends life, we just see it as a different way of life. So, we find that if we speak to our residents with small, simple instructions, explain everything, we will take that extra twenty minutes to explain . . . if their dementia is very advanced, that's when we just 'up' how many staff that we're using"* (Kim). Three participants across two homes described use of the lifting cushion as a habit or an automatic response to a fall, such as Nicola: *"when it first came about, I think it was something hard to remember because we were so used to the hoist. But then as time's gone on, 'Oh, we can use the* [cushion] *for this.'"*

Theme 5: Environmental context and resources

Several participants said more ***staff were needed*** when the cushion was used to mitigate resident perceived instability; *"I would like two* [staff]*, but I'd like three a lot. I feel like three, you're just secure then"* (Jessica). **Design changes** were recommended, particularly for residents with a higher level of dependence: "[it could be made] *almost like an armchair . . . so that you could be supported on the different sides"* (Gareth). Addition of the cushion to the care home's falls **policy** was a facilitator: *"if something happens one can go and grab* [the cushion] *quickly . . . it is one of our policies now"* (Sara).

Theme 6: Staff role and social influences

The experience and roles of those tasked with cushion implementation and their influence on others was both a barrier and facilitator to adoption. For example, in one home, two senior carers had been trained which they considered a barrier to adoption. Although Christine had cited residents' characteristics as the main barrier, she stated that rolling out training was challenging: *"the idea* [is] *that we go on it, is that we roll it out to the others . . .there's a lot of staff here and you can't just do it to a couple, you've got to do it all."* Conversely, two participants, both minimal handling trainers, were ***influential*** in adoption: *"I've been trained to do that, but they've all done the competencies, that's what we've been doing, we were all in yesterday to show people"* (Linda). Similarly, ***support of senior or respected colleagues*** was influential. For example, Linda said the doctor found the device *"really good"* and Lewis reported the home manager is *"always prompting"* cushion use. One deputy manager described herself as a "champion" for the device which was her "baby".

DISCUSSION

The main barriers to cushion implementation were knowledge and lack of confidence relating to risk-to-rise assessment and use of ISTUMBLE. Participants were concerned about resident safety and experience and suggested the cushion was not suitable for residents with dementia or poor upper body control. Some staff considered the cushion required modification. Planned roll out in individual homes was not achieved predominantly due to the lack of influence and authority of those who attended external training. Facilitators included senior and influential staff "buy in", inclusion in policy, comprehensive training and ease of cushion use.

This independent study was one of few to investigate implementation of an intervention into a care home setting. Despite the challenges of engaging care homes in research we maintained effective working relationships and were able to collect data as planned from 18 participant homes. Strengths included robust data extraction using all available records, however, quality of recording varied

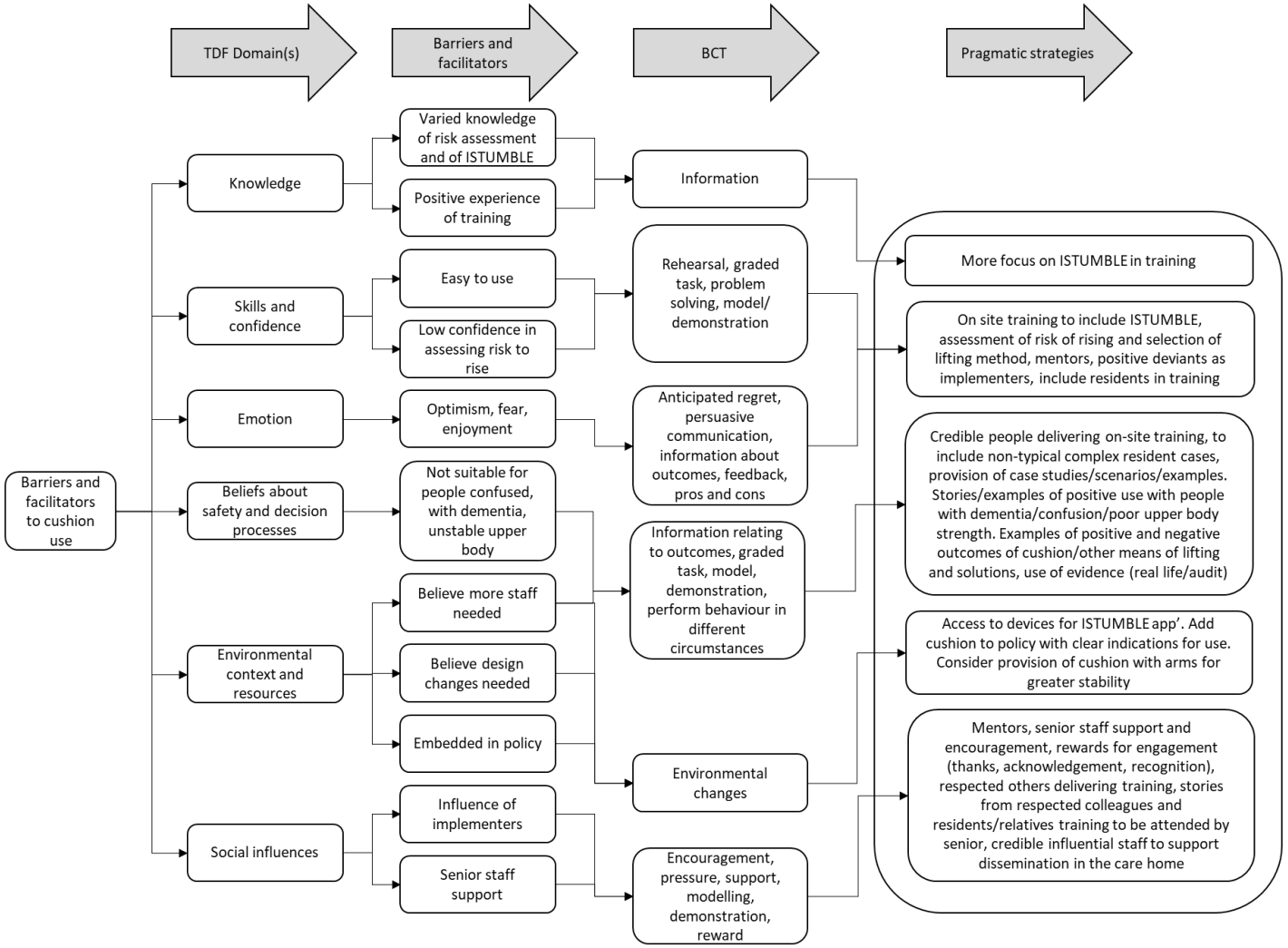
between homes. Qualitative data collection was underpinned by the TDF which not only allowed us to identify barriers and facilitators, but also enabled identification of pragmatic approaches to more effective future implementation. Although, not a mixed methods study, the qualitative results go some way to explaining quantitative findings, in particular, poor adoption of the cushion.

Outcomes from research undertaken in care homes has the potential to improve both day-to-day practice and residents' experiences of care. However, research in care homes remains limited. Possible explanations include inadequate research infrastructure (Gordon et al., 2022, Law and Ashworth, 2022), the disruption caused to care home dynamics (Peryer et al., 2022) and a failure to effectively communicate the benefits of participation, particularly for residents (Giné-Garriga et al., 2020). It is understandable, then, that where resources, staff capacity and workloads are strained, sustained engagement in research is "unlikely" and habitual ways of working soon take precedence over novel behaviours (Peryer et al., 2022, Stephens and Mankee-Williams, 2022). In our study we experienced challenges to maintaining contact with care home managers, often due to their having forgotten about the research or planned meetings, consistent with the findings of others (Collingridge Moore et al., 2019). Frequent changes of management structure over the course of our study led to attrition, a problem also recognised in the literature (Jenkins et al., 2016). Conversely, as with other studies (Nocivelli et al., 2023, Patel et al., 2019), we found when managers and staff were proactive, interested and well-prepared this facilitated and sustained engagement. Although there are challenges to care home research, our study demonstrates that despite suggestions that heterogeneity, variable size, access to resources, workforce and culture are inherent barriers (Leighton et al., 2022) these can be mitigated through flexibility, perseverance, recognition of staff challenges and appreciation of their engagement.

Improving care home practice is challenging. To date reviews demonstrate the most frequently used approach is quality improvement (Chadborn et al., 2021, Cowdell et al., 2024). Reported initiatives show limited impact or sustainability in practice and none focused specifically on post-fall management. Implementation of cushion relied on the traditional strategy of train and cascade. It is well established this approach has limited impact (Grimshaw et al., 2004). Training tends only to address knowledge and skills deficits; in our study multiple barriers were identified. Our approach to recommendations for practice took into account published evidence that tailored (Baker et al., 2015) and theoretically underpinned (Webb et al., 2016, Taylor et al., 2012) strategies are more effective. We i) theoretically (TDF) assessed ii) barriers and facilitators, tailored strategies by iii) mapping behaviour change techniques (BCTs) (Michie et al., 2008) to these, iv) translated to pragmatic implementation strategies (figure 5). For example, the barriers relating to lack of influential implementers (TDF domain, social influences) suggests BCTs such as role modelling may be effective.

A pragmatic interpretation of this may be use of mentors or engagement of “positive deviants” (individuals demonstrating creative solutions despite recognised challenges (Pascale and Monique, 2010).

Figure 5: Identification of implementation strategies



Implementation of the cushion was intended to improve quality of life and reduce delays in safely supporting fallen residents to rise. Reports indicate residents may wait for many hours for an ambulance when they could be moved safely (Barlow and Khashu, 2022). Complications of such a "long lie" include declines in mobility, reduced activities of daily living and increased awareness of physical and psychosocial limitations (Kubitza et al., 2022). Effective implementation of the cushion has the potential to prevent these outcomes and enhance resident's experience. Alongside this there are likely to be cost benefits. Although economic evaluation was beyond the scope of this study, publicly available information estimates that the average cost of a United Kingdom ambulance call, in which a resident is simply assessed and supported to rise, is £224. Approximately £19,710 was spent on lifting cushions for the study homes. Given the cushion was used 32 times, this equates to a cost of £498 per use, over double the cost of an ambulance call.

We have demonstrated in this study how a theoretically informed approach to understanding barriers and facilitators and designing implementation strategies can be used. We recommend a move way from traditional provision of training (addressing knowledge and skills deficits) to an evidence-based, comprehensive approach to addressing barriers and enhancing facilitators to improve resident experience and outcomes.

Recommendations for future research include further development and testing of the implementation of strategies recommended here. Although theoretically underpinned we suggest further development is needed using a co-design process with staff, residents and their families. Co-designed interventions are known to be more likely to be implemented in practice (Jackson and Greenhalgh, 2015) and there is guidance (Cowdell et al., 2020) and precedence (Glover. et al., 2020) for effective co-working with older people.

CONCLUSION

The purpose of this study was to evaluate the implementation of a lifting cushion in care home practice. Pre- and post-cushion implementation data demonstrated poor adoption. Qualitative interviews identified multiple barriers to adoption which would not be addressed using routine train and cascade processes. We identified facilitators that could be enhanced to promote uptake. Theoretically underpinned implementation strategies, tailored to assessed determinants are known to be more effective, however this approach has rarely been used in care homes. We have demonstrated a structured approach to implementation of one practice which may be transferable to other care home practices.

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