CORRECTION

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Correction to: Barriers and facilitators to infection prevention and control in Dutch psychiatric institutions: a theory-informed qualitative study



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Following publication of the original article [1], the authors identified some errors in Table 1. The correct Table 1 is given below:

Furthermore, the authors noticed a typo in the section 'implications for practice and conclusion': "theo ryinformed interventions" should be replaced with 'theory-informed interventions'.

The original article [1] has been corrected.

The original article can be found online at https://doi.org/10.1186/s12879-022-07236-2.

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Table 1 Barriers and facilitators to IPC implementation, perceived by professionals working at psychiatric institutions (n = 16), depicted per level of the integrated theoretical framework (see Fig. 1), and categorised by corresponding theme

Level	Barriers	Facilitators
Guideline level	Accessibility - Poor access to IPC guidelines, especially for social workers	Accessibility - Sufficient access to IPC guidelines ^a
	 Poor access to IPC guidelines, especially for social workers Applicability to (work)setting 	- Sufficient access to IPC guidelines ^a Applicability to (work)setting
	 Lack of up-to-date guidelines 	- Up-to-date guidelines
	 Lack of compatibility/applicability: lack of IPC guidelines tailored to mental 	 Practical IPC guidelines, including schemes and illustrations and clear
	health care	procedural descriptions (procedural clarity)
	- Poor feasibility/practicality: IPC guidelines too lengthy, lack illustrations	
Patient level	Nature of mental illness and associated behaviour	Cognitions and attitude
(as reported by the	- Risk behaviour related to mental condition (e.g., compulsive behaviour	- Willingness to adhere to IPC measures
professional)	[compulsions], neglection personal hygiene, withdrawal symptoms because of	
	addiction) challenges IPC application	
	Cognitions and attitude	
	 Lack of hygiene awareness and low risk perception (often related to mental illness and cognitive limitations) 	
	 Negative attitude towards IPC and non-compliance (often related to mental 	
	illness and cognitive limitations)	
	Belief that IPC is not important	
	 Unwillingness to comply to IPC 	
Professional level	Cognitions and attitude	Cognitions and attitude
	 Lack of awareness towards IPC 	- Willingness to change
	- Low risk perception: belief that patient has a low risk of infection	Experience and personal relevance
	- Negative professional attitude	- Personal experience with (consequences of an) outbreak
	Forgetting IPC implementation	Habits and routines
	 Laziness/laxness towards IPC implementation 	- IPC application is habit/part of routine
	Belief that IPC is not important	
	Resistance/lack of willingness to implement IPC Knowledge and shills	
	Knowledge and skills - Lack of IPC knowledge	
	- Lack of IPC knowledge Habits and routines	
	 Stuck in other work habits/issues of the day 	
Professional	Feedback and monitoring	Feedback and monitoring
interaction	 Lack of feedback between professionals on IPC performance 	Mutual feedback between professionals on IPC performance
	 Lack of monitoring of IPC behaviour among professionals 	Social support
	0	- Informational support (sharing IPC information) between professionals
Professional-	Social support	Feedback and monitoring
patient interaction	 Lack of support and stimulation for IPC application from professional to 	 Monitoring of IPC application of patient by professionals
	patient	 Addressing and holding patients to account by professionals (feedback)
		Social support
		- Motivating and informational support for IPC application from professional to
		patient
Patient interaction	b	Social pressure and social norm
		- Peer pressure between patients
		 Injunctive norm between patients
Organisational	Organisational support and priority	Organisational support and priority
level	 Lack of structural organisational attention towards IPC 	 Sufficient organisational awareness towards importance IPC
	- Lack of priority for IPC	- Support board of directors
	Resources, materials and facilities - Lack of adequate IPC materials, both educational materials (i.e., guidelines) as	Task division and change coaches - Professionals responsible for IPC (e.g., IPC committee, hygiene contact person,
	well as equipment (e.g., hand soap)	IPC attention officer)
	- Lack of financial resources	 Professionals acting as driving forces for IPC implementation
	- Inadequate facilities	Educational system
	Time availability and staff capacity	- IPC education and training aimed at IPC attention officers/hygiene contact
	 High work pressure 	persons
	- Staff shortages	- IPC education and training among all staff Leadership and institutional policy
	- Presence of flex workers	
	Task division and change coaches - Lack of professionals responsible for IPC (e.g., infection control professional,	Sufficient organisational action towards IPC (from leadership) Performance of IPC audits
	 Lack of professionals responsible for IPC (e.g., infection control professional, IPC committee) 	 Involving professional(s) in IPC policy development (participation and
	Educational system	ownership)
	- Lack of general IPC education and training among all staff	
	Leadership and institutional policy	
	- Lack of organisational action towards IPC (from leadership)	
	- Lack of IPC policy	
	Lack of IPC audits	
	Lack of institutional IPC protocols	
Community level	Care-sector related social norms and culture	Care-sector related social norms and culture
(i.e., mental health care sector)	 Sectoral belief that there is a low risk of contracting an infection 	 Increased sectoral awareness towards the importance of IPC (over the years) –
care sector)	 Mild and spacious sectoral culture Dominant sectoral (professional) norm in which mental health is a priority and 	sectoral shift Interorganisational networks
	 Dominant sectoral (professional) norm in which mental health is a priority and IPC less important (lack of balance between somatic and psychological aspects) 	Sectoral collaboration (between psychiatric institutions)
	PC less important (lack of balance between somatic and psychological aspects) Sector-related dilemmas between somatic and mental aspects	 Sectoral conaboration (between psychiatric institutions) Collaboration between psychiatric institutions and external health
	Interorganisational networks	organisations (i.e., hospitals or public health services)
	- Lack of sectoral collaboration (between psychiatric institutions)	
	- Lack of collaboration between psychiatric institutions and external health	
	organisations (i.e., hospitals or public health services)	
Societal level	Workforce	Involvement governmental agencies
	- Shortage of workforce	- Sufficient information provision from governmental organisations
	Design health care system	- IPC as an item on the political agenda
	- Market forces in the mental health care sector relating to reimbursement	
	organisational collaboration)	<u> </u>
	schemes and competition (leading to financial challenges and a lack of cross- organisational collaboration)	

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