



From Research To Practice: What Canada's First Wound Care Research Priority-Setting Exercise Tells Us

By Ahmed Kayssi MD DrPH FRCSC FACS

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Wound care in Canada is a field defined by an uncomfortable paradox: the burden is enormous, the evidence base is growing and yet the gap between what we know and what we do remains stubbornly wide. In a study recently published in *Advances in Skin and Wound Care*, the authors, of whom I am one, took a step toward closing that gap by doing something that has never been done before in Canada by asking wound care stakeholders, systematically and rigorously, what they think researchers should prioritize.¹

The authors (Gaballa, Blanchette, Summers deLuca, Kayssi) used a sequential mixed-methods design. A national survey collected research questions from 91 stakeholders across clinical, academic, industry and patient communities. Those questions were refined and then subjected to a modified Delphi process involving 29 expert panelists over three

questionnaire rounds and two virtual workshops. The result is a ranked list of 23 consensus research priorities, representing the first time Canadian wound care stakeholders have formally aligned on what the field most urgently needs to know.

Top Priorities

The top three priorities are worth quoting directly. First: what is the incidence, prevalence and healing time for diabetic foot ulcers, venous leg ulcers, pressure injuries and surgical wounds in Canada, and what do they cost the health-care system? Second: how much could be saved by prioritizing wound prevention, and what would that mean for patient morbidity and mortality? Third: how can wound data be collected nationally to inform knowledge translation, quality improvement and research?

These questions share a common logic. Before we can change wound care in Canada, we need to be able to see it clearly, and right now we cannot. As Blanchette and Kuhnke have previously documented, accessible and usable wound data in Canada are remarkably scarce.² The absence of a national wound registry, the inconsistency of wound coding across settings and provinces and the concentration of data in acute care to the exclusion of home and community settings where most wound care actually happens are not technical inconveniences. They are structural barriers to the entire research enterprise. You cannot measure what you cannot count and you cannot improve what you cannot measure.

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What strikes us about the consensus list is how consistently it points upstream. The questions that scored highest are not about which dressing to use or which device to apply. They are about incidence, cost, prevention, data infrastructure, education, equity and the design of care systems. This reflects something important about where the field’s own experts believe the highest-value work lies. Clinical product research is well-funded by industry and well-represented in the literature. What is underfunded and underrepresented is exactly what our panel identified: the foundational epidemiological data, the health economics, the system design questions and the equity analysis that would allow wound care to make its case to policy makers.

Underfunded And Underrepresented

That last point matters because several of the top priorities are explicitly about making the case. Priority 2 asks how much wound prevention would save. Priority 11 asks how we measure the financial impact of chronic wounds and limb loss and use that data to secure resources. Priority 12 asks what health policies are needed to implement best wound care practices and prevent amputation. These are advocacy questions dressed as research questions, and their rank in the consensus suggests that the wound care community understands that evidence alone is insufficient. The evidence needs to be translated into the language of health economics and policy if it is to move health systems.

Equity Is Vital

The inclusion of equity in the top ten priorities is also notable and appropriate. Priority 7 asks directly: access to wound care is not equal across Canada; what are the factors and how do we address them? The geographic and socioeconomic gradients in wound outcomes in this country are real and documented, and a research agenda that does not foreground equity is unlikely to produce change that reaches the patients who bear the greatest burden of disease.

Acknowledging Limitations

We acknowledge the limitations of our work. The phase one survey response rate was 10%, which is low and introduces nonresponse bias. Representation in the Delphi panel was concentrated in five provinces, with no territorial representation and limited francophone participation beyond the initial survey. Basic scientists and clinical trialists were underrepresented. These are significant gaps in a country where health care is provincially/territorially governed and where the practical experience of wound care varies enormously between an academic centre in Toronto and a remote community in Nunavut.

Our panel also did not include a formal patient advisory structure, which means that patient and caregiver perspectives, while present through lay expert panelists, were not systematically integrated into the governance of the process itself. In a field where patient-reported outcomes are increasingly recognized as central to quality measurement, that is a gap worth addressing in future iterations of this work.

A Mandate For Research

Despite these limitations, we believe the 23 ranked priorities produced by this exercise are in the genuine public good. They give researchers a mandate, funders a roadmap and Wounds Canada and its member organizations a defensible basis for strategic investment. They also give clinicians who want to contribute to the evidence base a clear signal about where that contribution is most needed.

The challenge now is to use them. Research priority lists have a way of being published and then sitting on a shelf while the field continues to work on whatever was already funded. The priorities we identified will only matter if they are actively connected to grant competitions, journal calls, fellowship training and the advocacy conversations that happen between wound care organizations and government. That work belongs to all of us.

Ahmed Kayssi MD DrPH FRCSC FACS is with the Division of Vascular Surgery, University of Toronto, Toronto, Ontario, Canada, and a member of the Wounds Canada Board of Directors.

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