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Résumé de l'étude

Le progrès au service de la cicatrisation
Introduction au guide en 5 parties destiné aux soignants de première ligne

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Points positifs

4 stratégies pour des **améliorations systémiques** dans le soin des plaies chroniques[1]

Étude de cas sur le changement de comportement visant à améliorer:
- la qualité des références
- les pratiques fondées sur les preuves
- les résultats thérapeutiques
- la confiance du personnel[2]

Guide aux meilleures pratiques: combler la différence de connaissances entre **spécialistes et généralistes**[3]

1e partie: Défis liés aux pratiques actuelles avec le soin des plaies chroniques

Plusieurs freins interconnectés compliquent la délivrance de soins de qualité et constants aux plaies chroniques pour les soignants:[1]

Données non-cohérentes

Les différences dans la définition, la classification et le rapport des plaies chroniques selon les régions nuisent à la qualité des données probantes et au développement des bonnes pratiques.

Fragmentation des soins

Des pratiques divergentes entre les nombreux acteurs entraînent des soins incohérents, centrés sur la plaie plutôt que sur une prise en charge holistique et patient-centrée.

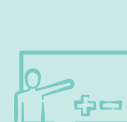
Un manque de formation

Les professionnels de santé et les patients manquent de formation et sont donc forcés de reposer sur des méthodes dépassées

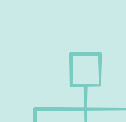
Retards de diagnostic

Résultent du manque de formation ou d'accès aux outils diagnostiques standardisés et du manque de protocoles de réévaluation

Stratégies pour surmonter ces obstacles:[1]



Améliorer l'éducation et la formation



Uniformiser la terminologie, les protocoles et les meilleures pratiques

Renforcer l'engagement des patients et la prise de décision partagée

Renforcer la coopération interdisciplinaire afin de donner la priorité aux soins centrés sur les patients

Lire maintenant: 1e partie: *Inertie clinique dans les soins des plaies chroniques*

2e partie: Créer des conditions pour le changement

Les professionnels de santé ont identifié des stratégies qui traitent à la fois les déclencheurs psychologiques et les pressions externes qui influencent la prise de décision des soignants[2]

- Recadrer l'objectif
- Simplifier pour encourager l'observance
- Favoriser la prise de décisions éclairées
- Promouvoir les comportements positifs
- Uniformiser les protocoles et le langage
- Rendre la formation pratique et accessible
- Apporter une assistance en temps réel sur le lieu de soin

Étude de cas: Comment les changements ciblés de comportements ont amélioré les résultats du traitement des plaies chroniques[2]

Mesures:

- Changer la mentalité sous-jacente pour se concentrer sur la «guérison» plutôt que sur la «gestion»
- Introduire des outils de soutien aux décisions cliniques
- Consultations virtuelles pour apporter une assistance en temps réel
- Mesure et communication des résultats

Amélioration des résultats:

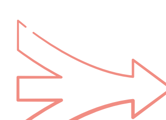
- Qualité des documents
- Engagement envers des pratiques basées sur des preuves
- Résultats thérapeutiques globaux
- Confiance du personnel, en particulier parmi les soignants généralistes

Lire maintenant: 2e partie: *De l'inertie à l'action*

3e partie: Donner des moyens aux infirmières

L'accès aux outils simplifiés et à des procédures claires peuvent aider les généralistes à prendre des mesures opportunes, confiantes et appropriées. Ces outils et itinéraires sont disponibles[3]

Connaissances essentielles: identification du type de plaie, repérage des signes d'alerte (red flags) et mesures thérapeutiques de première intention



Outils de prises de décisions simplifiés: organigrammes d'évaluation; guides des pansements, intégration numérique avec les Dossiers médicaux électroniques

Remontée confiante: critères cliniques, parcours de soins structuré, renforcement culturel pour reconnaître les meilleures pratiques pour la revalorisation

Engagement du spécialiste: lorsqu'il faut faire appel à des spécialistes des soins, un objectif à 7 jours permet d'aligner les équipes et d'optimiser les ressources

Lire maintenant: 3e partie: *Combler le déficit de connaissances*

À venir

4e partie: Surmonter les obstacles liés aux ressources et au remboursement: optimiser l'accès aux solutions avancées au traitement des plaies

«Le prochain article dans la série vise à aider les soignants à identifier les cas où les produits pour le traitement des plaies auront le plus grand impact, que ce soit en réduisant les changements inutiles de pansements ou en réduisant l'impact des plaies stagnantes. Démontrer cette valeur peut aider les soignants à surmonter les obstacles à l'accès et à accélérer les résultats significatifs.»

Prof. Sebastian Probst, DClinPrac, MNS, RN, Professeur en viabilité des tissus et en soins des plaies

5e partie: Optimisation des pratiques de soins des plaies : Réduire les écarts grâce à des cadres fondés sur des preuves et à des solutions évolutives

«Les cadres éprouvés ne favorisent le changement que lorsqu'ils sont intégrés dans les processus de travail quotidiens. Des solutions évolutives et rationalisées transforment les meilleures pratiques de simples orientations théoriques en actions cliniques pratiques confiantes.»

Dr Leanne Atkin, PhD MHSc (ANP) RGN, Chercheur universitaire/Infirmier conseil en soins vasculaires

Lisez la série publiée jusqu'à présent et inscrivez-vous pour recevoir les nouveaux articles qui paraîtront en janvier 2026 et en mars 2026.

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Clinical inertia in the care of patients with chronic wounds

Chronic wounds, defined as wounds that fail to progress through the normal stages of healing, represent a growing global health challenge with profound clinical, social, and economic implications (Frykberg and Banks, 2015). The burden of chronic wounds is multifaceted, affecting not only patients' quality of life but also straining healthcare systems worldwide. These wounds are associated with prolonged morbidity, increased risk of infections and higher mortality rates, especially in patients with comorbidities such as diabetes and peripheral vascular disease (Mahmoudi and Gould, 2020).

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Key words
- Chronic wound care
- Patients' quality of life
- Healthcare challenges
- Meeting report

Declaration
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Globally, chronic wounds impact millions of individuals, with estimates suggesting that up to 2% of the population in developed countries will experience a chronic wound during their lifetime. The prevalence is even higher in ageing populations, where comorbidities such as diabetes and obesity exacerbate the risk of non-healing wounds (Sen, 2019). The financial burden is equally staggering; in the US alone, care for patients with chronic wounds is estimated to cost between $28 billion and $31 billion annually, not accounting for indirect costs, such as lost productivity and long-term disability (Sen, 2019).

Low-resource settings bear a disproportionate share of this burden, with limited access to advanced wound care technologies and a reliance on traditional, often suboptimal, treatment methods. This disparity contributes to poorer outcomes and highlights the urgent need for global strategies that address these inequalities (Haesler, 2023).

The escalating costs associated with chronic wound management are compounded by systemic challenges, including clinical inertia, a lack of standardised diagnostic protocols and insufficient education for healthcare providers. Clinical inertia, the failure to initiate or escalate treatment despite clear indications, remains a significant barrier, hindering timely interventions and contributing to suboptimal outcomes (Harding and Queen, 2019).

In response to these challenges, the Applied Wound Management (AWM) Chronic Wounds Global Advisory Council convened on 17 and 18 November 2024, bringing together a diverse panel of experts to discuss the pressing issues in chronic wound care and propose actionable solutions. This report summarises the key discussions and recommendations from the meeting, emphasising that while the challenges are substantial, they are not insurmountable. Recognition of clinical inertia in the care of patients with chronic wounds is needed. A unified, evidence-based approach is essential to accelerate healing, optimise resource use and enhance patient quality of life. To achieve this, both systemic and psychological barriers must be addressed, paving the way for a more effective and sustainable model of care for chronic wounds.

Discussions on day one revealed the need for standardised terminology to enhance diagnostic consistency and data comparability, since variability in wound classification and reporting across regions impacts both research and practice. The panel acknowledged that tools such as the TIME/TIMERS framework (Atkin and Tettelbach, 2019), while widely referenced, are underutilised or not consistently used in daily clinical workflows.

The panel also recognised the need to align treatment plans with patient preferences and lifestyles, noting that shared decision-making and patient engagement are key to improving outcomes. Barriers such as low health literacy and the complexity of treatment regimens can make this difficult.

It was noted that emerging technologies, like AI and smart wound care products, could help bridge knowledge gaps and enhance treatment outcomes. Yet, while technology holds promise, its integration must complement rather than replace clinical expertise, especially as technology can be limited by regulatory, privacy and infrastructure concerns. AI support for clinical experts will be helpful, as they are better equipped to interpret and validate the guidance provided. However, AI use among generalists may be more challenging without appropriate expert guidance.

On day two, the complexity of care for patients with chronic wounds and the persistent gap between guidelines and real-world practice were highlighted. An emerging theme was the potential role of 'implementation science' as a means to ensure theoretical best practices are not only accessible but

actionable in real-world settings.

The panel recommended updates to the TIME/TIMERS framework to incorporate broader diagnostic considerations. The potential of a risk stratification tool to predict and mitigate the risk of non-healing wounds was also evaluated, with refinements advised to ensure clinical utility, validity and integration into workflows (Edwards et al, 2018).

Urgent action is needed to improve outcomes and establish a unified, efficient and patient-centred approach to wound care. With collective effort, informed by evidence and driven by a shared commitment to the future of care for patients with chronic wounds, it will be possible to change outcomes for the better. This article explores the key themes discussed by the panel in more detail, while laying the groundwork for a series of subsequent articles that will explore targeted solutions to these challenges.

Barriers in care for patients with chronic wounds

The panel identified several barriers to effective care, which are detailed below. Discussions revealed that these barriers are not only multifaceted but also deeply interconnected, highlighting how challenging it is to provide consistent, high-quality care – particularly against a backdrop of unprecedented healthcare system pressures.

Variations in diagnosis terminology

One critical issue identified by the panel is lack of reliable wound care data. There is variation in how chronic wounds are defined and classified across regions and healthcare systems, and in how such data are collected and reported, which makes it difficult to build a robust evidence base. This, in turn, limits development of effective care protocols.

For example, the term 'chronic wound' is interpreted differently across countries; in some regions, any lower-limb wound in a diabetic patient is automatically categorised as a 'diabetic foot ulcer', even if it may actually be a pressure injury or another condition.

Delays to diagnosis and provision of appropriate care

Another recurring theme is delayed diagnosis, which can lead to suboptimal treatment and worsen the severity of chronic wounds and may lead to suboptimal treatment provision (Ahmajärvi et al, 2022). This is compounded by variability in global data reporting, as outlined above.

The panel noted many possible reasons for delayed diagnosis. Healthcare providers may lack the education and training necessary to provide a timely diagnosis – some are reluctant to provide a diagnosis due to concerns about making an error, while others rely on 'guesswork' rather than evidence-based assessments; constraint of disciplinary boundries and scope of practice also remain notable barriers. There may also be limited access to standardised diagnostic tools, as well as an absence of reassessment processes, so treatment strategies remain stagnant rather than being updated as patients' needs evolve.

These delays are further exacerbated by the deprioritisation of chronic wounds, inadequate communication among healthcare providers (e.g., between generalists and specialists), rigid hierarchical structures and patients' own lack of knowledge or confidence to seek timely care.

Fragmentation of care

According to the panel, another considerable challenge is fragmentation of care, with lack of standardisation across wound care protocols, practices and practical tools undermining efforts to deliver optimal care and prolonging healing times. Moreover, wounds may be addressed as a standalone concern rather than as an important part of the patient's broader health picture.

This fragmentation manifests in several ways:

- Lack of access to standardised tools for wound assessment.
- Lack of clear wound care referral pathways.
- Regional disparities in access to wound care expertise, education and products (which leaves community care settings – often the frontline of wound management – particularly vulnerable).
- Varied priorities and goals amongst patients, caregivers and suppliers.

The panel noted that involvement of multiple stakeholders, including nurses, doctors, patients, caregivers and product suppliers, each with different priorities and perspectives, makes it difficult to address the barriers mentioned above.

Lack of quality education and training

The panel consistently noted that insufficient education and training – both for healthcare professionals and patients – is a key barrier to optimal care for patients with chronic wounds. Current approaches to teaching in wound care do not adequately prepare healthcare providers, while opportunities for continuous professional development are limited. Patient education is also a priority, with a need to improve health literacy and encourage greater

Key barriers to chronic wound care.

- Lack of a robust evidence base, due to inconsistent data reporting
- Delays to diagnosis and provision of appropriate care
- Fragmentation of care and an absence of standardised practices and protocols
- Lack of high-quality education and training for healthcare professionals and patients.

Strategies for systemic improvement in chronic wound care.

- Improve education and training, the cornerstone of effective wound care provision
- Standardise terminology, protocols and best practices across regions and healthcare systems
- Enhance patient engagement and shared decision-making
- Strengthen interdisciplinary collaboration, creating a unified approach that prioritises patient-centred care.

involvement in care decisions.

Lack of high-quality education means many clinicians operate without access to targeted education or advanced wound care knowledge, meaning they are ill-equipped to manage complex cases, are forced to rely on outdated methods and are unable to make timely, informed decisions.

Strategies to systematically Improve care for patients with chronic wounds

The panel proposed the following actionable recommendations to address barriers and facilitate the adoption of best practices.

Improve education and training

The panel emphasised that education and training are foundational to effective wound care. Developing robust, scalable education programmes tailored to the needs of community care settings is critical for addressing information gaps and fostering collaboration. A focus on capacity building among generalists is needed as they are often at the forefront of wound care provision.

The panel recommended developing simplified communication tools – such as plain language summaries, visual aids and tiered learning pathways – to help generalist nurses and non-specialists understand challenging topics like wound healing mechanisms and treatment aetiologies. Tools that address the complexities of wound care products and guidelines will equip providers with the knowledge required for informed decision-making, thereby reducing misdiagnoses, diagnostic delays and suboptimal care provision.

Partnerships with industry stakeholders and the considered use of technology is an opportunity to leverage funding and sustain these innovative educational initiatives. While technology can help address knowledge gaps, the panel cautioned against over-reliance, advocating instead for a balanced approach that preserves clinical expertise and ensures personalised care.

Standardise terminology, protocols and best practices

Standardising wound care terminology, protocols and practices was identified as a priority to streamline workflows, reduce variability and improve care consistency.

The introduction of globally recognised definitions for chronic wounds, combined with consistent data collection mechanisms that account for regional variations, could enhance diagnostic accuracy and care coordination. Establishing clear referral pathways was also highlighted as a strategy to minimise delays and improve alignment across care levels.

Enhance patient engagement and shared decision-making

Engaging and empowering patients through education and shared decision-making is essential for improving outcomes. The panel recommended aligning care plans with patients' individual goals and lifestyles to encourage adherence and collaboration, regardless of whether the objective is wound management or complete healing.

Tailored educational materials and structured communication tools, such as checklists, were suggested to simplify complex treatment regimens and foster active patient participation. By aligning patient education materials with standardised practices, the panel noted that patient understanding and adherence to treatment plans could be further improved.

Strengthen interdisciplinary collaboration

The panel stressed the importance of interdisciplinary collaboration and shared accountability in the care of patients with chronic wounds, emphasising that coordinated efforts between clinicians, caregivers and patients are essential to achieving holistic, patient-centred care.

Regular team meetings, workshops and resource-sharing were recommended to enhance communication and alignment amongst stakeholders. Establishing structured frameworks for knowledge-sharing and collaborative decision-making was also proposed as a means to improve care consistency, reduce diagnostic delays and foster better outcomes.

Targeting clinical inertia: behavioural change as a central solution

Globally, healthcare systems struggle to provide consistent, expert care for chronic wounds due to a lack of knowledge, services and often suboptimal evidence supporting many interventions. Yet, while innovation is clearly needed and recommendations for change have been explored extensively, change remains slow. One reason for this may be the pervasiveness of clinical inertia, which has not yet been explored extensively in wound care (Harding and Queen, 2019).

While the proposed strategies above offer a strong foundation for improvement, many barriers to improving care for patients with chronic wounds appear to be deeply rooted in clinical inertia – an inability to change driven by reliance on familiar routines, fear of

unfamiliar methods, and a lack of confidence in implementing advanced protocols. Indeed, clinical inertia is a major factor contributing to inadequate care for many chronic diseases (O'Connor et al, 2005).

To address these behavioural concerns, the panel highlighted the need for targeted interventions, including tailored education programmes, simplified workflows and structured support systems designed to empower clinicians to adopt and sustain evidence-based practices confidently and consistently.

Behavioural change is equally critical for patients, as their active engagement in care is essential for achieving positive outcomes. Many patients struggle with low health literacy, making it difficult to understand and follow care plans. Closing these gaps through education and shared decision-making will help to foster a collaborative relationship between patients and providers, promoting adherence and improving overall outcomes.

The panel further advocated for the integration of implementation science as a pragmatic means of translating knowledge into practice. Experience demonstrates that establishing the effectiveness of a clinical innovation is not enough to ensure its use; implementation science aims to bridge the gap between research and practice by testing strategies to integrate evidence-based innovations into widespread use (Bauer and Kirshner, 2020).

Utilising frameworks for implementability of healthcare interventions can help to establish their acceptability, fidelity and feasibility and ultimately influence the sustainability and scalability of them (Klaic et al, 2022).

A step-by-step, 'cookbook'-style approach was recommended to simplify the application of best practices. By embedding these implementation strategies within existing clinical guidelines and presenting them in accessible, clear language, such resources could better meet the needs of diverse healthcare providers – from non-specialists to seasoned practitioners – ensuring they are actionable, scalable and widely applicable.

Conclusion and next steps

The challenges identified by the AWM panel are significant, yet resolvable. Addressing the psychological and systemic barriers impeding progress provides an opportunity to establish a cohesive approach that ultimately accelerates healing, optimises resource utilisation and improves patient quality of life. Achieving this transformation will require a collective, evidence-driven effort based on a shared commitment to advancing the field of care for patients with chronic wounds.

This article marks the beginning of a series dedicated to exploring these critical issues in depth. Subsequent articles will examine the primary barriers identified by the panel, including knowledge deficits, resource limitations and obstacles to implementing best practices. Each publication will present practical, evidence-based solutions designed to empower stakeholders across healthcare sectors. By providing actionable strategies focused on behavioural change, education and systemic reform, this series aims to foster meaningful advancements, paving the way for a more effective, sustainable, and patient-centred model of care. ●

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From inertia to action: how to drive behavioural change in the care of patients with chronic wounds

The burden of care for patients with chronic wounds is a growing global concern with substantial clinical, economic and social impacts (Frykberg and Banks, 2015). These wounds disproportionately affect older people and individuals with comorbidities such as diabetes and vascular diseases, and pose a serious burden to healthcare systems, especially in ageing populations (Sen, 2019). This article examines the mechanisms behind behavioural change in wound care, exploring how clinicians, patients and organisations can move from knowledge to action by understanding what motivates or hinders change.

The Applied Wound Management Chronic Wounds Global Advisory Council convened in November 2024 to discuss the pressing issues in the care of patients with chronic wounds and propose actionable solutions (published in Wounds International, March 2025; see Probst et al, 2025). The AWM Advisory panel highlighted several challenges:

1. Lack of a robust evidence base due to inconsistent reporting of wound care data
2. Delays to diagnosis and provision of appropriate care, compounded by variability in data reporting
3. Lack of standardisation across wound care protocols, practices and practical tools, and
4. Lack of high-quality education and training for wound care professionals

The pervasiveness of clinical inertia—resistance to adopting new practices even when evidence supports change—was identified as a major impediment in the face of these challenges (Harding and Queen, 2019). While evidence-based guidelines provide a rational path forward for the clinician, behavioural choice, driven by both internal motivations and external pressures, ultimately determines whether change actually happens.

With this in mind, this article shifts the focus to the mechanisms behind behavioural change in wound care, exploring how clinicians, patients and organisations can move from knowledge to action by understanding what motivates or hinders change.

Barriers to change: Going beyond knowledge in wound care practice

Despite advances in clinical knowledge, outdated wound care practices are widespread—for example, wet-to-dry dressings continue to be used, even though evidence supports more effective alternatives (Fleck, 2009). This disconnect between knowledge and implementation may be attributed to several barriers, identified by the Advisory panel:

1. **Comfort with familiar practices:** Established routines provide a sense of reliability and safety, both for clinicians and patients. As a result, newer methods may be met with scepticism or hesitation, particularly if perceived as complex, even when evidence-based. Broader organisational or societal norms may also reinforce the use of outdated practices.
2. **Fragmented systems and inconsistent protocols:** Variation in protocols, terminology and training across different settings leads to fragmentation of care. This makes it difficult to implement unified standards and best practices, particularly when patients transition between services or providers.
3. **Lack of standardised metrics:** Inconsistent documentation and a lack of clear wound healing metrics make it hard to see whether treatments are working. Without reliable outcome data, identifying what constitutes progress — or poor care — also becomes challenging.
4. **Limited clinical confidence:** Generalist clinicians and nurses may lack the confidence to apply advanced wound care protocols, make diagnoses or interpret wound status, preferring to defer to specialists. This creates bottlenecks and may delay timely interventions.
5. **Education gaps and access challenges:** Training is often insufficient, overly theoretical or difficult to access. Combined with time pressures and competing clinical demands, this makes it challenging for clinicians to update knowledge or gain practical skills.
6. **Workforce turnover and knowledge loss:** High staff turnover results in a continuous need for retraining and reorientation. Knowledge gaps caused by these transitions undermine consistency and contribute to a cycle of

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recurring behavioural inertia.
Recognising and addressing these barriers will be essential to fostering a system where optimal wound care becomes the standard. Yet, these barriers are not just operational — they are shaped by how people think, feel and behave in clinical settings. To address them meaningfully, it is important to understand the psychological forces that underpin them.

The psychology behind behavioural barriers: what drives clinical inertia?

Clinical decisions are rarely the result of rational thought alone. "Rationality" in medicine refers to making decisions that best support patient health by thoughtfully weighing the potential benefits and harms of different actions. However, medical decisions are often not fully rational — poor outcomes persist, driven by decision-making that violates key principles of rationality (Djulbegovic et al, 2017).

Instead, they are shaped by a continuous interplay of internal and external triggers. Internal triggers include cognitive factors like cognitive dissonance (Klein, 2019), fear of clinical error, a leading factor influencing patient safety (Boyer et al, 2024), thinking patterns, core beliefs and cognitive overload; and emotional states, such as burnout and stress resulting from moral injury (violations of the clinicians' moral code outside of their control) (Mewborn et al, 2023), and feelings of being overwhelmed, frustrated, uncertain and lacking in confidence to name a few. In addition, the physical symptoms associated with these emotional states, plus exhaustion, pain or physical illness, can also have an impact.

These internal triggers do not directly determine clinical outcomes but instead can shape the context in which decisions are made, thus influencing clinicians' day-to-day decision making and their ability to initiate, sustain or adapt wound care practices, and the same can be true for external triggers. Clinician's personal circumstances — such as financial pressures and family dynamics — can create pressures that have an undesirable impact on continuity of care, availability of wound care services and workloads (Gray et al, 2019).

Workplace and organisational pressures including inadequate education and knowledge and limited resources also impact holistic care, with practice often based on experience, personal preference and colleague opinions, rather than on research evidence (Welsh, 2017). Other factors such as caseloads, expectations, time pressures and understaffing also add to the context in which clinicians are operating. Team dynamics, such as unresolved conflict, a low degree of support, or more destructive behaviours like bullying can also lead to negative consequences for patient care (Kim et al, 2017).

Internal triggers include ...

... emotional responses like fear of making mistakes, frustration when wounds fail to improve, or a sense of helplessness due to lack of understanding. These feelings may drive clinicians toward familiar routines, even if they are not evidence-based. Deep-seated beliefs—for example, that frequent dressing changes equate to better care—can override newer guidance, especially when habits, formed under intense pressure, have become automatic. When combined with fatigue or stress, they often take priority over thoughtful reflection

External influences include ...

... time pressures, resource constraints, or lack of specialist support, which all influence decision-making. In busy settings, clinicians may choose the fastest or most familiar option, rather than the most effective one. Social norms and local culture play a role too: if best practices are not modelled by peers, individual uptake is less likely. Feedback, either positive or negative, can also drive behavioural shifts; while environmental cues—like signage or equipment layout—can also subtly influence what actions are taken or avoided

In wound care, this dynamic might explain why evidence-based practices are not always implemented, even when clinicians are aware of them. A single clinical moment — such as assessing wound progress — could play out in very different ways depending on how these triggers interact and the clinician's thoughts, feelings and behaviours in response to such triggers.

Yet, despite the complexity and influence of internal and external triggers, clinicians retain the capacity to act intentionally; it is ultimately the clinician's choice, how they choose to think and act in response to situations and these ongoing triggers, informed by internal readiness and supported by the right kinds of external conditions, that drives meaningful and sustained clinical action. Yet we must not underestimate how difficult it can be to exercise that choice when faced with interacting internal and external triggers, especially those that directly relate to the workplace and their role. Thus, to make these choices and to address clinical inertia, clinicians must have access to high-quality research, improved pathways for collaboration, increased training, and access to standardised wound assessment protocols to support their decision-making (Vains and Finlayson, 2021), alongside systems that support the clinician as a whole and build their confidence.

Fostering a lifelong love of learning might help to build such clinical confidence, strengthen adaptability and reduce fear often associated with change. When learning is valued and curiosity nurtured, clinicians are likely to be better equipped to implement new knowledge effectively and cope with change (Holloway, 2024).

Strategies to drive behavioural change

It is clear that sustainable change in care for patients with chronic wounds requires more than disseminating best practices; it demands strategies that address both the psychological

triggers and external pressures that shape clinician decision-making. The following strategies are recommended to create the conditions for change, aligning with how decisions are made in real-world settings and addressing both the psychological and structural factors that influence clinician and patient behaviour.

Reframe the objective
Replacing terminology that reinforces passive or maintenance-based care — such as "managing" wounds — towards words that emphasise "healing" will help realign the focus across teams. This shift supports a more proactive and healing-oriented approach to care delivery.

Suggested actions:
- Replace "management of chronic wounds" with "healing chronic wounds" in clinical materials and communications
- Highlight positive and/or healing-focused language in training and patient discussions

Empower informed decision-making
Clinicians and patients alike will benefit from recognising their agency in care choices. Behavioural change begins with education that builds confidence, encourages accountability and reinforces the value of evidence-based actions. When individuals understand the "why" behind clinical recommendations, they are more likely to take ownership and act accordingly.

Suggested actions:
- Use decision aids that clarify roles and responsibilities in care pathways
- Offer communication tools that help patients understand and contribute to treatment plans

Simplify to encourage adherence
Overly complex protocols and guidelines can create confusion and discourage action, particularly under pressure. Breaking processes down into clear, manageable steps makes behaviours easier to adopt and maintain, especially for less experienced staff. Consistent and concise messaging across platforms further reduces cognitive load and improves retention of key practices.
- Redesign protocols and guidelines into easy-reference flowcharts or checklists
- Develop quick-reference resources about complex interventions tailored to specific roles (e.g. novice nurses, home carers)

Incentivise positive behaviours
Reinforcing desirable behaviours like following protocols and adopting best practices — through recognition, feedback or reward — helps embed them in routine practice. Even small incentives can build momentum, especially when individuals and teams feel their efforts are seen and valued.

Suggested actions:
- Share local success stories or healing rate improvements to motivate teams
- Introduce peer recognition programmes that celebrate adherence to best practices

Standardise protocols and language
Disparities in terminology and practice lead to inconsistency and confusion. Implementing a shared framework for wound progression and codifying treatment pathways will promote alignment across care settings, enabling clearer communication, consistent decision-making and measurable outcomes.

Suggested actions
- Standardise 'red flag' definitions (e.g. lack of 30-40% wound reduction in three weeks) to trigger timely escalation
- Implement structured workflows for key stages of care (e.g. assessment, dressing selection)
- Monitor adherence to red flags, and evaluation and escalation protocols
- Use data dashboards to drive local accountability

Make education practical and accessible
Continuous learning must be integrated into everyday clinical routines, especially in settings affected by high staff turnover. Educational programmes should prioritise essential, actionable knowledge rather than exhaustive theory, focusing on real-world application and decision-making. Technology can enhance learning by delivering bite-sized training modules, decision-support tools or point-of-care apps that reinforce correct behaviour without overwhelming staff.

Suggested actions:
- Develop short, role specific or proficiency focused e-learning modules or microlearning tools
- Introduce onboarding pathways for new staff with embedded wound care standards
- Use tech-enabled learning to support on-the-job upskilling

Provide real-time support at the point of care
Not all clinicians have immediate access to wound care specialists. Virtual or AI-driven tools can offer real-time guidance, boosting confidence and enabling faster, more consistent care decisions. Embedding support into workflows could also reduce delays and improve confidence across care teams.

Suggested actions:
- Develop virtual consultations or "ask an expert"

Case study: An illustrative example of how targeted behavioural change could improve chronic wound care outcomes.

A regional healthcare provider, responsible for wound care across multiple urban and rural clinics, identified significant variation in treatment approaches and outcomes. Despite access to clinical guidelines, chronic wounds were a significant concern across the region. Staff cited low clinical confidence, inconsistent protocols and high turnover as key barriers.
To address this, the provider implemented a behaviourally informed initiative aimed at promoting consistency and improving healing rates.

Actions included:
- Reframing language to focus on "healing" rather than "management," shifting the underlying mindset
- Introducing simplified decision-support tools, such as flowcharts and clear red flag criteria
- Providing real-time support through virtual specialist consultations to assist generalist staff
- Tracking outcomes and giving teams regular feedback, coupled with informal recognition for success.

After six months, improvements were observed in documentation quality, engagement with evidence-based practices and overall healing outcomes. Staff confidence, particularly among generalist clinicians, also increased.

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services for generalist clinicians
- Enable easy escalation or referral pathways directly from frontline apps or platforms
- Integrate AI-based triage or diagnostic tools into electronic health systems

Conclusion

The challenges in the care of patients with chronic wounds cannot be addressed through knowledge alone. While protocols and best practices are essential, they will only translate into consistent action when effective behavioural change strategies are embedded into the systems, environments and cultures where care is delivered.

Understanding the internal and external triggers that influence decision-making — such as habits, beliefs, peer dynamics and system pressures — offers a powerful framework for driving change. Meaningful improvements come when structures are simplified, incentives are aligned, education is targeted and individuals are empowered to make informed, confident choices.

Indeed, when behavioural change strategies are effectively applied, the potential impact could be transformative:
- More consistent wound care delivery across teams and settings
- Fewer unnecessary or outdated interventions, reducing treatment burden
- Greater clinician confidence and engagement, particularly among generalists
- Improved patient experiences and healing outcomes
- The emergence of a culture of continuous improvement, where adapting and evolving become embedded in the system.

These outcomes represent more than operational wins — they reflect a shift in mindset, where healing becomes the shared priority and each action is supported by both evidence and behaviourally informed design.

Overcoming clinical inertia in wound care requires thinking beyond "what should be done" to also focus on how change happens. It calls for integrating behavioural insights into every layer of the system — ultimately, making behavioural thinking central to innovation and implementation efforts in the wound care space.

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Bridging the knowledge gap: empowering generalists to make better decisions for patients with chronic wounds

Improving care for patients with chronic wounds requires more than clinical knowledge or updated guidelines: it calls for practical, system-wide changes that empower clinicians to act decisively at the point of care. While recent efforts have highlighted the need to overcome clinical inertia (Atkin and Probst, 2025a) and apply behavioural insights to support change (Atkin and Probst, 2025b), a persistent barrier remains: the disconnect between wound care knowledge and application, particularly for generalist healthcare providers. Bridging this gap means supporting generalists with practical, behaviourally informed strategies that foster confident decision-making without requiring specialist expertise (Atkin and Probst, 2025b). With the right tools and knowledge, and clear referral pathways, generalists could help to reduce delays, improve healing and support more consistent outcomes.

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Care for patients with chronic wounds is frequently delivered by generalists — such as community nurses, general practitioners (GPs), aged care staff and allied health professionals — who manage diverse caseloads across primary care, aged care, and community health settings (Ahmajärvi et al, 2024; Monaro, 2021). Despite their central role, these providers may face significant barriers to delivering effective wound care. The Applied Wound Management Chronic Wounds Global Advisory Council convened in November 2024 to discuss the pressing issues in the care of patients with chronic wounds and propose actionable solutions (published in Wounds International, 2025; see Probst et al, 2025a and 2025b).

Formal education is typically limited, even for basic wound care and management (Gould and Herman, 2025). Nurses lack adequate training in wound care clinical skills, with research suggesting a need for more specialised training in undergraduate and postgraduate nursing practice (Fernández-Araque et al, 2024). GPs may also be constrained by inadequate training, fragmented care pathways, and poor coordination with other services (Ahmajärvi et al, 2024). In recent years, some general practices in the UK have withdrawn or limited their provision of wound care services due financial pressures and increased demand on nursing.

This is set against the backdrop of a growing global wound care burden. In the UK alone, chronic wounds affect an estimated 1.5–2 million people, with annual treatment costs exceeding £5 billion (Guest et al, 2020). Globally, prevalence is rising due to ageing populations and increasing rates of diabetes and vascular disease (Frykberg and Banks, 2015; Sen, 2019). A recent Finnish cohort study identified that diagnostic delays beyond 42 days significantly prolonged healing trajectories and were associated with higher healthcare resource use (Ahmajärvi et al, 2025).

Why knowledge alone is not enough

The authors of recent behavioural trials in Australia suggest that embedding micro-interventions such as "point-of-care nudges" in EMR systems can meaningfully reduce clinical inertia in wound management decisions. These interventions produced a 27% improvement in timely escalation over 6 months (Varela et al, 2025). Indeed, fear of making clinical errors, one of the primary influences on patient safety, can make clinicians more likely to stick with familiar practices, even when those practices are outdated or suboptimal. This fear is associated with guilt, shame, anxiety and depression amongst healthcare providers, extending beyond patient harm to include concerns about reputation and job security (Boyer et al, 2024).

In fact, research directly demonstrates that knowledge does not consistently translate into behaviour change. For example, a study of family medicine clinicians found varying degrees of this knowledge-behaviour gap even after educational interventions. This same study identified that only two conditions reliably promote clinical action based on knowledge: "level of certainty and sense of urgency" (Kennedy et al, 2004). Without these conditions, even well-informed clinicians may default

to established routines, regardless of their knowledge base.

It is clear the knowledge-practice gap is not simply an educational problem, but a complex interplay of psychological, emotional and systemic factors that must be addressed through behavioural and organisational interventions, not just information dissemination. To support generalists to deliver better wound care, practical, behaviourally informed tools and support are needed to make evidence-based action the default choice, not the exception.

Bridging the gap: Best practice statement for empowering generalists

Improving generalist performance in wound care does not require transformation into specialists. Instead, it requires creating conditions in which they can take timely, confident and appropriate action using simplified tools and clear pathways. Improving generalist performance will also build expertise, a positive consequence that will impact the future of expertise in the field. The following best practice principles can help close the knowledge-practice gap:

1. Focus on essential knowledge, not exhaustive education

Deep, specialist-level knowledge is not the goal; actionable awareness is. Generalists need to be able to reliably recognise key wound types, identify red flags and know the first steps to take.

Essential knowledge for generalists includes:

- **Recognition of wound types:** such as diabetic foot ulcers, venous leg ulcers, and pressure injuries.
- **Understanding of red flag indicators:** including wounds that fail to improve by 30–40% within four weeks (venous leg ulcers or pressure ulcers), increasing exudate, odour, or signs of infection (Wounds UK, 2022).
- **Basic first-line interventions:** including appropriate dressing categories and indications for compression therapy or offloading.

2. Simplify decision-making with embedded tools

To be effective, clinical tools must be accessible, easy to use and embedded into everyday workflows. Rather than relying on memory or individual initiative, the system itself should prompt best practice.

Useful tools might include:

- **Wound assessment flowcharts:** visual aids that support initial wound classification and treatment planning.
- **Dressing selection guides:** providing stepwise recommendations based on wound characteristics.
- **Digital decision trees or apps:** integrated into electronic medical records or mobile platforms, offering real-time support at the point of care.
- **Goal-setting:** can also provide an oppurtunity to improve shared decision-making and patient involvement.

3. Enable confident escalation and referral

Timely escalation is one of the most critical elements of effective wound care, yet generalists may hesitate to escalate due to fear of overreacting, uncertainty about criteria, lack of access to specialist teams or cost to the individual and/or the service. Establishing clear escalation frameworks with defined clinical criteria and communication pathways and appropriate allocation of resources and funding can support confident, appropriate decision-making and improve patient outcomes.

A clear escalation framework should include:

- **Defined clinical criteria:** such as stagnant healing, suspected infection, or signs of arterial compromise.
- **Structured referral pathways:** including digital referral forms, predefined triage timelines, and clear contact points.
- **Cultural reinforcement:** messaging that escalation reflects good practice, not clinician failure.

4. Engage specialists within seven days of entry to care

Early intervention is associated with faster healing, fewer amputations, and lower overall treatment costs (Sen, 2019; Frykberg and Banks, 2015). Setting a clear, system-wide benchmark—such as a seven-day target for specialist input—helps align teams and resources around early escalation.

The goal is to:

- Minimise diagnostic delays, which currently average 57 days, and associated complications or deterioration of wounds, which may require hospitalisation or advanced interventions (Guest et al, 2020).
- Support generalist teams with timely feedback and specialist input.

From best practice to clinical practice

Closing the gap between best practice guidance and real-world clinical practice requires more than distributing knowledge:

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- Structured onboarding is a critical starting point. As staff rotate across services or enter new roles, they should be introduced early to the key elements of effective wound care, to ensure consistency from the outset: red flag criteria, escalation triggers and simplified decision aids.
- Digital solutions are another opportunity to support frontline decision-making. Prompts built into electronic medical records—such as reassessment alerts or escalation reminders when healing lags—could guide timely action without adding to cognitive load.
- At the team level, monitoring local data on escalation rates, response times, or healing outcomes provides valuable feedback for staff members. Dashboards that allow visualisation of this information can give real time feedback to teams and team members, highlighting areas of strength, signalling where further support is needed and keeping teams aligned on priorities.
- Finally, creating a culture that recognises good practice—whether through informal peer shout-outs or more structured feedback loops—can help to shift behaviour. Sharing short, local examples of positive outcomes following timely escalation or early intervention can help to build confidence and reinforce the message that proactive care leads to better results.

These changes are not about increasing workload. They are about designing environments that support the right actions, every time, by every clinician, so that evidence-based care becomes not only possible, but routine.

Conclusion

Confidence, not complexity, should define care. for patients with chronic wounds. Empowering generalists to deliver better care requires a shift in focus: from disseminating more information to designing tools and systems that support confident, evidence-based action.

Generalist providers do not need specialist-level expertise; they need clear guidance, timely feedback and accessible tools that simplify complex wound care decisions. Organisational levers, such as structured escalation policies, unit-level audit-feedback cycles and peer comparison dashboards, have proven effective in accelerating adoption of best-practice wound care models.

By embedding decision-support resources, defining escalation pathways and enabling early specialist input, healthcare systems could reduce delays, improve healing outcomes and mitigate the rising burden of chronic wounds.

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