

Patient-Centered Education in Wound Management: Improving Outcomes and Adherence

Lynelle F. Callender, DNP, RN, Vice Chair, Nursing Online, Advent Health University, Orlando, Florida

Arlene L. Johnson, DNP, RN, Coordinator, Nurse Practitioner Program, Advent Health University, Orlando, Florida

Rose M. Pignataro, PhD, DPT, PT, CWS, CHES, Associate Professor, Assistant Director, Physical Therapy Program, Emory & Henry College, Marion, Virginia



GENERAL PURPOSE: To educate wound care practitioners about methods of communication that can help promote patient adherence to wound healing recommendations.

TARGET AUDIENCE: This continuing education activity is intended for physicians, physician assistants, nurse practitioners, and nurses with an interest in skin and wound care.

LEARNING OBJECTIVES/OUTCOMES: After participating in this educational activity, the participant will:

1. Distinguish the use of theoretical frameworks to promote patient adherence to prescribed wound healing recommendations.
2. Synthesize the principles of motivational interviewing to best encourage patients to adhere to prescribed wound healing recommendations.
3. Select the appropriate self-care strategies for patients who have nonhealing wounds.

ABSTRACT

Patients with chronic wounds make daily decisions that affect healing and treatment outcomes. Patient-centered education for effective self-management decreases episodes of care and reduces health expenditures while promoting independence. Theoretical frameworks, including the Health Belief Model, Theory of Planned Behavior, Social Cognitive Theory, and Transtheoretical Model of Behavior Change, can assist healthcare providers in identifying strategies that enhance adherence. These strategies include the use of motivational interviewing, a communication technique designed to elicit patients' perspectives regarding treatment goals, outcome expectations, anticipated barriers, and intentions to follow provider recommendations.

KEYWORDS: barriers, chronic wounds, education, health behavior theory, patient outcomes, wound management, wound healing

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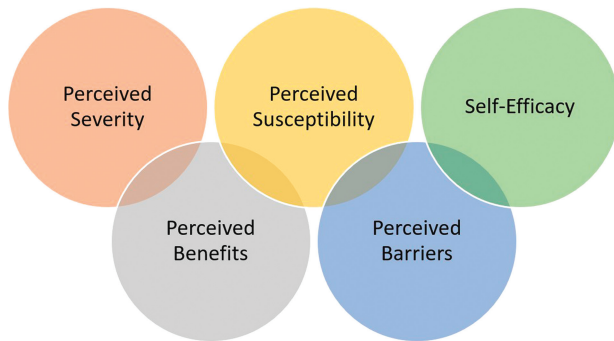
INTRODUCTION

Patients' daily decisions and activities have a significant impact on wound healing outcomes independent of the healthcare provider.¹ Therefore, patient-centered education for effective self-management is an essential component of the plan of care.² Instrumental self-management skills include wound cleansing, dressing changes, and recognizing signs and symptoms of infection.³ An understanding of theoretical frameworks and evidence-based approaches to patient-centered education can assist wound care practitioners in promoting patient adherence. The World Health Organization defines adherence as "the extent to which a person's behavior—taking medication, following a diet, and/or executing lifestyle changes—corresponds with agreed recommendations from the healthcare provider."⁴ It is important to note that adherence is not the same as compliance. The term "adherence" implies collaboration, in which patients actively choose to follow the provider's advice based on shared responsibility for health outcomes, as opposed to "compliance," which connotes submission to provider directives.⁵

Effective education and enhanced adherence decrease episodes of care, reduce health expenditures, and prevent serious complications.^{3,6} Impediments to adherence encompass provider characteristics as well as patient characteristics. Among providers, barriers include anticipated patient nonadherence, perceived lack of education effectiveness,

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Figure 1. HEALTH BELIEF MODEL



insufficient training in patient-centered education techniques,^{1,7} and time constraints within the clinical environment.¹ Many providers are also hesitant to discuss patients' personal behaviors for fear of provoking defensiveness or damaging rapport.^{2,7} Application of theoretical frameworks assists providers in selecting communication techniques that incorporate patients' perspectives to overcome barriers to quality wound care.

THEORETICAL FRAMEWORKS FOR PATIENT-CENTERED EDUCATION

Health Belief Model

The Health Belief Model (HBM) describes factors that influence patient adherence, such as perceptions of health risk severity, negative health outcomes, and the benefits of recommended health behaviors.² The HBM also incorporates self-efficacy, or patient belief in their ability to successfully enact provider recommendations and achieve intended goals. Providers can apply the HBM to discuss patients' personal risks and benefits of action. Using the HBM also helps providers understand patient barriers to enacting treatment recommendations, including patients' confidence in their ability to self-manage their condition (Figure 1).

Theory of Planned Behavior

According to the Theory of Planned Behavior (TPB), adherence is primarily determined by behavioral intentions. Factors that shape intentions include patients' attitudes toward provider recommendations, as well as outcome expectations, or the anticipated results of adherence.⁸ Like the HBM, the TPB also includes self-efficacy.² Low self-efficacy diminishes adherence even when patients strongly value the outcome.⁸ Providers can apply the TPB to investigate and address factors that influence self-efficacy and outcome expectations. These factors include personality, age, gender, education level, health literacy, socioeconomic status, and learning preferences⁸ (Figure 2).

Social Cognitive Theory

Like the HBM and TPB, Social Cognitive Theory (SCT) stresses the importance of self-efficacy. Wound care providers can apply SCT to build self-efficacy and match the benefits of treatment recommendations with the patient's personal goals.² Long-term adherence also requires that the patient have knowledge, skills, and the ability to self-assess and respond to changes in their condition.⁹ These changes may include signs of infection, delayed healing, and the need for further consultation.

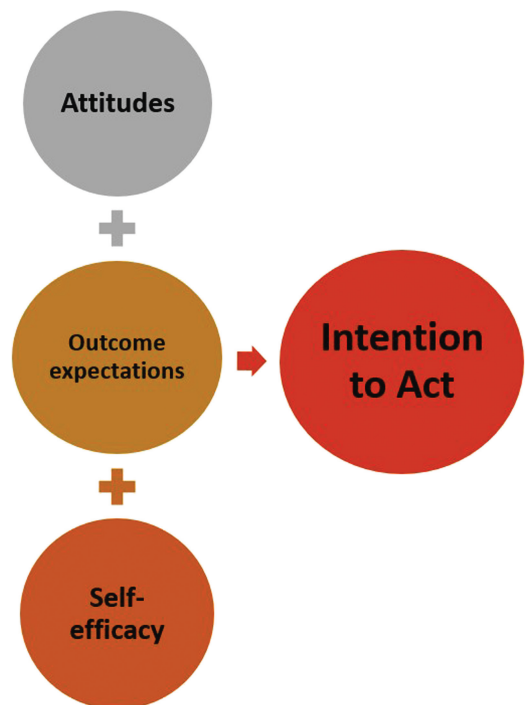
Transtheoretical Model of Behavior Change

The Transtheoretical Model (TTM)² describes patients' readiness to engage in health behaviors:

- (1) **Precontemplation** is when patients are not considering change. This may be attributable to a lack of awareness, low perceived importance, or low desire to engage in recommended health behaviors.
- (2) **Contemplation** occurs when patients begin thinking about adherence, or recommitment to adherence, if a lapse in behavior has occurred.
- (3) **Preparation** is when patients are taking steps toward initiating adherence within the next 2 weeks.
- (4) **Action** is when the person has initiated and is engaged in adherence.
- (5) **Maintenance** occurs when adherence is sustained for at least 6 months.

Patients do not always progress through the stages of change in a linear, predictable pattern. Some may lapse

Figure 2. THEORY OF PLANNED BEHAVIOR





into earlier stages when met with challenges. Even after maintenance, relapse can occur despite temporary success.² Providers can promote adherence by tailoring education interventions to match patients' readiness to change (Figure 3).

PATIENT-CENTERED COMMUNICATION TECHNIQUES

Motivational interviewing (MI) is a patient-centered communication technique designed to help patients recognize discrepancies between nonadherence and desired treatment outcomes.¹⁰ Providers can use this technique to encourage patients to prioritize outcomes based on their personal values. Further, MI enables providers and patients to collaboratively decide which recommendations work best given patients' lifestyle, preferences, and available resources.¹¹ During MI, providers ask open-ended questions to gain insight into patient intentions, abilities, and willingness to adhere to treatment recommendations.¹² Then, providers use these insights to create individualized goals and tailored wound management strategies.

Wound care providers can also promote adherence by tracking goals and acknowledging patients' accomplishments.² Setting small, incremental goals promotes gradual increases in patient self-efficacy.¹³ These goals should be SMART (specific, measurable, achievable, relevant, and timely); otherwise, lack of attainment can discourage adherence.² In addition, it is important for patients and providers to discuss potential challenges and collaboratively identify strategies to prevent behavioral lapses.² Scheduled follow-ups help affirm positive results and provide an opportunity to review any unexpected barriers to adherence.¹³ Discussing barriers helps patients maintain positive health behaviors, strengthen commitment, and identify new strategies when necessary.¹³

There are two basic phases in MI: (1) eliciting "change talk," that is, desire, reasons, and ability to change; and (2) promoting commitment to new behaviors.¹⁰ The mnemonic OARS (open-ended questions, affirmations, reflective listening, and summarization) describes communication techniques commonly used in MI. Open-ended questions inspire introspection regarding the pros and cons of provider recommendations and facilitate adherence. Affirmations foster confidence in patient ability to engage in effective self-care and achieve

positive outcomes. Reflective listening clarifies patients' intentions and meaning and allows providers to emphasize positive decisional balance, including the patients' expressed need for adherence, potential benefits, and ability to succeed. Summarization is a technique providers can use to wrap up the conversation or transition to a new topic by reviewing important points and confirming patients' understanding and agreement with the recommendations.¹⁴

Frameworks to assist providers in implementing MI include the "5 As" and "5 Rs."¹ During initial conversations with patients, providers can apply the "5 As:"¹

- (1) **Ask** patients about self-care.
- (2) **Advise** patients about the risks of nonadherence.
- (3) **Assess** patient readiness to follow recommendations.
- (4) **Assist** patients in creating goals and plans to implement recommendations.
- (5) **Arrange** for follow-up support.

If patients are not yet ready to engage in recommended health behaviors, providers can use the "5 Rs:"¹

- (1) Discuss the **relevance** of the recommendations within the context of patient goals.
- (2) Guide patients to consider **risks** of nonadherence.
- (3) Suggest possible **rewards** or positive outcomes.
- (4) Invite patients to share anticipated **roadblocks** or barriers to adherence.
- (5) **Repetition**: revisit topics during future conversations to negotiate a healthy course of action.

When using MI, providers should respect patient autonomy. Acknowledging patients' right to self-determination reduces the likelihood of resistance and defensiveness. By expressing empathy toward patient challenges and inviting opposing viewpoints, providers can promote patient ownership and control of their own health.¹⁰

Time constraints are one of the greatest barriers to applying MI within clinical settings.¹⁵ The pressures of a busy schedule can restrict provider ability to engage in detailed conversations with patients. Although traditional MI requires 30 to 60 minutes, brief MI can take as little as 5 to 10 minutes.¹⁰ Brief MI focuses on a single goal. Once the patient and provider select this goal, the provider can use MI techniques to guide the conversation toward specific steps designed to achieve the desired outcomes. Conversations should focus on the following

Figure 3. TRANSTHEORETICAL MODEL OF BEHAVIOR CHANGE

Precontemplation	Contemplation	Preparation	Action	Maintenance
<ul style="list-style-type: none"> • Patient is not considering a change in current behaviors 	<ul style="list-style-type: none"> • Patient is considering pros and cons of health behavior change 	<ul style="list-style-type: none"> • Patient is actively taking steps to initiate or recommit to a health behavior 	<ul style="list-style-type: none"> • Patient is engaged in recommended health behavior (0 to 6 months) 	<ul style="list-style-type: none"> • Adherence to health behavior has been sustained 6 months or longer

aspects: what actions patients should perform and what is an acceptable degree of adherence (eg, how often or how much adherence is required).

Communication throughout the course of treatment allows providers to continue to reinforce patients' motivations. For patients who are not ready to follow recommendations, further discussion of their concerns and perceived barriers may be necessary. Often, past failures and challenges can decrease patient confidence and ability to engage in appropriate self-care. Providers can help patients reframe failed attempts as opportunities to learn about ineffective approaches to adherence while identifying suitable alternatives.

Once an agreement has been reached, a written action plan promotes adherence. As part of the plan, providers should encourage patients to discuss feasibility and usefulness of the treatment recommendations.¹⁵ The plan should also include scheduled follow-ups in person, by phone, and/or electronic communication.¹⁶

Finally, providers must remember that nonadherence can be intentional or unintentional.¹⁷ Reasons for intentional nonadherence include pain and patients' perceptions regarding the feasibility and effectiveness of treatment recommendations, as well as insufficient explanations from clinicians regarding the rationale supporting recommendations.¹⁷

PATIENT EDUCATION

Effective patient education involves three essential components: self-care skills, how to recognize and respond to problems, and preventive management. Patients' understanding of the healing process may also greatly improve wound outcomes.¹⁸ For example, patients may not understand that wounds should heal from the base to the surface. It is also important that patients can distinguish "good" versus "bad" tissue. Pictures may help patients identify how "good" tissue should look as their wound begins to heal. Healthy granulation tissue has a red, glossy appearance. In contrast, necrotic tissue is tan, yellow, or black.¹⁸ Providers should also advise patients that drainage should decrease as healing progresses¹⁸ and "normal" drainage depends on the color, consistency, amount, and odor.

Other essential self-care skills include proper hand-washing, wound cleansing, and dressing changes. Providers should discuss appropriate cleansing solutions and caution patients to avoid irritating or cytotoxic substances. Using the wrong cleanser may delay healing.¹⁸ Further, many people believe that a dry wound prevents infection; providers should proactively educate patients and caregivers about moist wound healing. Providers should encourage patients to seek follow-up if the wound becomes too dry so that they can discuss the need for a different type of dressing.

Patients and caregivers also need education on how and when to replace dressings.¹⁸ During each dressing change,

wounds should be cleaned and assessed.¹⁸ Providers should review signs and symptoms of infection so that patients and caregivers can seek timely medical attention.¹⁸ Adverse changes include increased pain or tenderness, increased exudate, changes in the type of exudate (eg, pus versus serous drainage), swelling, heat, periwound discoloration, and foul odor.¹⁸ Patients and caregivers should also be aware of systemic symptoms of infection, such as fever, chills, nausea, and malaise.¹⁸ Pain may interfere with patient ability and willingness to clean wounds and change dressings.³ Therefore, providers may initiate patient and caregiver training in analgesic interventions, such as topical agents and/or nonadherent dressings.³

Ideally, providers should supplement verbal instruction with written material and demonstration.³ Consistent with theoretical frameworks for health behavior change, providers should tailor instruction to match patients' health literacy, language, culture, and specific concerns. Treatment outcomes are improved when providers emphasize the relevance of the information based on patient goals. Personalized education enhances adherence, patient satisfaction, and wound healing.³

Providers should also consider patient perceptions that pose potential challenges to adherence. Important factors include:¹⁸

- (1) What are patients' beliefs regarding the cause of the wound?
- (2) What are the effects of the wound on quality of life, ability to perform activities of daily living, and so on?
- (3) What is the perceived severity of the wound? How long do patients think it will take for their wound to heal?
- (4) How do patients think their wounds should be treated?
- (5) What are the most important treatment results patients hope to achieve?
- (6) What fears do patients have regarding wound treatment?

Nutrition

Education concerning specialized nutrition requirements is particularly important for patients with underlying comorbidities, such as diabetes, renal disease, anemia, or difficulty eating.¹⁹ Dietary advice and information concerning the use of supplements can enhance patients' sense of control over the wound healing process. Nutritional impediments to healing include inadequate protein and carbohydrate intake.¹⁹ Supplements, such as vitamins A, C, D, and E, and minerals, such as zinc, copper, selenium, and folic acid, may also be prescribed.¹⁹

Prevention and Treatment of Pressure Injuries

Patients with mobility and/or sensory impairments have an elevated risk of pressure injuries (PIs). Patient education on skin protection, turning and positioning, and notifying caregivers about tender and painful areas



increases autonomy by enabling patients to self-advocate and supervise appropriate treatment interventions, even when caregiver assistance is required to carry out provider recommendations.²⁰ Patients and caregivers should be aware of common PI locations (heels, sacrum, ischium, and greater tuberosity), as well as intrinsic and extrinsic factors that increase vulnerability and delayed healing, such as incontinence and localized skin trauma.^{21,22} Patients can decrease their vulnerability to tissue damage using specialized support surfaces and strategies for positioning and pressure redistribution.^{21,22} These strategies should include keeping the head of the bed at or below 30° whenever possible to decrease friction and shear.²¹ Depending on their physical abilities, patients may be taught how to use assistive devices, such as an overhead trapeze and/or grab bars, to perform repositioning.²³ Information regarding the characteristics of an ideal support surface also helps equip patients to ensure optimal prevention and treatment.²³

Providers should also educate patients on skin assessment and signs of impending damage. Even if patients are reliant on caregivers to examine their skin, the ability to recognize problems and seek appropriate treatment fosters independence.²³ In addition, patients and caregivers often require instruction regarding proper hygiene and skin care.²³ As with other types of chronic wounds, patients with PIs benefit from education regarding behavioral risks, such as tobacco use, nutrition, hydration, exercise, and medication adherence.²³

Peripheral Arterial Disease and Treatment of Arterial Ulcers

Patients with peripheral arterial disease often underestimate their risk of serious complications.²⁴ This may stem from lack of knowledge or denial about the impact of nonadherence.²⁴ Providers can address these issues by reviewing factors that mitigate risks, such as tobacco cessation, exercise, and proper diet.²⁵ Further, providers should encourage patients to engage in proper self-management of common comorbidities, such as hypertension and type 2 diabetes.²⁵ Adherence and self-care can be enhanced by teaching patients how to interpret their own test results (eg, total cholesterol and total triglycerides).²⁵

Depending on the severity of circulatory insufficiency, it may be best to keep arterial wounds dry pending revascularization. This is an exception to typical patient education regarding moist wound healing. Providers should explain that ischemic ulcers often involve thick, black, leathery eschar so that patients are not tempted to soak the wound.²⁵

Prevention and Treatment of Venous Leg Ulcers

One of the most damaging aspects of venous insufficiency is venous hypertension and lower extremity swelling. Therefore, patient education should be directed toward

strategies that promote venous return and reduce edema. These strategies often include the use of compression stockings, which patients should don immediately upon waking when limb volume is at its lowest. Applying stockings before placing the legs in a dependent position tends to be the most beneficial.¹⁸ As part of self-management, patients should avoid crossing their legs or keeping their legs in a dependent position for prolonged periods. Instead, patients should elevate their legs above the level of the heart at various intervals throughout the day.¹⁸

Because most lower extremity venous return results from muscle activity, exercises, such as walking and ankle pumps, are very helpful.¹⁸ Providers should tailor exercise recommendations to patients' individual fitness levels and any physical impairments. In addition, exercise may assist patients with weight management,¹⁸ because obesity also impedes venous return.

Patients with venous insufficiency often need advice about strategies to protect against inadvertent lower extremity trauma, dermatitis, and ulceration.²⁶ Effective prevention includes the use of appropriate footwear,¹⁸ skin cleansers, and topical agents.²⁶ Additional steps that patients can take to prevent or reduce venous insufficiency and risk of ulceration include tobacco cessation.²⁶

Prevention and Treatment of Diabetic/Neuropathic Foot Ulcers

In patients with peripheral neuropathy, the loss of protective sensation is a primary risk factor for wounds and delayed healing. Therefore, protective interventions are critical. Patients should be empowered to perform proper foot care, including choosing socks and shoes that prevent compression, friction, and shear.¹⁸ Throughout the day, patients should remove their shoes and socks to inspect the skin for any signs of redness or irritation.¹⁸ Timing for self-checks should be based on individual risks. When "breaking in" new shoes, self-checks should occur at least every 2 hours.¹⁸

Because most neuropathic ulcers occur on the plantar aspect of the foot, treatment for existing wounds often includes the use of offloading devices to redistribute pressure. Providers and patients should discuss barriers to adherence, including low perceived susceptibility and severity. This is exacerbated by sensory deficits that result in low or absent pain signals despite the presence of significant integumentary damage. Wearing shoes or slippers with closed backs and nonskid soles, even when ambulating short distances within the home, reduces the likelihood of inadvertent trauma. If an offloading device is used, it must be donned whenever the patient is weight-bearing, even if the patient is only going from the bed to the bathroom in the middle of the night.

Treatment outcomes for neuropathic ulcers are also heavily dependent on patients' adherence to nutrition recommendations, blood glucose monitoring, physical

activity, and weight management.²⁷ Patient education that includes explicit steps for diet and exercise is more likely to achieve success than generic recommendations.²⁷

Self-management is influenced by patients' cognitive understanding, motivation level, and ability to troubleshoot problems and barriers.²⁷ In patients with diabetes, low perceived severity of illness and its consequences may be influenced by family history and assumptions that diabetes is a natural part of genetics and/or aging.²⁷ These assumptions can reduce outcome expectations and self-efficacy by creating the impression that diabetes and its consequences are unavoidable.²⁷ Patients and providers should discuss these perceptions and promote skills that enhance self-care, including the ability to troubleshoot unanticipated problems and barriers.²⁷ Other barriers to adherence may include the lack of measurable results for patients who are adherent yet still experience disease progression.²⁷ These barriers can be mitigated by social-environmental support from family, friends, and community resources.²⁸

From a cognitive perspective, the ability to record and interpret glucose measurements, calculate medication doses, and read nutrition labels requires a certain level of literacy and mathematical skill.²⁷ Providers should also assist patients in understanding the difference between test results that show immediate glycemic control (plasma glucose level) versus long-range control (hemoglobin A_{1c}; Table 1).²⁷

CASE REPORT

Mrs H. (fictional patient) is a 60-year-old catering chef referred for outpatient wound management secondary to a nonhealing ulcer on the plantar aspect of her left foot. The wound has been present for more than 19 weeks and has increased in depth since onset. Clinical presentation

includes peripheral neuropathy with loss of protective sensation, poor glycemic management, and a history of tobacco use and sedentary lifestyle.

The patient is experiencing barriers to performing prior recommendations for wound cleansing, use of a hydrogel dressing, and left non-weight-bearing using a knee scooter. The following represents a dialogue between Mrs H. and her doctor of physical therapy (DPT)/certified wound management specialist. The conversation exemplifies the use of MI techniques and theoretical frameworks.

DPT: Mrs H., thank you for agreeing to meet with me to discuss your plan of care. I understand that you are concerned about the lack of healing in your foot. I agree that we need to talk about what we can change to make sure that your wound improves.

Mrs H.: I just don't see the point in coming here. This wound keeps getting bigger no matter what I do.

DPT: I am sure that must be very frustrating for you. I see that you are not using the knee scooter today. Are you having trouble with it?

Mrs H.: It makes my other leg very tired, and my back gets sore.

DPT: Thank you for telling me. We certainly don't want to cause any other problems for you. We can definitely talk about some other ideas besides the scooter. First, can you tell me about some of the things you have been doing at home in between visits?

Mrs H.: Well, my husband helps me take the bandage off so that I can soak my foot every night. I make sure I dry it really well, and then we put a new piece of gauze on it.

DPT: What type of shoes have you been wearing?

Mrs H.: I usually wear these plastic clogs because they are easy to slip on and off.

DPT: Because this wound is on the bottom of your foot, one of the things that could help it heal is to take some of the pressure off the area with a special walking boot. Is that something you might be interested in?

Mrs H.: Well, it would depend on how hard it is to get the boot on by myself. My husband leaves for work before I get dressed in the morning, and it's hard for me to bend.

DPT: Well, the type of boot I am thinking of slides on and closes with Velcro. Can we try one on to see what you think? [produces walking boot]

Mrs H.: Oh man, that thing looks bulky and heavy.

DPT: It is kind of bulky, but I think you have enough strength and balance to move around using the boot. It may not be as heavy as you think. [Hands Mrs H. the walking boot]

Mrs H.: [makes a face and shakes her head] I think I would rather stick with my clogs.

DPT: Would it be all right if I explained a little more about why I think the walking boot will be so helpful?

Table 1. ESSENTIAL SELF-MANAGEMENT KNOWLEDGE AND SKILLS

- Cause of the wound and contributing factors
- Anticipated healing time
- Moist wound healing principles (assuming there is adequate blood supply for healing)
- Characteristics of a healthy wound bed
- Wound cleansing techniques and timing
- How and when to change wound dressing
- Signs and symptoms that indicate need for urgent medical attention
- Guidelines and techniques for treating the wound cause (eg, turning, positioning, and pressure redistribution for pressure injuries)
- Activity modifications and rationales
- How to monitor and manage comorbidities
- Medication dosing and reason for each medication
- Nutrition recommendations, including proper hydration



If you still don't agree, I will respect your decision. I just want you to have all the necessary information to make good choices.

Mrs H.: [sighs] OK, I am listening.

DPT: Imagine you cut your finger here on the knuckle while you were working in the kitchen. Every time you bend your finger, it puts strain on that cut and stops it from healing. What's happening now with your foot is that every time you stand or walk, it puts the same type of strain on the wound and makes it harder for the body to repair it.

Mrs H.: That makes sense, but I can't sit around and put my feet up. I need to stand and walk to do my job, and we can't afford to have me out of work.

DPT: I understand that would be very difficult. Instead of having you stay out of work, this walking boot would help redistribute the pressure on the bottom of your foot while the wound is healing. You could use it to stand and move around the kitchen while you are filling your catering orders.

Mrs H.: OK, I am willing to try it.

DPT: Great! There are several different options for redistributing the pressure. This is the type of boot we use with most of our patients, but if it isn't comfortable, or you have trouble putting it on or taking it off by yourself, I want you to let us know so that we can work together to find something else that will work for you. How does that sound?

Mrs H.: That sounds reasonable.

The conversation continues after a brief session of gait training using the walking device/pressure redistribution boot:

DPT: What do you think of the boot now that we have tried it out?

Mrs H.: It's OK, but it looks ugly.

DPT: I agree, I don't think we will be starting any fashion trends with this one! On a serious note, how important is the look of this boot compared with your ability to continue to work while your foot heals? Do you think you can make that compromise?

Mrs H.: Of course—I mean, we aren't really dressing for looks while we are working in the kitchen.

DPT: OK, great. For this to work, it will be important for you to put it on whenever you are on your feet, even if you are just going from the bed to the bathroom in the morning when you first wake up. Aside from the appearance, is there anything else that might make it difficult for you to wear the walking boot?

Mrs H.: Well, I do feel a little uneven when I walk in this thing, like one leg is longer than the other.

DPT: Good point; one leg is essentially longer than the other because of the height difference between your clog and the walking boot. Let's have you put on the sneakers you brought in when you came for your last visit. We should be able to place a small lift inside your other shoe to help make the height a little more even.

Mrs H.: I think that would really help. Is there anything else we can do to help this stupid foot heal faster? I am really getting tired of this.

DPT: Yes, there are definitely other changes we can talk about. Because you are coming back in 2 days, let's see how the walking boot works for you first. Then, if you are open to it, my recommendation would be for us to start thinking about how you can improve your blood sugar levels, which is another common barrier to healing.

Mrs H.: You're not going to lecture me about losing weight, are you?

DPT: I am not a big fan of lecturing another adult, but it is something I would like to discuss. Just like everything else we talk about, please let me know if you feel like I am crossing the line, and I will back off.

Mrs H.: I really appreciate how you give me a say in things. Thank you.

DPT: Thank you for trusting me and telling me what you really think! If we are going to get this wound to close, it's very important that you and I work together as a team. I will see you in a couple of days. Please call if you have any questions in the meantime.

CONCLUSIONS

Providers can become frustrated by patient nonadherence and its effects on chronic wound outcomes. Reexamining reasons for nonadherence enables providers to respond productively.¹⁸ Patients may feel overwhelmed by the physical and psychological changes caused by chronic wounds. Self-management can also feel overwhelming because of the number and complexity of treatment recommendations.⁵

The likelihood of adherence is improved when clinicians link recommendations to individual outcome expectations and goals.¹⁷ Despite patient willingness to follow recommendations, unintentional nonadherence may still occur, particularly if provider instructions are not clear.¹⁸ Collaborative communication strategies, such as MI, can help providers detect and address problems with comprehension or other unforeseen barriers. Providers should also consider patient readiness to change. Successful wound management often takes time, patience, and effort to develop a deeper rapport before patients can adhere to provider recommendations.¹⁸

PRACTICE PEARLS

- Patient education on wound management skills, such as cleansing, dressing changes, and recognizing infection, can significantly improve treatment outcomes.
- A collaborative approach to wound prevention and management also optimizes treatment outcomes.
- Theory-based assessment helps providers work with patients to determine the patient's readiness to change, need for information, and perceived barriers to adherence.

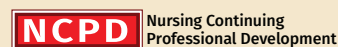


- Asking open-ended questions, such as in MI, allows providers to better understand patient perspectives.
- Important questions to ask include: What caused this wound? How does this wound affect your day-to-day life? How long do you think it will take for your wound to heal? How do you think this wound should be treated? What are the most important results you hope to achieve with treatment? What fears or concerns do you have about your treatment? ●

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