From evidence to practice: Strategies for streamlining wound care implementation across settings

Rising healthcare costs, aging populations, and the increasing complexity of comorbid conditions mean chronic wound care continues to be a significant clinical, social and economic challenge worldwide (Sen, 2019). In the UK alone, chronic wounds affect more than 2 million people, with annual treatment costs exceeding £5 billion (Guest et al, 2020).

This series of articles began by identifying *clinical inertia* as a fundamental obstacle to evidence-based practice (Atkin and Probst, 2025a), then explored *behavioural change strategies* that address the psychological and structural factors influencing clinical decision-making (Atkin and Probst, 2025b), before showing how *empowering generalist clinicians* could enable confident, timely action without requiring specialist-level expertise. Recent literature continues to emphasise that knowledge alone is insufficient to change practice unless supported by structured systems, standardised pathways and organisational reinforcement (Atkin and Probst, 2025b).

However, even with empowered individuals and team-level behavioural strategies in place, variability persists in care of patients with chronic wounds due to inconsistent use of evidenced-based medicine and guideline implementation across healthcare settings, with many clinicians using outdated practices (often due to the difficulty in obtaining the appropriate instruments/materials, mainly in primary care) despite evidence supporting more effective approaches (Fleck, 2009).

Real-world evidence from >17,000 patients found that only 51% of wounds are improving at any given time, while antimicrobials are both overused and underused (withheld in 40% of infected wounds, used in 35% of non-infected wounds), primarily due to the inadequate application of basic clinical knowledge of infection. In addition, whether a wound is improving or not does not always influence treatment selection (Milne et al, 2025). These findings are consistent with recent international reviews reporting persistent unwarranted variation in chronic wound management across care settings (Guest et al, 2020)

As such, this article addresses a fundamental challenge, articulated by Advanced Wound Management (AWM) Chronic Wounds Global Advisory Board at their meeting in November 2024: the gap between knowing what to do in wound care (the existence of evidence-based guidelines) and knowing how to implement these guidelines widely and consistently across diverse settings.

The vision is clear: care in patients with chronic wounds that is consistently evidence-based regardless of geographic location, care setting, or individual clinician expertise; patients receiving the best possible care whether they present in an urban specialist centre or a rural community clinic.

Achieving this vision requires moving beyond individual and team-level interventions, to address system-wide coordination and implementation. While previous articles have explored how to identify barriers and empower individual clinicians, this article examines why isolated instances of exemplary practice may fail to translate to widespread transformation, and what infrastructure is needed to ensure evidence-based practice becomes the default across organisational and geographic boundaries.

Why individual excellence does not guarantee system-wide success

The AWM advisory Board highlighted several structural barriers that might prevent local pockets of excellence from scaling, contributing to the inconsistent implementation of effective care in patients with chronic wounds.

Firstly, the involvement of multiple stakeholders with differing priorities and perspectives, including clinicians, patients, caregivers and product suppliers, creates complexity that isolated individual organisations are often unable to resolve. Variability across sites of healthcare service, coupled with the siloed operation of sectors such as hospital and community care, can also

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lead to fragmented care pathways.

Even when individual teams achieve best practice, for example, by quickly securing specialist input for a patient (i.e. within seven days of presentation), patients moving between organisations may encounter divergent standards, protocols and resource availability. Recent evidence highlights that fragmentation between acute, community and home-based services remains a major barrier to continuity of wound care and timely escalation (Wounds UK, 2022).

Furthermore, definitional inconsistency, such as variation in the interpretation of a chronic wound across countries, organisations and even within individual teams, illustrates how local progress may be undermined at a systemic level (Milne et al, 2025).

International consensus documents have highlighted the need for shared terminology and standardised assessment frameworks to support coordinated care and data comparability (Schultz et al, 2003). These structural barriers explain why even organisations achieving excellent outcomes might remain isolated successes rather than catalysts for system transformation; the complexity cannot be solved by individual organisations acting alone. System-level governance and cross-organisational accountability mechanisms are therefore required to sustain and scale improvement (Marshall and Øvretveit, 2011).

A case study: The framework implementation challenge

The case of the TIME framework illustrates how the very challenges identified above might prevent even well-established, evidence-based approaches from achieving consistent implementation.

The original TIME framework (recently updated to TIMERS, i.e., Tissue, Infection/Inflammation, Moisture balance, Edge, Repair/Regeneration, Social) was developed more than 20 years ago as a structured guide for wound bed preparation and management of chronic wounds. While the core TIME principles remain unchanged, their application has since expanded given developments in wound care knowledge (Leaper et al, 2012).

Yet, while it is widely referenced and taught in educational settings, the advisory board found the TIME framework to be "underutilised in daily clinical workflows" and "often used for educational purposes rather than direct clinical decision-making." This gap between conceptual knowledge and practical application mirrors findings in recent implementation research across chronic disease management (Greenhalgh et al, 2017).

The advisory board stated that practical application of TIME is affected by a range of issues, including:

- inconsistency in training and clinical practice
- language barriers
- limited applicability to certain patient populations or wound types
- lack of recognition of the patient with the wound and potential factors that may impair healing (such as malnutrition or poor diabetic control), and
- the complexity of integration in the clinical workflow.

Clinical guidelines are inevitably a work in progress due to the constantly evolving nature of the understanding of wound pathology, healing processes and evidence-based therapies. To ensure future-proofing of the TIME framework, there is a need for widespread awareness and training, evaluation of its use across settings and measurement of its impact on patients, clinicians and healthcare economics. In doing so, it may be positioned as a sustainable approach to improve healing outcomes and reduce the burden of wounds on both patients and health systems (Leaper et al, 2012).

The advisory board also recognised these limitations, suggesting the TIME framework could benefit from incorporating scientific evidence about wound healing mechanisms, criteria for assessing stalled wounds, patient-level factors that affect healing capacity, (e.g. diabetic control or malnutrition and treatment adherence) and clearer guidance for addressing non-healing phenotypes.

Best Practice Statement: Streamlining wound care through systematic implementation is crucial to improving patient outcomes

The TIME framework example illustrates that even evidence-based approaches require practical support to be effective across different real-world settings. Barriers such as inconsistent training, language differences, and limited relevance for certain populations or wound types may prevent successful use. The following practical best practice recommendations are proposed to help overcome these challenges.

1. Standardise implementation infrastructure across organisations

System-wide success will require a coordinated infrastructure that addresses both processes and technology platforms simultaneously.

Previous aticles in this series

Scan the QR codes below to access the previous articles in this series

Article 1: 'Clinical inertia in chronic wound care'

Article 2: 'From inertia to action: how to drive behavioural change in chronic wound care'

Article 3: 'Bridging the knowledge gap: Empowering generalists to make better chronic wound care decisions'

Essential implementation infrastructure includes:

- **Standardised integration protocols:** Shared templates that specify identical documentation fields for wound assessment across all settings. For example, assessments that require the same tissue classification options, infection indicator checklists and moisture scales whether completed in hospital, the community, or aged care settings.
- **Unified digital platforms:** Coordinated technology that delivers identical clinical prompts across organisations. When a venous leg ulcer shows less than a 30% reduction at four weeks, the system would automatically flag the record, prompt escalation review and pre-populate referral templates. Such a system would function identically in urban specialist centres and rural community clinics. Emerging evidence suggests that digital wound assessment tools and decision-support systems can improve consistency of documentation, early identification of non-healing wounds, and appropriate escalation, particularly in community and rural settings (Bai et al, 2024).
- **Consistent training standards:** Standardised educator competency requirements and learner assessments. Trainers would be required to demonstrate the ability to teach chronic wound care concepts using identical clinical scenarios, while learners complete the same supervised patient encounters with uniform pass criteria, ensuring clinicians receive equivalent preparation regardless of their employing organisation.

2. Establish clear clinical pathways and escalation protocols

Clear referral pathways are essential given that current diagnostic delays are reported to be a median of 57 days (Guest et al, 2015; Guest et al, 2020). Systematic pathways require infrastructure that work across organisational boundaries, while supporting individual clinician confidence in escalation decisions.

Clear clinical pathway infrastructure includes:

- **Defined escalation criteria:** Standardised indicators embedded as automated alerts. Systems calculate percentage improvement from baseline and generate explicit escalation prompts when wounds fail to meet reduction targets at four weeks (typically 50% for diabetic foot wounds or 30-40% for typical-size venous leg ulcers), removing interpretation burden and making escalation decisions unavoidable (Schaper et al, 2023).
- **Structured communication processes:** Digital referral systems that automatically route to appropriate specialists based on wound type and location, confirm receipt within 24 hours, provide scheduled consultation dates within seven days, and transfer seamlessly when patients move between organisations.
- **Specialist access coordination:** Regional shared consultation networks where specialists from multiple organisations provide virtual clinics on rotating schedules, ensuring timely access beyond what any single organisation can provide independently.

3. Build coordinated governance and accountability systems

Since there are often multiple stakeholders involved in decision-making, effective scaling demands governance structures that align incentives, coordinate resources and maintain consistent measurement across participating organisations.

Governance and accountability infrastructure includes:

- **Regional clinical leadership councils:** Cross-organisational leadership groups establish shared standards, coordinate purchasing of advanced therapies and balance specialist resources across the region.
- **Shared accountability frameworks:** System-wide metrics replace individual organisational measures. Regions are assessed on percentage of wounds receiving timely specialist input, consistency of framework documentation completion (e.g. 95% target), and collective healing rates, with financial incentives tied to achieving regional rather than individual organisational targets.
- **Coordinated improvement systems:** Benchmarking dashboards that identify high-performing organisations, facilitate systematic investigation of successful practices, support adapted implementation in other contexts, and track impact of spread efforts across subsequent quarters.

Conclusion

The transformation of care for chronic wounds from fragmented, variable practice to consistent, evidence-based delivery represents both an urgent necessity and an achievable goal. Yet success requires recognising that standardisation does not mean rigidity. As the advisory panel noted, effective implementation

combines standardised processes with flexibility to accommodate patient complexity and local context, supported by ongoing evaluation and governance. The recommendations presented here provide structure while allowing for adaptation to local contexts and resources.

Importantly, this standardisation effort serves patients whose healing outcomes depend not on luck or geography, but on receiving consistent, evidence-based care from empowered healthcare teams working within integrated, supportive systems.

The standardised infrastructure described here, including unified protocols, coordinated pathways and shared governance, creates the platform necessary to address the remaining challenge identified by the advisory board: ensuring these evidence-based practices are not only consistently implemented but also sustainably resourced and equitably accessible. Indeed, they are fundamental requirements not only for diagnostic and therapeutic success, but also for achieving economic efficiency.

Building on the implementation foundation established here, the final article in this series will examine how to overcome resource constraints and reimbursement barriers. It will also discuss how to address inequalities that can undermine even well-coordinated systems.

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