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.

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 In recent years, some general practices in the UK have withdrawn or limited their provision of wound care services due financial pressures and increased demand on nursing.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

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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:

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

- 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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