

# From inertia to action: how to drive behavioural change in chronic wound care

Chronic wounds are a growing global concern with substantial clinical, economic and social impacts (Frykberg and Banks, 2015). These wounds disproportionately affect 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 facing chronic wound care and propose actionable solutions (published in *Wounds International*, March 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Despite advances in clinical knowledge, outdated wound care practices are widespread—for example, wet-to-dry dressings continue to be used, even though evidence supports more effective alternatives (Fleck,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 recurring behavioural inertia.

## Dr Leanne Atkin

PhD MHS (ANP) RGN  
Research Fellow/Vascular  
Nurse Consultant, School  
of Human and Health  
Sciences, University of  
Huddersfield and Mid  
Yorkshire NHS Teaching  
Trust, UK

## Prof Sebastian Probst

DClinPrac, MNS, RN,  
Professor of Tissue  
Viability and Wound  
Care; HES-SO University  
of Applied Sciences and  
Arts Western Switzerland,  
Geneva, Switzerland;  
Care Directories, Geneva  
University Hospitals,  
Geneva, Switzerland;  
Faculty of Medicine,  
University of Geneva,  
Geneva, Switzerland;  
College of Medicine  
Nursing and Health  
Sciences, University of  
Galway, Galway, Ireland;  
Faculty of Medicine  
Nursing and Health  
Sciences, Monash  
University, Clayton  
Campus, Clayton, Victoria,  
Australia

## Maria Collins-Donnelly

HCPC Registered  
Counselling Psychologist,  
Collins-Donnelly  
Consultancy, UK

## Key words

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

## Declaration

This meeting report has been supported by an unrestricted educational grant from Smith & Nephew

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 chronic wound care 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 “chronic wound management” with “chronic wound healing” in clinical materials and communications
- Highlight 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., junior 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 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 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” services for generalist clinicians

### 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.

- 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 facing chronic wound care 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. ●

### References

- Boyer L, Wu AW, Fernandes S et al (2024) Exploring the fear of clinical errors: associations with socio-demographic, professional, burnout, and mental health factors in healthcare workers – a nationwide cross-sectional study. *Front. Public Health* 12: 1423905
- Djulfbegovic B, Elgayam S, Dale W (2017) Rational decision-making in medicine: Implications for overuse and underuse. *J Eval Clin Pract* 24(3):655–665
- Fleck CA (2009) Why “Wet to Dry”? *J Am Col Certif Wound Spec* 1(4): 109–13
- Frykberg RG, Banks J (2015) Challenges in the treatment of chronic wounds. *Adv Wound Care* 4(9): 560–82
- Gray TA, Wilson P, Dumville JC et al (2019) What factors influence community wound care in the UK? A focus group study using the Theoretical Domains Framework. *BMJ Open* 9: e024859
- Harding K, Queen D (2019) Innovation and inertia in wounds. *Int Wound J* 16(5): 1079
- Holloway S (2024) The journey of lifelong learning in wound care—a road best taken. *Wounds UK* 20(2): 6–7
- Kim S, Bochatay N, Relyea-Chew A et al (2017) Individual, interpersonal, and organisational factors of healthcare conflict: A scoping review. *J Interprof Care* 31(3): 282–90
- Klein J, McColl G (2019) Cognitive dissonance: how self-protective distortions can undermine clinical judgement. *Med Educ* 53(12): 1178–86
- Mewborn EK, Fingerhood ML, Johanson L, Hughes V (2023) Examining moral injury in clinical practice: A narrative literature review. *Nurs Ethics* 30(7–8): 960–74
- Sen C (2019) Human wounds and its burden: an updated compendium of estimates. *Adv Wound Care (New Rochelle)* 8(2): 39–48
- Vains AS, Finlayson K (2022) How generalist nurses inform their clinical decision-making in wound management: a scoping review. *Wound Practice and Research* 30(2): 112–8
- Welsh L (2018) Wound care evidence, knowledge and education amongst nurses: a semi-systematic literature review. *Int Wound J* 15(1): 53–61



Scan the QR code above to access the recently published Best Practice Statement ‘Implementation of a validated non-healing wounds pathway in practice: learning from UK healthcare settings’ (Wounds UK, 2025)