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Nurses' Perceptions of Fundamental Care in Preventing Venous Ulcer Recurrence: A Qualitative Focus Group Study

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ABSTRACT

Venous ulcers are the most prevalent among those affecting the lower limbs, with high economic and quality of life impact. Due to the chronicity of venous disease, healing and recurrence cycles are common. Patient adherence to self-care activities to prevent recurrence is very low, so it is crucial to reflect on nurses' experiences with this phenomenon. A qualitative and descriptive study was developed to analyse nurses' perceptions about preventing venous ulcer recurrence. According to the inclusion criteria, focus groups with nurses were implemented. Three focus groups were conducted through the Colibri platform, ensuring all ethical assumptions. Content analysis was performed according to thematic criteria, using the WebQda software. Three main themes emerged: integration of care, context of care, and relationship. The participants emphasised the importance of holistic assessment and the establishment of common goals to promote adherence to fundamental recurrence prevention care. Understanding and respecting individual values, empathy and active listening, considering the established relationship, anticipating the person's needs, and trust are essential to overcoming barriers to implementing recurrence prevention care and to its continuity. Taking these aspects into consideration implies that the professional is part of the process of preventing the recurrence of venous ulcers.

1 | Introduction

Venous ulcers are the most prevalent among those affecting the lower limbs [1–5], with an impact on approximately 0.3% of the global population [2], although this evidence is not sufficiently widespread worldwide. With an ageing population in most Western countries, it is expected that this prevalence may still be exacerbated in the coming years [6, 7]. The impact that these ulcers have on the health-related quality of life of their sufferers reveals the dimension of this problem, with a decrease

in the general quality of life, impacting the emotional state, the aesthetic aspect, the self-image, and the control of pain [8–10], which translates into a real clinical challenge [2]. Also, their economic impact, estimated to be in the billions of pounds in the United Kingdom as of 2012/2013 [11], increased by 48% by 2017/2018, aligning with the rise in prevalence, and it is anticipated that this increase will remain constant to this day [7].

Due to the chronic nature of venous disease, which is inherent to its aetiology, cycles of healing and recurrence are standard and

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Summary

- Due to the chronic nature of venous disease, which is inherent to its aetiology, recurrence rates can reach approximately 70% within 12 months of healing.
- Fundamental care measures can be developed and promoted to prevent this recurrence, minimising its impact and maximising the number of days without ulcers. The use of a compression device is the intervention established as the most relevant for preventing venous ulcer recurrence; whereas other care measures such as physical exercise, foot exercises, leg elevation, and skin hydration are also necessary.
- The development of the entire therapeutic relationship, grounded in understanding and respect for individual values, empathy, and active listening, as well as anticipating the needs of the person with a venous ulcer and fostering a relationship of trust, is essential for involving that person in their fundamental care and ensuring its delivery.

assumed to be inevitable [10, 12]. Recurrence rates can reach approximately 70% within 12 months of healing [13–16]. This rate is why it is increasingly assumed that a venous ulcer will never be cured, only put in remission [17].

Fundamental care measures can be developed and promoted to prevent this recurrence, minimising its impact and maximising the number of days without ulcers. Fundamental care focuses on the integration of care, such as essential life activities, whether physical, psychosocial, or relational. The nurse–patient relationship, based on the practice of person-centred fundamental care and focusing on these practical acts of care, helps patients manage their needs. There is also an awareness that the context in which care is provided may facilitate or hinder the action of the first two dimensions [18–20].

Prevention measures for venous ulcer recurrence consist of fundamental care aimed at preventing recurrence, reducing the risk of recurrence, and minimising inherent complications. The initial key to prevention comes from understanding that its aetiology is a chronic condition, and this entire process will only begin when there is the same awareness [15, 17]. The use of a compression device is the intervention established as the most relevant for preventing venous ulcer recurrence [4, 5, 9, 15, 16]; whereas other care measures, such as physical exercise, foot exercises, leg elevation, and skin hydration, are not as well documented. They are, however, consensually recommended [4, 15, 16].

Although these preventive measures are described, very high recurrence rates are reported; several factors have been documented that influence adherence to these fundamental measures to prevent recurrence [1, 3] and appear to constrain these high recurrence rates.

Thus, therapeutic education aimed at these fundamental measures to overcome the existing factors and barriers should be personalised, seeking to increase knowledge about venous ulcers, their disease process, and self-care [17]. For prevention to be continuous, the health professional's role at the time of

intervention must decisively influence the care of the person with an ulcer, as well as in the management of most chronic diseases [15].

Internationally, few studies have been developed based on the experience of professionals, as in Portugal, where the existence of any type of study aimed at the recurrence of venous ulcers is unknown. The complexity of this prevention clearly shows the multidimensionality of these fundamental preventive measures, where different types of needs subsist, depending on the nurse–patient relationship and with an evident influence of the context. Due to the dimension and impact of the problem, the complexity of the phenomenon, and the limited evidence available on the nurse's perspective, this study aims to analyse nurses' perceptions about preventing venous ulcer recurrence.

2 | Materials and Methods

2.1 | Study Design

This study was developed according to a qualitative, descriptive design, and the research method chosen was to conduct Focus Group (FG) interviews with subsequent content analysis. Using FGs allows us to generate information on complex and multifaceted topics by listening to the perspective of the main stakeholders and learning about their experience with the phenomenon [21, 22]. In qualitative research, FGs are beneficial for developing and evaluating complex interventions for behaviour change [23], as is the case in the broader study in which this study is included.

To analyse nurses' perception of venous ulcer recurrence prevention, three FGs were carried out, stratified according to this homogeneity, but still seeking the richness of some heterogeneity so that the discussion could be fostered, namely through different ages and experiences in this area, as well as distinct socio-professional contexts [21, 22, 24].

This article was prepared following the Consolidated Criteria for Reporting Qualitative Research (COREQ) checklist [25], ensuring a transparent and complete analysis of the study's main elements.

2.2 | Sampling and Recruitment

The study was conducted in the central region, inland of Portugal. The inclusion criteria for the sample included being a professional for more than 2 years at the institution, providing care to people with venous ulcers, voluntarily agreeing to participate in the study after being duly explained and informed about the study's objectives, and authorising the recording of the FGs.

The FG sample was composed using a convenience sampling technique. The heads of nine primary healthcare units of this region were invited to nominate professionals who typically provide care to people with venous ulcers. These nine units had 96 nurses, but the precise number of nurses providing care to people with venous ulcers was unknown. Of these 96 nurses, 36 who met the inclusion criteria were selected for referral. Of a

total of 96 nurses, 36 who met the inclusion criteria were chosen for referral. An email invitation was sent to them asking them to select one of three dates for the FG, allowing 12 participants to be assigned to each date. To reinforce the email, a telephone contact was also made. It was assumed that some people would not attend, resulting in a final attendance rate between 5 and 10, as recommended [21, 22]. The number of three FGs is consistent with the literature [22, 26], which states that the number of FGs in which saturation frequently occurs.

To facilitate participation, the FGs were conducted online through the Colibri platform. The use of online platforms allows FGs to be undertaken more quickly and efficiently, making it easier, especially in cases where the distance between participants or the time available could be a problem; making FGs unfeasible using traditional methods [27–29]. It was previously ensured that all participants had access to a computer or cell phone and the Colibri platform.

2.3 | Interview Guide

A semi-structured interview script was used to conduct these FGs, encouraging sharing and discussion while maintaining focus on the objectives. To this end, opening, introductory, transitional, key, and closing questions were asked [22], with the first part providing a sociodemographic characterisation of the participants and then seeking to understand the importance attributed by nurses to self-care measures for preventing recurrence; describing the barriers identified by nurses in the adherence of people with a history of venous ulcer recurrence to fundamental care for preventing recurrence; or understanding how nurses perceive group programmes or interventions for preventing venous ulcer recurrence.

2.4 | Ethics Statement

All ethical assumptions were developed and guaranteed before the entire procedure. The study was authorised by the Health Ethics Committee of the Regional Health Administration of the Center—Portugal (CE 15/2022). Free and informed consent was also requested from the participants, and each one was given the possibility to withdraw at any time during the process, with anonymity and confidentiality guaranteed. After the present study and broader project are finished, all recordings of the FGs will be destroyed.

2.5 | Data Collection

After obtaining prior informed consent, three FGs were conducted through the Colibri platform. Their duration varied from 71 min to 83 min, with the number of participants ranging from 7 (FG1) to 6 (FG2) and 8 (FG3), in the Portuguese language, on 10.01.2024, 15.01.2024, and 30.01.2024. In all FGs, a moderator/main interviewer and a co-moderator were used, taking field notes and recording nonverbal communication or expressions considered relevant. After the third FG, the research team agreed that no new themes had emerged and assumed that data saturation had occurred [22, 26].

2.6 | Data Analysis

The principles of content analysis, through thematic analysis, were used to interpret the significance of the FGs according to the 6 phases of Braun and Clarke [30]. In the first phase, there was a natural familiarisation with the information, starting immediately as the researchers (FG, AM, and CB) conducted the FG. Although the transcription was done using the *TurboScribe* online platform, it was later corrected and validated by two of the researchers (FG and AM), contributing to the familiarisation with the depth and breadth of its content and its respective interpretation. Subsequently, reading and rereading allowed the first patterns and aggregations of units of meaning to begin to appear. Representing phase 2 [30], the transcribed content was coded inductively and deductively, with the organisation of its information into meaningful parts and these into units of analysis or themes [31, 32], using the WebQda software (researchers FG and CB) in this process. According to phase 3 [30], the codes were aggregated into themes, categories, and some subcategories, generating an interpretative matrix of the phenomenon. In phases 4 and 5 [30], the aggregation process was reanalysed, and each of the themes, categories, and subcategories (researchers FG and CB) was reanalysed, constituting the final matrix of interpretation of the phenomenon (Figure 2). Phase 6 [30] of report production (researchers FG, CB, AM, AC, and AH) culminates this same process and constitutes the present article.

2.7 | Researcher's Positionality and Reflective Lenses

The principal investigator is a nurse who has been directly involved in caring for people with venous ulcers and preventing their recurrence throughout his career. To reduce the potential influence of this experience on the entire research process, the following actions were taken: this researcher did not participate in the selection of participants; a co-moderator was involved to regulate the principal investigator's involvement; and another researcher also participated in the content analysis and respective coding.

2.8 | Methodological Rigour

Methodological rigour was ensured according to the 1985 Lincoln and Guba criteria [33, 34] which focus on credibility, confirmability, and reliability, and transferability. The research process, led by FG, CB, and AH, was systematic, structured, and transparent. The authors FG and CB conducted the inductive analysis and also moderated the FGs (together with AM), ensuring reliability.

Credibility was supported by the fact that the principal investigator (FG), as well as another auxiliary researcher (AM), was a nurse, a specialist in wound care, and highly experienced in this context. All other researchers developed a long-term involvement with the topic, with regular meetings for the analysis process. Different sources of information were also used, with the inclusion of participants from 9 basic health units, and, although it was a convenience sampling process, they were referred by a third person other than the researchers. As a qualitative

investigation, carrying out three focus groups would probably allow for the saturation of information [22, 26], which could be verified.

Reliability was achieved through the members (FG and CB) who participated in the analysis process. Any disagreements were resolved with a third person (AC) until a consensus was reached. Transferability was ensured by knowing the study participants in detail and seeking to transfer the findings to locations and people with similar characteristics and conditions.

Confirmability was reinforced by documenting field notes and checking the transcripts. Researchers FG, CB, and AH discussed and adjusted the phenomenon analysis matrix.

3 | Results

Three FGs were conducted with 7 (FG1), 6 (FG2), and 8 (FG3) participants present in each of them. The sample of participants was aged from 35 to 61 years with a mean of 48.76 years and a standard deviation (SD) of 6.66. Only 3 participants were male. The years of experience as nurses ranged from 12 to 34 years, with a mean of 25.67 years of professional activity and a SD of 6.46, while the years of experience in caring for people with venous ulcers ranged from 6 to 32 years, with a mean of 18.48 years and a SD of 7.82.

In the transcription of the FG and with the creation of a word cloud (Figure 1), “ulcer” appears prominently. Still, other words, more related to prevention, also appear, although without standing out as much, such as “hosiers”, “compressive”, “compression”. It is also worth highlighting “person”, “family”, “team”,

or even “assessment”. This preliminary analysis reveals, on the one hand, concern and focus on the person and prevention measures, with several references to the difficulty in their implementation (“hard” and “difficulty”), but without neglecting the importance of their assessment as a team (“team”) and valuing family support (“family”).

Together with the transcription of the FGs, their reading and rereading enabled the aggregation of information by coding it into themes, categories, and subcategories. This content analysis was carried out according to deductive and inductive processes and, in the latter, the existence of the influence of Fundamental Care and its three dimensions is assumed: nurse-person relationship; integration of care with physical, psychosocial, and relational needs; and the context in which care occurs [18–20].

This content analysis yielded three themes that enable us to understand the experience of preventing venous ulcer recurrence, as reported by the professionals involved in its treatment: Integration of Care, Context of Care, and Relationship (Figure 2).

3.1 | Integration of Care

The *Integration of Care* theme encompasses several categories that nurses consider essential in preventing venous ulcer recurrence; it is the theme with the most significant number of categories. It reveals a concern not only with how to understand the multidimensionality of the needs and perspectives of thinking of the person with venous ulcers as a whole, but also with the overall assessment when it comes to addressing the treatment and recurrence of venous ulcers, with the determination and understanding of the etiological factors, their diagnosis, and how the interventions to prevent recurrence are developed and experienced.

The *Holistic Assessment/Intervention* category describes a holistic view as essential in both the treatment and prevention of recurrence:

“(…) we must always consider the patient as a whole, not just the ulcer itself, but the patient's entire history, all their antecedents, for example, the type of professional activity the person has, so we have ulcers in younger people and older people, in more active people and less active people. So, we must look not at the ulcer itself but at who it belongs to, so to speak” (P1, FG1).

The assessment emphasises the significance of the characteristics and context of the ulcer patient, focusing on their clinical and life history. This focus may help us to understand the patient's experience concerning the fundamental care needed to prevent recurrence.

The Etiological Factors/Characterisation Person with VLU corresponds to the characteristics that nurses consider as predisposing to venous ulcers:

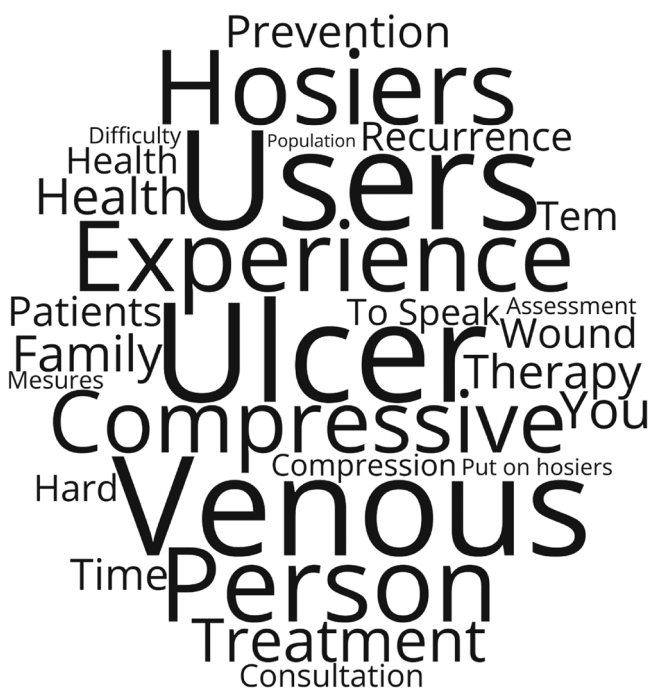


FIGURE 1 | Word cloud, adapted from WebQda.

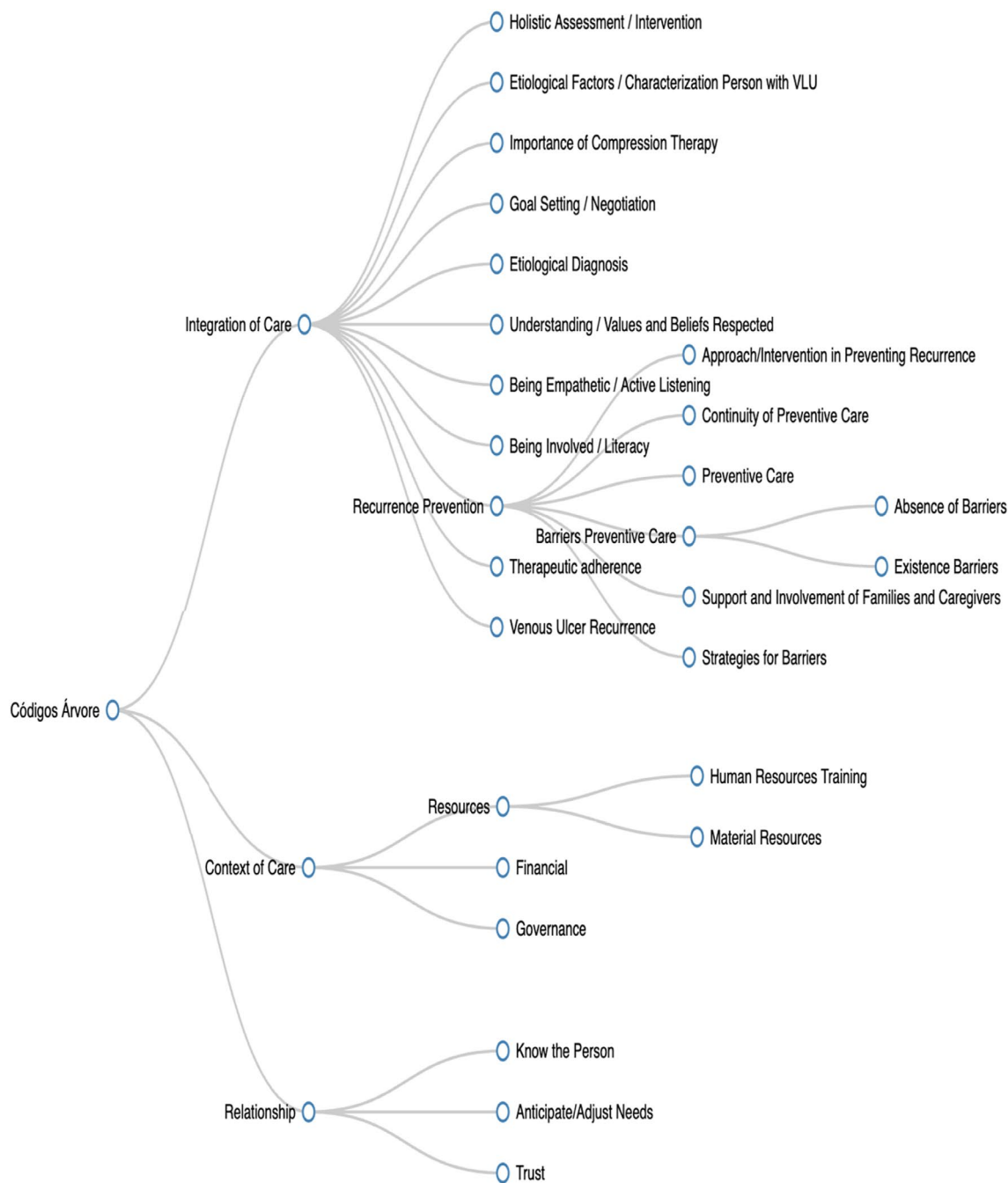


FIGURE 2 | Code tree, WebQda.

“I have also encountered young people in the hotel industry, but always in contexts of obesity, a lack of physical exercise habits, a very sedentary lifestyle, obesity, and poor diet.” (P5, FG1).

Therefore, the profession, obesity, lack of physical exercise, sedentary lifestyle, and eating habits of the patients are considered characteristics of individuals with venous ulcers and may serve as etiological factors for the ulcers themselves.

The Importance of Compression Therapy compiles all the findings related to the participants' references to the significance of compression in both treatment and prevention of recurrence; cited numerous times by the participants.

“More important than the material is the compression itself.” (P1, FG1).

Although most participants mentioned it frequently, acknowledging a point universally accepted in the scientific community, the fact remains that, while its importance is recognised, it is not always employed in the recommended circumstances.

Awareness of recurrence is often noted in *Venous Ulcer Recurrence*, as we find:

“(…) there are many recurrences; we treat them, and after some time, some after years, others after months,

and others after a short time, they recur again (...)" (P6, FG3).

An implicit aspect of the participants' discourse is the assumption of a certain inevitability in the recurrence process, indicating that instead of fostering a proactive attitude toward prevention, a sense of frustration emerges, leading to the belief that there is no point in making efforts to prevent it.

Goal Setting/Negotiation emerges as one of the strategies to reach and understand individuals with venous ulcers, stating that:

"And what care... and how we are going to treat it, we are going to negotiate. I think that the whole process, from the beginning when the patient arrives, is a negotiation about their habits, what they can change, or the health problems that need to be treated, and then, we have to choose the treatment." (P5, FG1).

Some participants mentioned the need to negotiate the therapeutic objectives to be achieved with the person, perhaps not with the formal awareness that they are including the person in the decision-making process and focusing care on them, but recognising that it adds value.

There is also a concern regarding the *etiological diagnosis* of the ulcer, with several references from the participants as it influences the therapeutic plan:

"Our team always starts with this type of approach, knowing what type of ulcer we have and how this approach is carried out, so it depends on the type of ulcer..." (P1, FG2).

Understanding/Values and Beliefs Respected about people with venous ulcers emerges as another fundamental aspect to consider for intervention with this population.

"... my old people believed in me; they even did everything (...) currently, (...) we have a population, I mean, I have "n" doctors, "n" teachers, "n" nurses; I don't know how many... they know some, as much as I do... and there you have it. It is much more difficult, perhaps, for us to work to change these people's habits, but it's easier in terms of finances and understanding. They understand why they have to moisturise their legs..." (P5, FG 1).

More operationally, this understanding and respect imply adapting language, type, and volume of information according to their characteristics.

In this same sense, *Being Empathetic/Active Listening* facilitates the therapeutic relationship and better achieves the outlined objectives:

"... a good relationship, a relationship of empathy, between nurse-user/client, or between

nurse-caregiver, when there is this empathy, it is easier to achieve (...) the objectives that we want in terms of treating and getting the patient to collaborate with us so that everything is easier..." (P2, GF1).

The participants recognise the impact that an empathetic relationship, characterised by active listening, has on a person's relationship and involvement, and can enhance knowledge and foster trust. Most participants believed that *Being Involved/Literacy* will also directly influence adherence to self-care aimed at preventing recurrence:

"It is crucial to explain the pathophysiological process of leg ulcers, particularly venous ulcers, from the outset so that the person understands the problem. (...) If we clarify how compression works on the leg, (...). If we apply the bandage with compression without explaining the reasoning behind it, people may not adhere to it later due to this factor (...)" (P2, FG 3).

Although it may seem natural, it is often forgotten that special attention must be paid to how information is transmitted. Understanding this is essential to recognising the importance of certain behaviours, and for that to happen, the person must be involved in the process.

The *Recurrence Prevention* category also includes several sub-categories that aggregate information related to the entire process of preventing venous ulcer recurrence, such as *Approach/Intervention in Preventing Recurrence; Preventive Care; Barriers to Preventive Care; Strategies for Barriers; Continuity of Preventive Care, and Support and involvement of families and caregivers*. In the *Approach/Intervention in Preventing Recurrence*, the importance of viewing preventive measures as a cohesive whole is highlighted, while also ensuring they are tailored to the individual:

"The family, proper hydration, vigilance by the user or a family member, effective medication, and good hygiene—all of these factors combined will, of course, prevent these recurrences" (P6, FG 3).

The implementation of specific measures can influence tolerance toward others; for instance, if a leg is hydrated, it decreases the likelihood of feeling itchy when wearing compression stockings.

In *Preventive Care*, several fundamental care measures aimed at preventing the recurrence of venous ulcers are discussed, along with their significance:

"(...) good hygiene and hydration of the skin, even after healing (...) always wash very well, dry very well (...) good hygiene, good hydration" (P3, FG3).

"Mainly, the mobilisation of the ankle region involves raising the toe of the foot toward the user and flexing it, similar to pedalling." (P3, FG2).

“Keeping the compression stocking on is similar to walking with a bandage. If the person puts it on first thing in the morning and wears it throughout the day, it significantly reduces the recurrence.” (P8, GF3).

When it comes to preventing recurrence, the use of compression stockings naturally stands out, along with skincare, hygiene, hydration, exercises to mobilise the tibiotarsal joint, and the extension and flexion of the foot and toes.

In the development of preventive care, there is a reported perception of barriers hindering its progress, which have been categorised under *Preventive Care Barriers* in *Existence Barriers*:

“But there is also a problem that we have with users, which is when they live alone, they sometimes have difficulty putting on the stockings, or the economic problem, that sometimes they do not buy them” (P1, FG 3).

“(…) They do not understand that they are for life and that they must be careful afterward so the ulcers do not open again.” (P6, FG2).

Key barriers to implementing preventive measures include the difficulty of putting on and taking off the stockings, the economic aspects of acquiring them, living alone, and the widespread misunderstanding that this condition is chronic and requires ongoing care.

However, there are also references to the absence of barriers to their application, aggregated in *Absence of Barriers*:

“Most of our users continue using the compression stockings.” (P6, FG3).

The nurses who are aware of some of these barriers often seek to develop strategies to overcome these difficulties, which are categorised under *Strategies for Barriers*:

“(…) sometimes we also limit ourselves a little to that basic, traditional sock, the elastic sock... But there is a range of compression systems (...) So, all of this can make the choice of compression method... better tolerated by the person (...) Then, there are also devices called butlers, which can also help more dependent people, who have greater difficulty putting on their shoes” (P2, FG3).

“Communicate in the best possible way with the user and the family so that they understand that it is not quite like that (...) And work, for example, with social workers to turn things around in terms of the economic side of things.” (P4, GF3).

Therefore, choosing the appropriate compression system, support devices for putting on and taking off the stockings, effective

communication, family involvement, and exploring other social solutions are all considered essential strategies for overcoming barriers to their implementation.

Another aspect that is often mentioned is the *Continuity of Preventive Care*, which highlights the need for ongoing monitoring even after healing:

“In principle, I think it makes perfect sense... especially because if we can view these venous ulcers as a chronic disease, they should be treated the same as any other chronic disease. (...) Because if I see a diabetic every six months, or if I have a patient who has an ulcer (...) to monitor the skin to see how things are and where it is (...) How could we do that? I don't know.” (P2, FG2).

This continuity of care is deemed essential, but it is not applied by any participant in a structured and consistent way.

The need for and importance of caregivers was also evident, highlighting the *support and involvement of families and caregivers*:

“But... sometimes, even reaching out to a family member helps (...) Sometimes these support networks can be essential for us to develop.” (P5, GF3).

“Most patients with venous ulcers live alone and do not have children nearby, and therefore, those who provide some support (...) end up helping with the treatments and the well-being of the patient are the daycare centers.” (P3, FG2).

The participants emphasised the importance of family involvement, as well as formal caregivers in some cases, who are hired to promote the implementation of prevention measures.

Participants also referred to the importance of adhering to fundamental preventive care, particularly the continued use of compression after healing, in *Therapeutic adherence*:

“(…) these can be factors for non-adherence to therapy (...) because if the skin is not well cared for, and if, for example, it is not properly isolated with compresses before the synthetic bandage, etc., it can cause itching... and, therefore, non-adherence to the bandage itself. Therefore, this is also an aspect to consider; maintaining good hygiene of the wound and the surrounding skin and ensuring its hydration is important.” (P2, FG3).

The complexity of preventing venous ulcer recurrence is illustrated in this initial topic by a multidimensionality of factors that span from assessment and diagnosis to the identification of predisposing factors, along with the necessity to understand values and beliefs with an empathetic approach, allowing for a

focus on preventing recurrence. While barriers to implementation are acknowledged, strategies to overcome them also exist; ongoing surveillance may be crucial.

3.2 | Context of Care

The *Context of Care* theme encompasses categories that nurses perceive as influential in preventing recurrences. This theme includes the categories of *Resources*, *Financial*, and *Governance*.

The *Resources* category consists of two subcategories: *Human Resources Training* and *Material Resources*.

In *Human Resources* training, there is a strong emphasis on the significance of training:

“I have already completed a couple of basic courses in the application of compression therapy, but I still do not feel very comfortable with it. (...) I cannot say that I have experience in performing IPTB.” (P4, GF3).

In this case, some participants admit that they do not feel comfortable or even capable of, for example, assessing the ankle-brachial pressure index. The importance of applying compression therapy using bandages and evaluating the ankle-brachial pressure index is noted, but there are no references to training on recurrence prevention. Regarding *material resources*, some professionals reported difficulties in providing materials and equipment:

“Another challenge we face, which I believe is common, is the lack of resources needed to conduct the assessment. If we aim to perform a thorough assessment, it is consistently very challenging. Either we lack a Doppler, or we don't have a cuff, or we don't have a blood pressure monitor” (P6, FG2).

In the *Financial* category, it is clear that the economic situation somehow restricts the development of preventive measures:

“I believe the economic factor is among the most important points. I'm not sure if it will be the most significant, but it carries a lot of weight, and the elastic stockings are quite expensive (...)” (P4, FG3).

For *Governance*, the findings regarding the non-reimbursement of these devices in supporting the prevention of recurrence, such as compression stockings, were aggregated:

“But adding this aspect of economic insufficiency is crucial because there is non-reimbursement. These are wounds that significantly diminish the quality of life for users, and the government has yet to recognize this reality (...) However, there is a lack of co-participation in this area, specifically regarding elastic stockings.” (P5, GF2).

Once again, both categories reference the economic factor as a condition affecting the acquisition of compression stockings, which is influenced by political and governance options, given the lack of support or co-participation from the Portuguese State for this purpose.

3.3 | Relationship

The *theme of Relationships* includes the categories *Know the Person*, *Anticipate/Adjust Needs*, and *Trust*, which illustrate the impact of the relationship formed between the health professional, in this case the nurse, and the individual with venous ulcers on the prevention process.

The *Know the Person* category closely relates to the *Goal Setting/Negotiation* category within the *Integration of Care* theme, as understanding the characteristics and needs of individuals is essential for initiating effective negotiations aligned with their objectives. Therefore, information such as:

“I believe it is not an easy approach, and it depends on who we have in front of us. It varies based on the type of user and their willingness to accept help, as well as the relationships often established, including those with family members or caregivers (...)” (P1, FG2).

Anticipate/Adjust Needs is also connected to *Know the Person* and *Goal Setting/Negotiation*, as previously demonstrated, along with information such as:

“Try to adjust the treatment to the user's needs because, otherwise, it will be very complicated (...)” (P3, FG2).

Finally, the *Trust* category appears, and the trust established should be transversal to the entire relationship, as it is essential for the therapeutic relationship to be fruitful in achieving the established objectives:

“A good relationship, one built on empathy, between the nurse and the client, or between the nurse and the caregiver, makes it easier to achieve our objectives in terms of treating the patient to collaborate with us so that everything is easier” (P2, FG1).

The relationship between the nurse and the person with an ulcer is recognised as essential for focusing on the multidimensional aspects of fundamental care, emphasising the close connections among knowledge of the person, trust, anticipation, and adjustments to their needs.

4 | Discussion

The implementation of the 3 FG, involving nurses in the treatment of individuals with venous ulcers, enabled us to analyse their perceptions regarding the prevention of venous ulcer recurrence.

In the content analysis of these FGs, it is clear from the initial analysis that preventing recurrence, as an emerging theme, relies on the relationship established between the person with venous ulcers and the care providers. Some participants indicated that this relationship is a determining factor in the training process for fundamental preventive care. Investing in a therapeutic relationship built on trust is vital, allowing us to understand the person better and grasp their real needs. This trust fosters greater involvement in their fundamental care through treatment and monitoring activities and, in turn, the relationships established with the professionals also become stronger, creating a kind of two-way flow [35].

In integrating care, another theme that emerged is the understanding and respect for values and beliefs as determinants of a person's involvement and the negotiation of common objectives, which are essential for building a therapeutic prevention plan. The perspective of the person with an ulcer, including their priorities, expectations, and goals, should be considered and discussed [12].

In this integrated and continuous process, the involvement of the person with an ulcer in the prevention process and overall care is essential. This is not necessarily a passive element and depends on the quality of care provided. Given that the therapeutic relationship relies on more than just one participant, a transition to a self-care model centred around the individual is required, emphasising involvement and shared decision-making [36, 37].

By doing so, one can genuinely understand the significance and the methods of implementing prevention measures, which are closely linked to awareness of the phenomenon. In other words, there is a reciprocal relationship between involvement and understanding; involvement fosters understanding, while understanding simultaneously enhances participation. Both, of course, rely on the established relationship with the individual, particularly in terms of trust, familiarity with the person, and anticipating or adjusting to their needs, as previously noted.

The need for a holistic assessment of individuals with venous ulcers is widely acknowledged by the participants, and treatment of the venous ulcer, along with its prevention, should begin in this manner. The focus cannot and should not be solely on the ulcer, but instead on the individual with the ulcer. To achieve this, the holistic assessment should encompass lifestyle, family history, clinical information, psychosocial factors, professional activity, quality of life, expectations, and knowledge about the condition and interest in involvement [12, 38, 39].

This comprehensive assessment enables an accurate diagnosis tailored to the individual's needs [38], which will influence the recognition of the unique characteristics and risk factors of venous [9, 12, 38, 39].

The etiological diagnosis of the lesion is crucial for decision-making processes, especially concerning the use of compression therapy [9, 39, 40]. Compression therapy is recognised as essential for treating and preventing the recurrence of venous ulcers, demonstrating high efficiency levels [9, 12, 39–42]. However, the participants mainly refer to it as part of treatment, emphasising

that it is not always the first treatment option. This can often explain the delay in healing and the exacerbation of some related symptoms.

Naturally, the participants widely highlight the importance of preventing recurrence, assuming this should be addressed through prior assessment and a multidisciplinary team. However, there are some references to a lack of knowledge regarding all prevention measures, with only the use of compression being consistently acknowledged. Other existing studies also report low adherence among health professionals to the available guidelines for venous ulcer management, suggesting difficulty in identifying them, along with limited material resources and an excessive focus on clinical experience, which devalues these guidelines [1]; thus demonstrating a lack of knowledge among professionals about prevention measures.

Regarding possible barriers to the use of measures to prevent recurrence, a particular dichotomy was observed, as some participants reported no barriers, which somewhat contradicts the recognised low adherence to these measures, particularly the use of compression [13], with these same participants not finding explanatory factors for the high recurrence rates. However, the participants identified barriers to using these measures, such as difficulty in putting on and taking off compression stockings, lack of close support, economic challenges in acquiring them, and certain stereotypes regarding hydration and the use and image of compression stockings. Additionally, a lack of knowledge about treatment plans was mentioned, including an insufficient understanding of the consequences of not using compression and the discomfort associated with its use [3].

Some strategies have been mentioned that align with recommendations from various authors to overcome these barriers [16, 43], such as the use of devices that help with taking off or putting on shoes; the support and involvement of family members and other caregivers; the engagement of formal caregivers for the same purpose; the acknowledgment of the need to share information about the necessity of using preventive measures, their functionality, and some potential sensations experienced; participation in decision-making to define personalised goals; the selection of the compression system that best suits the individual's characteristics and context; the support from other professionals and even users with similar experiences.

Throughout this entire process, the role of caregivers appears to be crucial in implementing measures to prevent recurrence [12, 39, 44]; often serving a more instrumental role, such as assisting with putting on and taking off a compression stocking and reminding the user of the importance of following certain precautions.

The participants also emphasise the importance of continuity of care in preventing recurrence. However, all nurses indicate that they do not implement this according to a specific programme with that goal, nor do they approach it in a minimally structured manner. Consequently, it remains challenging to understand how they could conceptualise it, especially given the lack of validated programmes that promote self-care with a holistic perspective on preventing recurrence [41].

This ongoing surveillance may be crucial in managing and preventing the recurrence of venous ulcers, promoting adherence to essential care [16]. Its reassessment should occur every 12 months, regardless of personal history or ulcers, with an emphasis on educating about the importance of ongoing surveillance and paying special attention to any changes in the patient's dermatological condition. This includes assessing adherence and tolerance to compression, as well as the circumstances and integrity of the compression systems [12]. Thus, this monitoring would maximise resources, encourage skills and competencies [35], and make self-management efficient for preventing recurrence [15].

On the other hand, it is not surprising, as mentioned in some studies [1], that the context of care, specifically public policies and financial limitations, influences how the prevention process occurs, such as when addressing the costs of understanding systems and the lack of state support for this purpose, which limits their adoption and implementation. From a resource perspective, diverse realities emerge regarding the training of professionals, highlighting a lack of standardisation in their training. This situation reflects the significance attributed to the phenomenon, which largely depends on personal interest rather than institutional perceptions of the inherent policies.

The interconnection among these categories that reflect important concepts is also evident, making it essential to focus on the multidimensionality of care to prevent recurrence. Therefore, therapeutic education targeting these self-care activities should be personalised, aiming to enhance knowledge about venous ulcers, their disease process, and the self-care measures themselves [17]. Therefore, it is necessary to involve the person with the ulcer, their families, and other caregivers, at a level appropriate to their capacity and competence, and if they so desire [12].

4.1 | Limitations and Implications for Future Research L

Regarding the limitations of this study, a potential bias related to the intentional selection of participants arises. Having asked each coordinator of the care units to identify nursing professionals for participation in the FG may have created a sample that is not representative of reality, as there may have been a tendency to refer professionals who have a connection, involvement, and specialised knowledge of the phenomenon. Additionally, something intrinsically related to the intended heterogeneity for each FG could condition the participation and exchange of sincere, spontaneous opinions among all those involved. Another limitation is the impossibility of generalising and transferability of the main findings, considering the methodology developed, the sampling process, and the geographical limitations of the study.

5 | Conclusion

In conclusion, through the three themes that emerged: care integration, care context, and relationship, participants emphasised the importance of holistic assessment and the establishment of shared goals between the individual and the professional to

promote adherence to fundamental care for recurrence prevention, overcoming barriers, and enhancing the continuity of this care. However, establishing shared goals is impossible without understanding and respecting individual values, empathy, and active listening.

A therapeutic relationship based on anticipating the needs of the person with venous ulcers and fostering a relationship of trust is essential for their involvement in their fundamental care.

The context in which care is provided can also limit or enhance it, particularly due to the availability of human and material resources or government policies that reimburse specific prevention measures, such as compression systems.

These results should imply a change in the way the therapeutic relationship is established, reinforcing shared decision-making, in which therapeutic objectives are common and in which, to overcome barriers to the implementation of fundamental care for the prevention of relapse, different strategies should be developed, with the need for regular monitoring and surveillance and, when possible, with the support of family members or other caregivers.

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Ethics Statement

The study was authorised by the Health Ethics Committee of the Regional Health Administration of the Center-Portugal (CE 15/2022).

Conflicts of Interest

The authors declare no conflicts of interest.

Data Availability Statement

Data available on request due to privacy/ethical restrictions.

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