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Facilitators and barriers to delayed medical-seeking in adults with pressure injuries: a qualitative study

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ABSTRACT

This study aimed to: (1) explore factors associated with delayed medical consultation among patients with pressure injuries (PIs); and (2) provide a theoretical basis for formulating PI intervention strategies to curb injury progression and improve patients' quality of life. This was a qualitative descriptive study. Patients with PIs who had delayed seeking medical treatment, or their caregivers (n = 18), were interviewed using a semi-structured interview guide. Interviews were audio-recorded, transcribed verbatim, and coded using NVivo. Four overarching themes were identified: (1) pressure injury awareness; (2) family support; (3) ability to seek medical care; and (4) medical resources. Barriers to timely care substantially outnumbered facilitators. The findings underscore the need for patient-centered, interprofessional education for PI prevention and management. Meaningful, needs-based interventions can improve health literacy and empower both patients and caregivers to engage in wound care. Increased investment in prevention and sustained public-awareness campaigns are essential to reduce delayed help-seeking and PI incidence. These results provide practical guidance for healthcare professionals and researchers seeking to enhance patient services and develop effective PI-prevention strategies.

Key messages

- This study highlights the importance of patient-centered education and interprofessional collaboration in improving pressure injury (PI) prevention and management. Targeted educational interventions can enhance health literacy, empowering patients to adhere to self-care practices and achieve better outcomes.
- The study also calls for greater investment in preventive measures and sustained public-awareness campaigns to reduce PI incidence, with an emphasis on early intervention and holistic care approaches.

1. Introduction

Pressure injuries (PIs)—historically labelled decubitus ulcers, pressure sores, or pressure ulcers—were formally renamed by the National Pressure Ulcer Advisory Panel (NPUAP) in 2016 and redefined in 2025 as localized damage to the skin and/or underlying tissue, usually over bony prominences or in contact with medical devices, resulting from prolonged pressure or pressure in combination with shear [1]. PI is a global health concern; its worldwide incidence continues to climb and has become a critical patient-safety issue [2]. Reported prevalence ranges from 5.5% to 26.2% [3], and a recent meta-analysis of 39 studies documented a pooled rate of 8.4% (95% CI 7.6–9.3%) for hospital-acquired pressure injuries [4], far exceeding commonly perceived estimates. As a distinct category of chronic wounds, PIs inflict considerable pain, generate high treatment costs, and can precipitate life-threatening sepsis [5]. They increase disability and mortality [6,7], impose severe psychological burden [8], and markedly erode quality of life [9,10]. Complex and costly management further strains both patients and health systems [11–13]. Data from the World Union of Wound Healing Societies (WUWHS) confirm that the high incidence and

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protracted course of PIs consume substantial medical resources and impose a heavy societal economic burden [14]. Indirect costs from lost productivity add an extra layer of hardship [15], creating a vicious cycle of rising expenditure without income replacement [16,17].

The key modifiable factor influencing PI outcomes is the timeliness of care initiation. Delayed medical-seeking, first conceptualized in 1938, refers to the interval between symptom discovery and initial presentation to a healthcare facility [18]. Definitional thresholds vary across studies (≥24 h, 48 h, or several days), directly affecting comparability and intervention sensitivity. Existing research on delayed medical-seeking in chronic disease concentrates on conditions such as COPD, stroke, and diabetes [19–21]; within wound care, studies predominantly address diabetic foot ulcers [22–24], while PI-specific evidence remains scarce.

Delayed medical-seeking in PI patients exacerbates wound severity, prolongs healing, intensifies suffering, and amplifies healthcare costs. Previous reports indicate that such delay increases healing time, complications, length of stay, and mortality [25,26]. Conversely, prompt PI management shortens treatment duration, lowers readmission and complication rates, and reduces resource consumption [27]. The determinants of delay are multifactorial: a Turkish retrospective study linked male sex, advanced age, and prolonged hospitalization to longer delay [28], while Australian work highlights deficits in early recognition and the limited availability of educational materials for patients and families [29,30].

In summary, although retrospective studies have identified factors associated with delayed medical-seeking in PI patients, qualitative evidence remains limited and has largely focused on nurses' perspectives. The present study therefore employs a phenomenological qualitative approach to explore, from the caregiver's standpoint, the determinants of delayed medical-seeking after symptom onset. The aim is to provide a theoretical basis for interventions that promote timely care-seeking, curb injury progression, and improve patients' quality of life.

2. Objectives

This study aimed to: (1) explore caregiver-reported factors associated with delayed medical consultation for older adults with pressure injuries; (2) provide a theoretical basis for developing multi-level intervention strategies to shorten delay time and improve patient quality of life.

3. Methods

3.1. Ethics approval and consent to participate

All methods used in this study were carried out following all relevant guidelines and regulations (Declaration of Helsinki). The Ethical Review Committee at Shanghai University of Medicine & Health Sciences Affiliated Zhoupu Hospital provided ethical clearance (Ethics No. 2024-C-041). The purpose of the study was fully disclosed to all participants, and all participants provided informed consent. All data gathered for this study was kept private and secure, and the anonymity was maintained throughout the study, with participants' names replaced with number PX (X stands for the participant's number).

3.2. Semi-structured interview guides

A semi-structured interview guide was developed, informed by phenomenological methods [31], to explore patients' and caregivers' experiences with delayed medical care for PIs. A single semi-structured interview guide was developed and used for all 18 interviews. Before the interviews, the research team reviewed relevant domestic and international literature [32–34] and consulted two wound-care specialists (associate senior professional title or above) to refine the questions. The guide was pilot-tested with two participants and subsequently revised for clarity and relevance. The final guide covered: (1) understanding of the wound condition; (2) reasons for delayed care-seeking; (3) self-management attempts; (4) decision-making factors; (5) healthcare system experiences; and (6) knowledge assessment. This structured yet flexible approach enabled in-depth exploration while maintaining methodological consistency.

3.3. Participants

Purposive sampling was conducted in three sequential steps:

① The PI nurse-coordinator daily screened electronic medical records to identify eligible in-patients or nursing-home residents who met stage ≥2 PI and > 2-week delay criteria;
② Potentially eligible participants were approached face-to-face by the first author (LJY) who explained the study aim, confidentiality and right to withdraw; written consent was obtained from patients or legal guardians;
③ For patients lacking capacity, family caregivers were invited to participate as proxy interviewees. Recruitment continued until data saturation (no new themes emerged after three consecutive interviews).

The guide was informed by van Manen's lifeworld phenomenology, focusing on lived space, time, body and relation to explore caregivers' embodied experiences of delay.

From February to July 2025, 18 patients with PIs and delayed medical consultation who were treated in medical or elderly care institutions were recruited by purposive sampling, including participants from 2 tertiary general hospitals, 3 community hospitals, and 2 elderly care institutions. The sample size was determined by data saturation [35]. Inclusion criteria: (1) diagnosis of stage 2 or higher PI (including suspected deep tissue injury and unstageable) according to the 2019 Clinical Practice Guideline for the Prevention and Treatment of Pressure Injury [5]; (2) delayed medical consultation time >2 weeks [4]; (3) age ≥55 years; and (4) informed consent and voluntary participation, with patient's primary caregivers(caregivers who bear the main caregiving responsibility, spend the most cumulative time on care, participate in medical decision-making, and are unpaid, mainly including spouses, parents, and children) allowed to assist in completing the questionnaire.

Exclusion criteria: (1) comorbid mental illness or other severe skin diseases; and (2) PI occurring during hospitalization.

In total, 18 patients and their caregivers were interviewed. The average patient age was 83.5 years (6 males, 12 females). Delay time ranged from 15 to 180 days (mean 35.64 days). PI stages were: stage 2 (n = 8), stage 3 (n = 4), stage 4 (n = 1), unstageable (n = 4), and deep tissue injury (n = 1). Basic information on interviewees is shown in Table 1.

3.4. Data collection

3.4.1. Demographic information

Demographic data were collected for all participants, including patient age, gender, delay time (days), PI stage, admission diagnosis, patient source (e.g., tertiary hospital, community health center, nursing home), interviewee role (patient/family/caregiver), relationship to the patient, and interviewee age.

3.4.2. Interviews

Semi-structured interviews were conducted by the first author (LJY, female, 8-year wound-care experience) and a master-level research assistant (ZY, female, 3-year qualitative-research training) [31]. Interviews lasted 15–29 min (mean = 21 min) and took place in a quiet side-room on the ward, in the community health-centre counselling room, or in the nursing-home activity room according to participant preference. The interviewee was the sole family caregiver (or hired

Table 1
Summary table of basic information on interview subject.

No.	Patient Age (years)	Gender (M/F)	Delay Time (days)	PI Stage	Admission Diagnosis	Patient Source	Interviewee (Patient/ Family/Other)	district	Interview time (min)
P1	66	M	40	Stage 3	Lung-tumor, Heart disease	Tertiary hospital	caregiver	rural	26:30
P2	80	M	41	Unstageable	Severe pneumonia	Tertiary hospital	caregiver	urban	23:57
P3	80	F	24	Unstageable	Post-stroke sequelae	Tertiary hospital	caregiver	urban	25:15
P4	85	F	180	Stage 2	Diabetes	Tertiary hospital	caregiver	rural	17:53
P5	85	F	30	Deep tissue injury	Cerebral infarction	Tertiary hospital	caregiver	rural	14:10
P6	81	M	14	Stage 4	Cerebral infarction	Tertiary hospital	caregiver	urban	29:28
P7	94	F	15	Stage 2	Heart failure	Tertiary hospital	caregiver	urban	15:12
P8	78	F	32	Stage 2	COPD	Tertiary hospital	caregiver	urban	24:30
P9	81	F	19	Stage 2	Advanced cancer	Tertiary hospital	caregiver	urban	16:20
P10	83	M	43	Stage 3	Post-stroke sequelae	Tertiary hospital	caregiver	urban	17:20
P11	82	M	17	Stage 2	COPD	Tertiary hospital	caregiver	rural	23:53
P12	81	F	45	Stage 3	Cerebral infarction	Tertiary hospital	caregiver	urban	22:12
P13	73	F	51	Unstageable	Thymic cancer	Community health center	caregiver	rural	19:19
P14	83	F	18	Stage 3	Pancreatic tumor	Community health center	Caregiver	urban	24:30
P15	84	M	30	Unstageable, Deep tissue injury	Septic shock	Community health center	caregiver	urban	16:20
P16	82	F	16	Stage 2	Hypertension	Nursing home	caregiver	rural	17:20
P17	90	F	28	Stage 2	Hypertension, Diabetes	Nursing home	caregiver	rural	23:53
P18	95	F	18	Stage 2	Post-stroke sequelae	Nursing home	caregiver	Rural	22:12

caregiver) who had signed the consent form; no extra relatives were present, ensuring undisturbed narrative. A second researcher (SHH) observed and recorded field notes on participants' nonverbal behaviors and emotional responses. Interviews were audio-recorded, transcribed verbatim within 24 h by the research team, and cross-checked for accuracy by an independent reviewer. To ensure anonymity, all transcripts were de-identified and assigned unique codes (P1–P18).

3.4.3. Enhancing rigor and trustworthiness

Credibility was enhanced through investigator triangulation, with two researchers independently coding all transcripts. Dependability was supported by adherence to Colaizzi's seven-step analysis method and by maintaining an audit trail of coding decisions [36]. Transferability was strengthened by: (a) maximum-variation sampling of caregivers across tertiary hospitals, community centres and nursing-homes; (b) detailed Table 1 enabling readers to compare caregiver age, relationship, PI stage and setting; (c) thick description of caregiver-reported behaviours and quotes.

3.4.4. Data analysis

Colaizzi's seven-step framework was selected because it offers systematic guidance for transforming caregiver narratives into exhaustive themes while preserving the essence of their lived experience. Thematic analysis was conducted following Colaizzi's framework. All team members (LJY, ZY, XPH) jointly coded the first three transcripts to develop a preliminary codebook. Five researchers (LJY, ZY, XPH, LWC, TY) then independently coded five additional transcripts to refine the codebook. NVivo 12 (QSR International) was used to organize the data. Final themes were derived through iterative discussions among the team, which included two wound-care specialists (both associate professors) to ensure clinical relevance. Discrepancies were resolved through consensus meetings. The analysis emphasized reflexivity, with researchers documenting personal assumptions and potential biases throughout. Example of code allocation: the caregiver quote 'I thought it was just a blister' was initially labelled 'misconception-minor injury', then grouped under 'normalisation', and finally abstracted into the theme 'Deficits in pressure injury awareness'. All discrepant codings were resolved by consensus and audit-trail documentation. Reflexivity on synthesis: During axial coding the multidisciplinary team held two 90-min reflective sessions to question whether emerging themes truly reflected caregivers' perspectives or researchers' assumptions. Memos tracked interpretive turns, and deviant cases were deliberately examined to refine the thematic map, thereby enhancing interpretive rigor.

4. Results

Eighteen interviews were conducted from **3** February 2025 to 31 July 2025. Interviews ranged from 15 to 29 min, with a mean duration of 21 min.

4.1. Demographics

Tabel1 displays the demographic characteristics of the participants.

4.2. Overarching themes and sub-themes

Through rigorous thematic analysis, four core themes emerged that characterize factors influencing delayed medical care for pressure injuries (PIs): (1) deficits in pressure injury awareness; (2) insufficient family support; (3) barriers to healthcare access; and (4) systemic limitations in medical resources. Each theme encompassed multiple dimensions (Table 2).

4.3. Theme 1: pressure injury awareness

Patients' caregivers identified two shortcomings in disease awareness and care: (a) lack of disease knowledge and care skills; and (b) resignation to symptoms. Interviews revealed that most patients and families had limited understanding of PIs, often mistaking them for minor skin issues that would heal spontaneously. Many caregivers lacked essential knowledge—especially in recognizing signs of acute exacerbation—leading to delayed intervention or inappropriate home treatment.

For example, P6's caregiver noted: *"I didn't realize this was a medical condition. At first, I thought it was just a blister that would heal. After it burst from pressure, we applied disinfectant, and it worsened."* P8's family relied

Table 2
Core themes and sub-themes characterizing delayed medical-seeking for pressure injuries.

Theme	Sub-theme	Quotes
Theme 1: Pressure Injury Awareness	Lack of disease knowledge and care skills	"I didn't realize this was a medical condition. At first, I thought it was just a blister that would heal."
		"We applied disinfectant and it worsened."
	Resignation to symptoms	"I've grown accustomed to it—it's just skin damage, not a big issue."
		"Minor skin breakdown in their 95-year-old mother as normal"
Theme 2: Family support	Insufficient disease awareness	"Not serious enough to involve other relatives"
		"Ignored nurses' advice about repositioning until the injury progressed severely"
	Lack of caregiver availability	"No time to take him to the hospital otherwise" (factory worker)
		"Caring for grandchildren and elders" multitasking barrier
	Family decision-making conflicts	"Disputes over financial responsibility"
		"Debated hospitalization repeatedly … opting for nursing-home care"
Theme3: Healthcare access	Transportation difficulties	"Unwilling to call 120 just for wound dressing"
		"Depending entirely on her daughter's availability"
	Financial constraints	1000+ RMB per visit, always leading to hospitalization"
		"100 RMB per dressing change plus taxi fares"
Theme 4: Medical resources	Inadequate medical resources	"Community hospitals no longer stock medications for chronic conditions"
		"Emergency beds are too few; waiting takes days"
	Limited community healthcare services	"Only perfunctory blood-pressure checks … no wound-management guidance"
		"Family doctor refused home visits for wound care"
	Insufficient health education	"Basic cleaning with towels without professional input"
		"No interviewee mentioned nutritional prevention strategies"
	Complex treatment procedures	"Repetitive cycle of referrals and ambulance transfers"
		"Every consultation required emergency transport"

on a relative's advice to *"use cephalosporins and repositioning,"* while P13's family sought community hospital care only after skin breakdown occurred. Home caregivers frequently lacked skills in wound dressing and repositioning. P4's caregiver treated the injury as a *"minor cut covered with band-aids,"* but observed worsening redness and expansion after one week. Some families perceived PIs as an inevitable consequence of aging or prolonged bed rest, thereby downplaying their severity. P2's family reported that a nursing home initially dismissed skin redness as harmless, yet the condition deteriorated. P10's caregiver stated: *"My father's condition has persisted for over half a year. I've grown accustomed to it—it's just skin damage, not a big issue."* P18's family similarly accepted minor skin breakdown in their 95-year-old mother as *"normal."*

4.4. Theme 2:Family support

caregivers highlighted three key challenges in providing support: (a) insufficient disease awareness; (b) lack of caregiver availability; and (c) family decision-making conflicts. Many families underestimated the severity of PIs. P9's caregiver considered the wound *"not serious enough to involve other relatives,"* while P11's family dismissed recurrent symptoms as *"typical fluctuations."* P12's caregiver admitted ignoring nurses' advice about repositioning until the injury progressed severely after 1.5 months. Conflicts between work schedules and caregiving responsibilities were common, particularly among nursing-home residents. P3's caregiver, a factory worker, could seek care only during emergencies (*"no time to take him to the hospital otherwise"*). P17 and P18's families cited multitasking demands (*"caring for grandchildren and elders"*) as barriers, relying on nursing homes for basic care such as repositioning. Disagreements among caregivers often delayed treatment. P6's family faced disputes over financial responsibility, while P18's siblings *"debated hospitalization repeatedly, opting for makeshift nursing-home care."* In one case, unresolved conflicts were followed by rapid progression from Stage 1 to unstageable/Stage 4 within two weeks.

4.5. Theme 3:Healthcare access

Two major obstacles to timely medical care were identified: (a) transportation difficulties; and (b) financial constraints. Mobility limitations among older PI patients (e.g., bedbound or disabled individuals; those living alone), compounded by logistical challenges, hindered hospital visits. P7 relied entirely on her daughter's availability, while P3 depended on ambulances for non-emergencies (*"unwilling to call 120 just for wound dressing"*). Notably, accompanying caregivers' mean age was 55.2 years (maximum: 79 years), exacerbating mobility issues. Four interviewees cited unaffordable costs as a deterrent. P9's family avoided hospitals due to high emergency fees (*"1000+ RMB(about 138 USD) per visit,always leading to hospitalization"*), while P11 had exhausted insurance coverage. P4 highlighted recurring expenses ("100 RMB*(about 14 USD) per dressing change plus taxi fares"*). Some families turned to self-treatment (e.g., herbal ointments), perceiving hospital care as costly yet ineffective.

4.6. Theme 4:Medical resources

Four systemic gaps emerged: (a) inadequate medical resources; (b) limited community healthcare services; (c) insufficient health education; and (d) complex treatment procedures. Bed shortages were critical. P5's family failed to secure hospitalization despite prior appointments (*"emergency beds are too few; waiting takes days"*). P6 emphasized inequities: *"Community hospitals no longer stock "medications"(alginate and foam dressings essential for PI care.) for chronic conditions like stroke, forcing referrals to larger hospitals."*Families reported inadequate support from primary care providers. P2's family doctor refused home visits for wound care, while P16's nursing home received only perfunctory blood-pressure checks from community physicians, with no wound-management guidance. Families lacked formal training and often relied on unreliable sources (e.g., online searches or peer advice). P11's family used *"basic cleaning with towels"* without professional input, and P12 relied on *"first-aid training at work."* Notably, no interviewee mentioned nutritional prevention strategies. Misconceptions persisted, such as P4's belief that *"community hospitals offer inferior care."*-Multimorbid PI patients faced bureaucratic hurdles. P2 described a *"repetitive cycle of referrals and ambulance transfers"* without streamlined pathways. P18's nursing home, lacking medical staff, required emergency transport for every consultation. Families advocated for *"green channels"(a direct, nurse-led fast-track from nursing home to inpatient wound unit.)* to simplify hospitalization.

5. Discussion

As a highly prevalent chronic wound, pressure injuries (PIs) often receive delayed medical care, which exacerbates patient suffering and treatment complexity, increases the burden on families and society, and seriously damages health-related quality of life [37]. This qualitative

study identified four core factors underlying delayed care-seeking: insufficient disease awareness, inadequate family support, limited healthcare access, and imbalanced medical resource allocation. Addressing these challenges requires multifaceted intervention strategies.

5.1. Strengthening health education and building a comprehensive prevention system

Our caregiver narratives consistently reveal that misperceiving early pressure injury (PI) signs as "normal" is the primary driver of delayed medical-seeking, echoing Hulme et al.'s Canadian findings where caregivers interpreted skin redness as ordinary pressure marks and postponed professional assessment [38]. A Taiwan qualitative study similarly showed that informal caregivers relied on "wait-and-see" heuristics, leading to avoidable hospitalisations [39]. Consequently, simply distributing leaflets is insufficient; behaviour-change techniques such as photo-enhanced decision aids and teach-back demonstrations are needed to correct cognitive biases [39]. This study identifies lack of disease knowledge as the primary cause of delayed care. Many interviewees misunderstood the nature of PIs—viewing them as an "inevitable consequence of aging" or "minor skin damage"—and adopted inappropriate practices (e.g., local massage, ring-shaped cushions), which further delayed treatment. These issues likely reflect gaps in current health-education systems. Clinically, providers often focus on acute symptom management during hospitalization but offer limited long-term preventive guidance for high-risk, post-discharge populations (e.g., stroke or fracture patients). Community-level follow-ups and interventions for bedridden patients are also insufficient, perpetuating caregivers' misconceptions about the effectiveness of self-treatment. Recommended actions include:1. **Enhance discharge preparedness**: train patients and families in early PI prevention and identification, emphasize treatment urgency, and provide clear care-seeking guidelines to support timely diagnosis and intervention.2. **Expand education outreach**: develop wound-care knowledge repositories and diversify dissemination channels (e.g., decision aids such as brochures and videos, public-health campaigns via lectures, peer support, and multimedia platforms) to increase public awareness.

Family decision conflicts often revolve around financial responsibility and hospitalization timing, as seen when P6's siblings disputed the 1000 RMB deposit, resulting in a 5-day delay and rapid deterioration to unstageable stage. Inadequate resources in community health centres—stock-outs of alginate dressings reported by P6—mirror a 2023 nationwide survey where 62% of Chinese primary-care nurses lack basic wound supplies [40], confirming that supply-side deficits amplify caregiver delay.

5.2. Optimizing medical resources and implementing tiered healthcare

Limited accessibility and inequitable resource distribution emerged as structural barriers. Although community health centres (CHCs) are geographically convenient, their wound-care capacity (e.g., access to advanced dressings or home-visit services) remains weak, forcing patients to seek care at distant tertiary hospitals. Caregivers' descriptions of "emergency bed shortages" and "community hospitals no longer stocking wound materials" mirror the resource-mismatch reported in a 2023 nationwide survey of 3457 Chinese community nurses, where 62 % lacked basic alginate dressings [41]. Adapting the Monash Partners Capacity Building Framework to Shanghai context—namely, a nurse-led "green channel" from nursing home to inpatient wound unit—could shorten the median delay found in our study (35.6 days) closer to the 13 days achieved in an Australian fast-track programme [42]. Conversely, overcrowded tertiary facilities face bed shortages and bureaucratic hurdles (e.g., redundant emergency referrals), which further prolong delays.

5.3. Financial and transportation burden

Out-of-pocket payment emerged as a key barrier; P4's estimate of "100 RMB per dressing plus taxi twice a week" is consistent with a 2022 cost-of-illness study which reported that community-dwelling PI patients in China spend 14 % of annual household income on wound care, far above the 5 % catastrophic threshold defined by WHO [43]. Transport difficulties were compounded by caregiver age (mean 55.2 y, max 79 y); a Korean study showed that when caregivers are $\geq$65 y, the odds of delay >30 days increase 2.3-fold [44].

5.4. Future reasearch directions

Mixed-methods cost-effectiveness analysis of community nurse-led wound clinics and caregiver mobile-photo feedback should be prioritised to quantify delay reduction and healthcare savings.

6. Limitations and future directions

This qualitative study provides an in-depth view of delayed medical consultation for pressure injuries across hospital, community, and nursing-home settings. Several aspects merit consideration when interpreting the findings. First, the purposive sample (n = 18) was drawn from a limited number of institutions, which may constrain transferability to other systems. Second, data were based on participant reports and may be influenced by recall and social desirability. Third, we operationalized "delay" as >2 weeks; while consistent with the literature, alternative thresholds might capture additional patterns for the problem itself. Finally, provider perspectives and objective clinical endpoints (e.g., wound trajectory, rehospitalization) were not systematically triangulated. These features reflect typical trade-offs in qualitative research and point to concrete opportunities for subsequent work. Additionally, we did not stratify participants by rural versus urban residence; rural caregivers may face longer travel distances and fewer community resources, which could independently influence delay. Future studies should control for this potential confounder. Building on these findings, future studies could broaden the sampling frame across multiple regions and care models, and adopt mixed-methods, longitudinal designs to link care-seeking timelines with clinical outcomes (e.g., time-to-presentation, stage progression, costs). Intervention work is also warranted to evaluate (1) structured discharge education for high-risk patients and caregivers; (2) caregiver support and respite options; (3) community-based wound-care capacity, including home visits and telehealth follow-ups; and (4) streamlined referral "green channels" between community and tertiary services. In parallel, applying behavioral frameworks (e.g., Theory of Planned Behavior) to co-design decision aids, and developing standardized measures of delay, would facilitate comparability and implementation.

7. Conclusion

This study identifies four interrelated domains which are pressure injury awareness, family support, healthcare access, and medical resources. They together shape the timeliness of help-seeking for pressure injuries. The results highlight actionable opportunities at the patient, family, community, and system levels: strengthen patient- and caregiver-focused education, support family decision-making and caregiving, improve accessibility and affordability of services, and optimize coordination across tiers of care. Together, these insights provide a practical basis for targeted interventions and policy alignment aimed at reducing delays, curbing injury progression, and improving outcomes for older adults with pressure injuries.

Ethics approval

This study was approved by the Research Ethics Committee of

Shanghai University of Medicine & Health Sciences Affiliated Zhoupu Hospital (Approval No.: 2024C041). All participants provided written informed consent.

Data availability statement

Research data are not shared due to ethical restrictions.

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Conflict of interest statement

All authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this manuscript titled “Facilitators and barriers to delayed medical-seeking in adults with pressure injuries: a qualitative study”.

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