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Clinical and practical issues around dressing use in primary abdominal wounds: a qualitative study of healthcare professionals' and patients' views

--Manuscript Draft--

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Abstract:	<p>Primary surgical abdominal wounds are usually covered with a dressing. However, little is known about practical issues and costs around these dressings. This study aimed to provide an in-depth description of patients' and healthcare professionals' (HCPs) perspectives on the clinical and practical issues associated with standard and novel dressing (glue-as-a-dressing) use on primary surgical wounds, and to establish whether and how their experience compares with these perspectives. During semi-structured interviews, patients and HCPs discussed their positive experience of glue-as-a-dressing and no dressing around six themes: wound contamination and infection, wound healing, wound care, physical protection afforded by simple dressings, potential psychological impact of an exposed wound, and ability to carry out everyday tasks. Current views on the practice of dressings for primary abdominal wounds are influenced by ingrained clinical practice. These views can be challenged when exposed to novel dressing strategies or as new evidence of the clinical effect of dressing strategies emerges.</p>
Suggested Reviewers:	
Response to Reviewers:	Dear Editor, We would like to thank the reviewers for their constructive comments on our paper. We have responded to Reviewer 1's comment below and we hope it is to their satisfaction. We are happy to provide any further information and clarification, should they need any more.

	<p>Reviewer #1 "A picture of the glue-as-a-dressing and the standard dressing side by side would add to this paper but apart from that I can suggest no further changes or additions"</p> <p>Response: We agree that including a picture of a wound covered with glue-as-a-dressing and another one covered with a simple dressing would add to the paper and help the reader. We have included the pictures of page 4 (lines 81-82).</p> <p>Furthermore, in addition to the six co-authors included on this paper, we would like to make sure that the published paper will say "on behalf of the Bluebelle team" which includes all the co-authors mentioned on the title page.</p> <p>Yours sincerely, Christel McMullan</p>
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Clinical and practical issues around dressing use in primary abdominal wounds: a qualitative study of healthcare professionals' and patients' views

acknowledgment, conflict of interest statement

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Abstract

Primary surgical abdominal wounds are usually covered with a dressing. However, little is known about practical issues and costs around these dressings. This study aimed to provide an in-depth description of patients' and healthcare professionals' (HCPs) perspectives on the clinical and practical issues associated with standard and novel dressing (glue-as-a-dressing) use on primary surgical wounds, and to establish whether and how their experience compares with these perspectives. During semi-structured interviews, patients and HCPs discussed their positive experience of glue-as-a-dressing and no dressing around six themes: wound contamination and infection, wound healing, wound care, physical protection afforded by simple dressings, potential psychological impact of an exposed wound, and ability to carry out everyday tasks. Current views on the practice of dressings for primary abdominal wounds are influenced by ingrained clinical practice. These views can be challenged when exposed to novel dressing strategies or as new evidence of the clinical effect of dressing strategies emerges.

Keywords: Feasibility studies; qualitative methods; wound dressings; exposed wounds; glue;

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Competing interests

None declared

1

2 **Introduction**

3 Abdominal surgical procedures are amongst the most common operations performed (Eurostat,
4 2014). At the end of most procedures the wound is closed and the healing process begins (Dumville
5 et al, 2016). The next step, recommended by the National Institute for Health and Care Excellence
6 (NICE), is to cover the wound with a dressing, despite insufficient evidence to demonstrate that
7 dressings reduce surgical site infection (SSI) (NICE, 2008). A recent survey undertaken as part of the
8 Bluebelle feasibility study (NIHR HTA 12/200/04) found that 68% of primary abdominal wounds were
9 covered with simple adhesive dressings, 27.4% of wounds had tissue adhesive applied over closed
10 skin (termed 'glue-as-a-dressing' here), and 3.6% of wounds did not have a dressing (Bluebelle Study
11 Group, 2016a). The remaining 1.0% of wounds were covered with advanced dressings.

12

13 Most wound dressing research focuses on the association with risk and cost of SSI (NICE, 2008;
14 Smyth et al, 2008; Borkar & Khubalkar, 2011) despite well-known uncertainties around whether
15 dressings are needed at all (Dumville et al, 2016; Blazeby et al, 2016). In their systematic review of
16 dressing use and SSIs, Dumville et al. (2016) recommended that the views of HCPs and patients
17 should be considered in decisions that concern dressing strategies. Such decisions about the use of
18 post-surgical wound dressings may require the consideration of practical as well as clinical and cost-
19 related issues (Blazeby et al, 2016).

20

21 Some existing qualitative research has explored patients' perspectives on specific and specialised
22 wound dressing types used in open and chronic wounds (Kelly et al, 2016; Fagerdhal et al, 2013;
23 Abbotts, 2010). Very little is known, however, about patients' perspectives about having their
24 wound covered with common wound dressings. Patients' views on exposed wounds have been
25 described qualitatively, but only after early removal of a dressing (Meylan & Tschantz, 2001).

26 Although a small number of patients found dressing removal uncomfortable and reported not liking

27 the sight of their undressed wounds, these findings lack detailed information about patients' views
28 on dressed and undressed wounds. Other than research conducted in the context of the Bluebelle
29 study (Elliott et al, 2017), we are not aware of any in-depth research that has examined HCPs' and
30 patients' views on the practical and clinical issues associated with routine post-surgical dressing use,
31 novel dressing strategies (e.g. glue-as-a-dressing), and no dressing use (Elliott et al, 2017; Bluebelle
32 Study Group et al, 2016b).

33

34 **Aim**

35 The aims of this article are to (i) provide an in-depth description of HCPs' and patients' perspectives
36 on the clinical and practical issues associated with post-surgical wound dressing use, and (ii)
37 establish how experience of novel dressing strategies (including no dressing use) compares with
38 these perspectives.

39

40 **Methods**

41 Qualitative data were collected as part of the Bluebelle feasibility study to explore the perspectives
42 of patients and HCPs on post-surgical dressing use (Figure 1 & Box 1). Semi-structured interviews
43 were conducted in the three NHS University Teaching hospitals and three district general hospitals in
44 the South West and the West Midlands regions of England, focusing on gastrointestinal (GI) and
45 obstetric surgery. Ethical approval for this work was granted by the Camden and King's Cross
46 Research Ethics Committee (14/LR/0640) on the 10th April 2014.

47

48

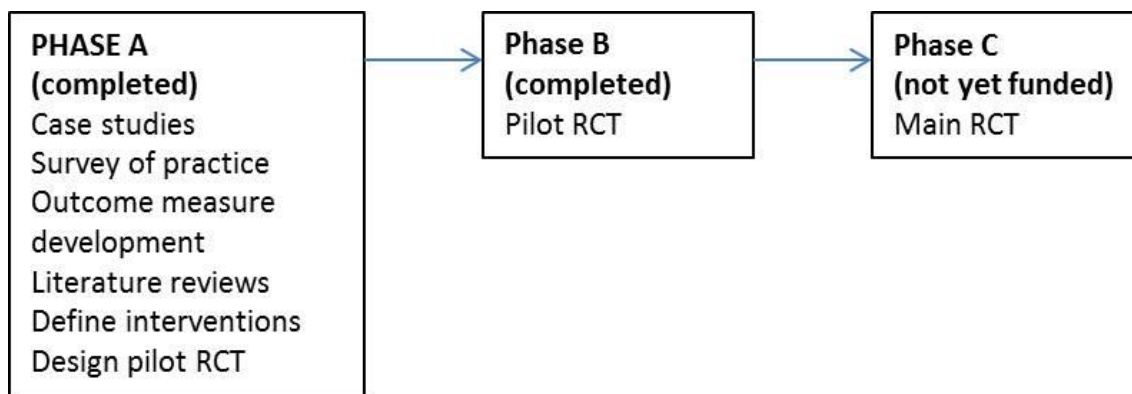


Figure 1 – Overall structure of the Bluebelle study

49

50

Box 1 – Description of the Bluebelle study

51

Bluebelle was designed to investigate the feasibility and acceptability of conducting a randomised controlled trial (RCT) of post-surgical dressing use that included a no dressing group. Bluebelle was conducted in two phases: Phase A consisted of preparatory qualitative research exploring HCPs' and patients' perspectives on wound dressing use and practice, as well as their views regarding the proposed trial (Bluebelle Study Group et al, 2017_14). Findings from Phase A informed Phase B, an external pilot RCT, allocating patients to one of three groups: simple dressing, glue-as-a-dressing, or no dressing (Fig 1) (The Bluebelle Study Group et al, 2017_15). Qualitative data were collected during both Phase A and Phase B.

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59 Sampling and recruitment

60 For the qualitative interviews in Phase A and B the research team recruited HCPs working in

61 upper/lower GI and obstetric surgery, including surgeons, nurses, research nurses, and midwives.

62 Eligible patients in Phase A were aged 18 years or over and had recently undergone, or were due to

63 undergo abdominal surgery. Patients in Phase B were 16 or over and had recently undergone

64 elective or unplanned abdominal or obstetric surgery. The qualitative research team used purposive

65 sampling for both phases to ensure a diverse range of patients were included, according to age,

66 gender, type of surgery, and in Phase B according to dressing allocation. In Phase B, the sample was

67 weighted toward patients who were allocated to receive either glue-as-a-dressing or no dressing in

68 order to explore the experience of these dressing strategies. Written informed consent was provided
 69 before each interview.

70

71 **Data collection**

72 One-to-one semi-structured interviews were conducted face to face or via telephone by CM, LR, DE
 73 and JM. Face-to-face interviews took place on hospital premises or in participants’ homes.

74 The interview schedules were informed by the research objectives of the Bluebelle feasibility study
 75 (Bluebelle Study Group et al, 2016b) and evolved as data collection progressed. Interviews during
 76 Phase A of the study focused on HCPs’ perspectives on wound dressing use and practice and
 77 patients’ experiences of wound dressing use, as well as hypothetical perspectives on the use of no
 78 dressing within the pilot trial. Further interviews were carried out during Phase A to investigate
 79 participants’ views around the use of glue-as-a-dressing. Phase B interviews aimed to explore HCPs’
 80 and patients’ actual experience of the use of simple dressings, glue-as-a dressing and no dressing
 81 within the pilot trial. An example of wounds covered with glue-as-a-dressing and a simple dressing
 82 can be seen in pictures 1 and 2.

83 A total of 106 HCPs and 88 patients were interviewed. The breakdown of HCPs and patients
 84 interviewed in Phase A and Phase B is shown in tables 1-3. Procedures were wide ranging and
 85 included hernia repair, colectomy, recto-anal surgery, gallbladder removal, liver surgery, and
 86 caesarean sections.

87

STAFF	Upper / Lower Gastro-intestinal Surgery					Obstetric surgery		
	Consultant surgeon	Registrar	Ward nurse	Theatre staff	Research nurse	Consultant Surgeon	Registrar	Midwife
Understanding wound dressing practice (Phase A)	25	11	23	n/a	n/a	7	7	15
Pilot trial	1	2	4	4	4	0	0	3

(Phase B)

88

PATIENTS	Upper / Lower Gastro-intestinal Surgery	Obstetric surgery
Understanding wound dressing practice (Phase A)	44	7
Pilot trial (Phase B)	30	7

89

PATIENTS (Pilot trial - Phase B)	Upper / Lower Gastro-intestinal Surgery	Obstetric surgery
Simple Dressing	4	1
No dressing	15	3
Glue-as-a-dressing	11	3

90

91 **Analysis**

92 Interviews were audio-recorded and transcribed verbatim. Data were analysed thematically using
93 NVivo10, guided by the constant comparison method (Glaser & Strauss, 1967). A sample of interview
94 transcripts was coded independently by two researchers to help develop an initial coding
95 framework. Each transcript was then read several times. Some codes were developed *a-priori*,
96 based on the topic guide. More codes were subsequently developed inductively. These codes were
97 then reviewed and indexed into broader categories. The research team met on a regular basis to
98 discuss the coding frame, data interpretation, and whether the topic guide needed to be adapted in
99 light of the emerging findings.

100

101 **Findings**

102

103 **Themes emerging from Phase A interviews**

104 During Phase A interviews six core themes were identified as integral to HCPs' and patients'
105 perspectives on the purposes and practice of wound dressings in GI and obstetric surgery: wound
106 contamination and infection, wound healing, wound care, physical protection afforded by simple
107 dressings, potential psychological impact of an exposed wound, and carrying out everyday tasks.

108

109 **1. Wound contamination and infection**

110 It was clear, during the initial interviews, that a consensus about the role of simple dressings in SSI
111 prevention did not exist, despite SSI being a key topic for discussion in relation to dressing use.

112 Some nurses posited a role for simple dressings in preventing infection as they provide a physical
113 barrier against the external environment, such as the hospital environment or patients picking at
114 their wound, which otherwise could contaminate it, thereby causing infection (quote 1).

115 When SSI prevention was discussed as a reason for simple dressing use it was suggested,
116 predominantly by surgeons, that this mechanism of SSI prevention was only a purported or
117 theoretical role of simple dressings. These participants questioned the notion that dressings prevent
118 infection via wound contamination. Indeed, some went further to suggest that dressing use might
119 actually cause infection, for instance by keeping the wound area moist and providing an
120 environment that promoted the growth of 'bugs' (quote 2).

121 Further demonstrating the complexity of this issue and perhaps the uncertainty surrounding it,
122 surgeons offered different explanations at different points of Phase A interviews. Others suggested
123 scenarios where they felt that the risk of SSIs associated with contamination of the post-surgical
124 wound was higher without the use of some form of dressing. Examples included wounds near
125 caesarean sections (the theatre environment following the delivery of a baby was considered as
126 'messy') and stomas, where glue-as-a-dressing was used to protect the wound from contamination
127 from the ostomy, resulting in lower infection rates and perhaps providing advantages over simple
128 dressings (quote 3).

129 The specific post-surgical events following delivery of a baby were a further reason for obstetric
130 professionals' concern about leaving wounds undressed. Mothers' attention was thought to be
131 concentrated on their newborn babies, not on keeping their wound clean. This, according to some,
132 made these women especially in need of a dressing (quote 4).

133 Some patients also demonstrated uncertainty around the role of simple dressings in SSI, and
134 whether or not it would be best to leave a wound open to the air (quote 5).

135

136 **2. Wound healing**

137 There was a lack of consensus from HCPs regarding whether or not simple dressings promoted
138 wound healing. Some believed that they contributed to wound healing by maintaining warmth
139 around the wound site by not disturbing the wound and avoiding lifting the dressing too often
140 (quote 6).

141 In addition, nurses felt that simple dressings would help the wound healing process by absorbing any
142 exudate or sweat (quote 7).

143 However, some HCPs and patients disagreed with this idea, suggesting that simple dressings slowed
144 down the wound healing process by preventing the wound from drying (quote 8).

145 Similar to discussions concerning the role of dressings in SSIs it was clear that many HCPs were
146 uncertain about the relationship between dressing use and wound healing. Again, some
147 interviewees expressed this doubt and when probed further challenged their own earlier statements
148 about the impact of wound dressings on wound healing (quote 9).

149

150 **3. Wound care**

151 The main concerns regarding post-operative wound care were the ability to manage exudate and the
152 identification of wound infections.

153 Several HCPs and patients felt that simple dressings should be used to absorb exudate, avoiding the
154 possibility of leaky undressed wounds soiling their clothes or bedding (quote 10).

155 Some HCP interviewees were also concerned that glue-as-a-dressing could delay the detection and
156 management of SSIs, as they would prevent leakage associated with infection (quote 11):
157 Other interviewees, however, said that infection could be detected through other ways, such as the
158 redness of the skin, the level of pain, swelling, fever, and a raised pulse rate.

159 **Box 2 – Quotes from participants**

Quote 1

From my experience I would say a wound dressing is to protect the wound, and basically it's to prevent infection, that's what I would believe it to do from my nursing practice and midwifery. The whole reason they have a dressing is to protect that area from, you know, foreign bodies and bacteria and the environment (Midwife, Phase A)

Quote 2

I would imagine that if the skin flora can get under the dressing then all the dressing does is keep a nice warm moist growbag environment for whatever bugs are there (Obstetric surgeon, Phase A)

Quote 3

I like the idea that it's nice and sealed, particularly when we make stomas [...] The great thing about the superglue is that it glues it shut so it feels like it's sealed away from the muck (Registrar, General surgery, Phase A)

Quote 4

Especially when they're preoccupied with their babies and the last thing on their mind is hmm looking after their wound site (Midwife, Phase A)

Quote 5

It may do [prevent infection], but if it's left and you haven't got anything on and it was...to the air, it may do, I don't know. But otherwise, it's probably best without the dressing on and left how it is (Patient, Phase A)

Quote 6

We try and not disturb open wounds too frequently [...] Every time you take a dressing off, the natural body heat drops. So the temperature around that wound bed drops when you remove a dressing, because you're opening it to the air (Nurse, General surgery, Phase A)

Quote 7

When there's an overhang then it gets sweaty and wet and that's probably not conducive to the wound healing (Midwife, Phase A)

Quote 8

By having it [the wound] open [in the air] earlier would it mean it would heal quicker, or by having a dressing on, is it going to make the dressing, is the dressing going to keep it like moist and soft where it's not going to heal so quick? (Patient, Phase A)

Quote 9

I think specifically related to C-sections I would answer that, you know, they're (simple dressings) used again to, I keep reiterating: promote healing, prevent infection

[Later during the interview]

I don't think in terms of promoting healing [...] I don't think a wound dressing by itself can necessarily speed up healing. I don't know, it's interesting to (see) (Midwife, Phase A)

Quote 10

The day after, two days after, that's fine, I don't mind not having a dressing but straight after surgery, especially because it's leaking blood and all the rest of it, I would want it covered. It would worry me (Patient, Phase A)

Quote 11

If there is sufficient amount of pressure I suppose underneath that wound then that could probably

Box 3 – Quotes from participantsQuote 12

Because your wound when it's new is very sensitive so if it brushes against something then in theory it might protect it. And some of our wounds are very big, particularly in my speciality, we're talking about things all across the abdomen, so our patients' pain issues are very important (General surgery registrar, Phase A)

Quote 13

When I'm sat up the wound is kind of tucked under because of my belly so big the wound actually pushes against my legs hmm so when I stand up I can feel the hmm the wound and when I'm hot as well peeling away from my legs. If I didn't have a dressing on it I think, I think the stitches would like stick to my leg and it would hurt a lot more (Obstetric patient, Phase A)

Quote 14

I mean that's just my bias view but you know when you do a ward round and you take the dressing off to have a look at the wound for example they are always very anxious about having the wound exposed and they're you know very keen for the wound to be dressed and covered up quite quickly (General surgeon, Phase A)

Quote 15

Maybe if I did not have a dressing [...] maybe I would have been a little more, I would say a little more careful and more concerned about how I did things around my daily chores, like having a shower or going to the toilet and stuff like that (Patient, Phase A)

Quote 16

I think it dried quicker [...] because the air was going to it [...] it healed quicker (Patient, no dressing, Phase B)

Quote 17

If we have got things like oozing or redness or something that doesn't look quite right, we are spotting it earlier (Nurse, general surgery, Phase B)

Quote 18

I'm just making sure I be careful at night time and [...] I'm making sure I'm wearing sort of tops and um so I don't knock it or rub myself or when I roll I don't pull (Patient, no dressing, Phase B)

Quote 19

Well that's where, that sort of having the baby stomach is actually a bit of help in that as well because then it just tends to keep everything away from... [clothes] (Obstetric patient, no dressing, Phase B)

Quote 20

*Um... to be honest, it didn't really bother me, um, it didn't affect me in any way being able to see it [my wound] (Patient, no dressing, Phase B)
I've been quite pleased with it actually, it's, it's quite neat (Patient, glue-as-a-dressing, Phase B)*

Quote 21

It gave me a bit of confidence because the more I can see the more then I feel I'm in control and therefore I know what's going on with my body (Patient, glue-as-a-dressing, Phase B)

Quote 22

It was completely straightforward you know. I got home from hospital on... So I got there in the evening, the following day I had a shower and you know my wounds were absolutely fine, I had not, not an ounce of [...] bother or trouble (Patient, no dressing, Phase B)

161

162 **4. *Physical protection afforded by simple dressings***

163 Both HCPs and patients in Phase A thought that simple dressings provide protection for the wound
164 from physical trauma and from the wound closure catching on clothes. While patients expressed
165 concern at the thought of an undressed wound leaving them vulnerable to knocks, HCPs suggested
166 that this was partly mitigated by the use of simple dressings (quote 12).

167 Interviewees, especially in obstetrics, also expressed some concern that the wound closure (sutures,
168 staples, clips) on an undressed wound would catch on clothes. Indeed, interviewees in obstetrics
169 seemed to be more concerned about the prospect of leaving wounds undressed during the Phase A
170 interviews. For example, the following obstetric patient was concerned that her stitches would stick
171 to her legs if she did not have a dressing, which eventually would be more painful for her (quote 13).

172

173 **5. *The potential psychological impact of an exposed wound***

174 Seeing the wound was a potential issue raised by several HCPs and patients during the Phase A
175 interviews, especially in the case of undressed wounds. Despite the fact that a small minority of
176 nurses believed that seeing an undressed wound could help patients come to terms quicker with
177 their wounds, some HCPs thought that seeing an undressed wound would lead to psychological
178 discomfort for patients who may be concerned by the appearance, which could look 'messy'.

179 Several patients believed that they would not be comfortable seeing their wound, which according
180 to some of the HCPs could lead to some anxiety among patients (quote 14).

181

182 **6. *Carrying out everyday tasks***

183 Although HCPs did not raise the issue during the Phase A interviews, some patients thought that
184 they would need to be more careful without a simple dressing when carrying out everyday tasks,
185 such as having a shower or moving around. This was perhaps interrelated with thoughts about

186 perceptions regarding the physical and psychological protection afforded by simple dressings (quote
187 15).

188

189 **How patients' experiences compare to their initial perceptions**

190 Overall, the main concerns raised by participants during the Phase A interviews were not confirmed
191 in Phase B and the majority reported a positive experience of using glue-as-a-dressing or having
192 exposed wounds.

193 No serious concerns relating to no dressing use and SSIs were reported by participants, even the
194 obstetric ones. In addition, the idea that not using a wound dressing facilitated the process of wound
195 healing by allowing the wound to dry was discussed several times both by patients and nurses
196 (based on the understanding that no SSI was present) (quote 16).

197 HCPs and patients in Phase B were generally enthusiastic about wound care for an undressed wound
198 or a wound covered with glue-as-a-dressing and appreciated the fact that in both cases there was no
199 dressing to lift, re-apply or change. Some nurses suggested that undressed wounds allowed them to
200 notice any issues faster than with a simple dressing (quote 17):

201 This also meant that that glue-as-a-dressing and undressed wounds were reportedly not intrusive for
202 patients, making it easier to check for infection.

203 Patients and HCPs in Phase B did not report negative physical experiences of undressed wounds.

204 Patients also seemed content with the physical experience of glue-as-a-dressing, with several stating
205 that they did not notice that they had glue on their wound. However, some patients with glue-as-a-
206 dressing were aware of their wound and of a slight pulling sensation around it, implying that they
207 had to be more careful around it, particularly at night (quote 18).

208 In order to avoid the wound closure catching on clothes, several patients with undressed wounds
209 reported wearing loose clothing. One obstetric patient felt that her post-birth 'baby stomach' was
210 an advantage as it provided some physical protection (quote 19).

211 Patients allocated to no dressing or glue-as-a-dressing did not find their wound 'messy' as
212 mentioned by some participants in Phase A and felt at ease with seeing their wound (quote 20):
213 In addition, some patients suggested that being able to view the wound had given them a feeling of
214 control, increased their confidence in relation to it, and allowed them to check whether their wound
215 was healing properly (quote 21)

216 Overall, patients with undressed wounds and glue-as-a-dressing felt that they were able to carry out
217 everyday tasks including having a shower, walking, getting up, lying down, and that they were able
218 to do so sooner than with a simple dressing (quote 22).

219 In the case of having a shower, it was the waterproof feature of glue-as-a-dressing that patients
220 found to be a major advantage. Some explained this freedom of movement by the way glue-as-a-
221 dressing stuck to the wound, enabling it to move with the contours of the body, therefore allowing
222 patients to move freely.

223

224 **Discussion**

225 We have elicited and explored HCPs' and patients' views on the clinical and practical issues
226 associated with wound dressing use in primary wounds following abdominal and obstetric surgery.
227 We have also presented data showing how the experience of novel dressing strategies, in this case
228 no dressing and glue-as-a-dressing, compare with these perspectives. Issues raised in the Phase A
229 interviews related to the purpose and practice of wound dressings included concerns about wound
230 contamination and infection; wound healing and wound care; the physical protection afforded by
231 simple dressings; the potential for psychological impact resulting from exposed wounds; and the
232 ability of patients to carry out everyday tasks. All of these were discussed by patients and staff in
233 the exploratory work we undertook before our pilot trial, except the importance of being able to
234 carry out everyday tasks following surgery, which was only raised as an issue by patients. During
235 Phase B interviews it was clear that concerns raised during Phase A were not being confirmed by
236 patients or staff. Rather, participants tended to discuss the advantages of the novel dressings used

237 instead. This work highlights the value of using qualitative research methods before and during an
238 RCT to understand the acceptability and views of staff and patients about the trial interventions.
239 To our knowledge, Bluebelle is the first study that has explored in-depth views of a range of HCPs,
240 and of patients undergoing various GI and obstetrics procedures on having undressed wounds and
241 views relating to immediate exposure (in the case of no dressing) of wounds (Elliott et al, 2017; The
242 Bluebelle Study Group, 2016b), rather than early removal of wound dressings (Meylan & Tschantz,
243 2001). Bluebelle is also the first study to describe perspectives on the use of glue-as-a-dressing.

244

245 Limitations include the relatively low number of HCPs who delivered the pilot trial during Phase B,
246 who were therefore available for interview. We also had a relatively low number of patients
247 undergoing obstetric surgery who took part in an interview. However, the views of staff and
248 obstetric patients that did participate were consistent and we did not see any clear differences in
249 the views expressed between upper or lower GI and obstetric surgery. Further confirmatory
250 research in obstetrics and other surgical specialties to strengthen this finding may be warranted. In
251 addition, we have not been able to follow patients longitudinally to examine whether views and
252 concerns related to dressing strategy change based on actual experience of novel approaches. There
253 is a possibility that some patients who had strong concerns that would predispose them to negative
254 views concerning the experience of no dressing or glue-as-a-dressing may not have agreed to take
255 part in the pilot trial.

256

257 Our study demonstrates that current views and practice are not necessarily a consequence of active
258 reflection on the part of the HCPs. We have described how some interviewees during Phase A
259 challenged their own (automatically and initially) proffered reasons for dressing use, such as for SSI
260 prevention. Indeed HCPs' views about pertaining to the role of wound dressings in infection and
261 healing demonstrated considerable uncertainty. Whilst they suggested potential mechanisms for
262 these outcomes, they were often unable to state whether these were valid or not. These clinical

263 concerns may be of less importance to HCPs than practical issues such as wound care. During Phase
264 A, simple dressings were thought to have a clear role to play in this, for example, by absorbing
265 wound exudate. In the pilot trial (Phase B) a specific protocol to deal with exudate was
266 implemented without compromising allocation to no dressing. Thus, although participants
267 expressed certain concerns, these concerns did not become manifest. Indeed, HCP interviewees saw
268 certain advantages with no dressing and glue-as-a-dressing in terms of ability to view the wound
269 easily. Whilst patients did discuss these issues in Phase A, they were also concerned with practicality
270 and everyday tasks. Again, during Phase B the patients we spoke to suggested that the novel
271 dressing strategies were advantageous in these respects. During Phase A, whilst the potential
272 benefits of seeing the wound was briefly mentioned, a majority of HCPs hypothesised that patients
273 may not like to see the wound and we were interested to explore whether this was the case. We
274 subsequently found that Phase B patients reported a feeling of control, confidence and reassurance
275 in being able to do so. This shows that assumptions about patients on the part of the HCPs may not
276 always be correct and can be challenged through discussion and qualitative research with patients.

277

278 On the whole, participants were positive about their experience of glue-as-a-dressing. Glue-as-a-
279 dressing sits in between simple (non-transparent) dressings and undressed wounds, providing the
280 advantages of being able to view the wound that were detailed by HCPs and patients, whilst offering
281 some covering to the wound. Other advantages include the absence of need for multiple
282 applications or for assistance to remove a dressing. Previous research evaluating transparent wound
283 dressings has also shown perceived benefits associated with being able to monitor the wound more
284 easily (Stephen-Hayes et al, 2014).

285

286 **Conclusions**

287

288 We have described the views of professionals and patients about the purpose and practice of wound
289 dressings in primary post-surgical wounds. Findings suggest that views are embedded and ingrained
290 clinical practice. Healthcare professionals and patients may start to challenge these views when
291 they are exposed to the experience of novel dressing strategies, as in the Bluebelle study pilot trial,
292 or as new evidence of the clinical effect of dressing strategies emerges, such as their role in wound
293 infection and healing. Further research is required to explore the association between dressing use
294 and the issues of concern to staff and patients, and to establish the association and underlying
295 mechanisms of effects for the clinical and practical issues identified here, including those of
296 psychological and practical relevance to patients. The Bluebelle study has demonstrated that there
297 can be value in understanding the views of HCPs to enable those views to be discussed and
298 challenged where appropriate.

299

300 **Key points**

- 301 • Six themes emerged from the interviews: wound contamination and infection; wound
302 healing; wound care; physical protection afforded by simple dressings; potential
303 psychological impact of an exposed wound; and ability to carry out everyday tasks.
- 304 • Overall, participants were positive about their experience of glue-as-a-dressing and the
305 option of no dressing.
- 306 • Current views on wound dressing practice are not necessarily a consequence of active
307 reflection on the part of the HCPs and views are part of embedded and ingrained clinical
308 practice.
- 309 • These views can be challenged when they are exposed to the experience of novel dressing
310 strategies within a randomised trial, or as new evidence of the clinical effect of dressing
311 strategies emerges.

312

313 **Reflective questions**

314 • What is the association between dressing use and issues of concern to staff and patients?

315 • Do these findings apply to other surgical specialties?

316

317

318

319 **Contributions**

320 All authors have read and commented on the final version of the article.

321

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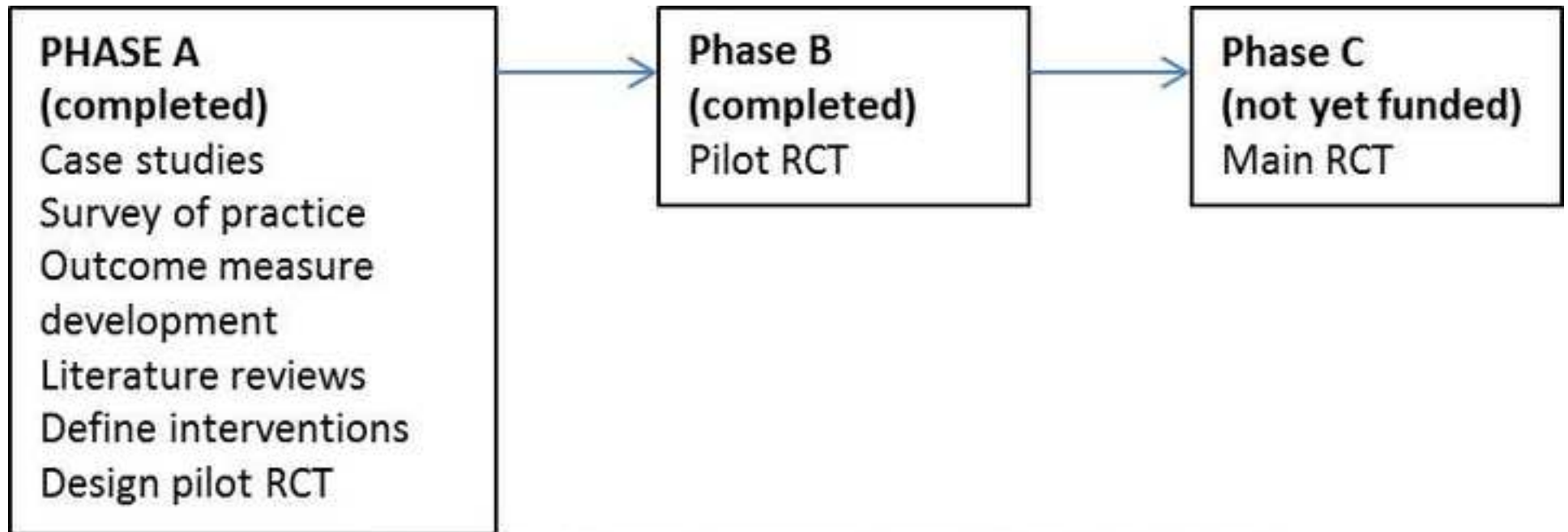


Figure 1 – Overall structure of the Bluebelle study

STAFF	Upper / Lower Gastro-intestinal Surgery					Obstetric surgery		
	Consultant surgeon	Registrar	Ward nurse	Theatre staff	Research nurse	Consultant Surgeon	Registrar	Midwife
Understanding wound dressing practice (Phase A)	25	11	23	n/a	n/a	7	7	15
Pilot trial (Phase B)	1	2	4	4	4	0	0	3

Table 1 – Number of HCPs by surgical specialty

PATIENTS	Upper / Lower Gastro-intestinal Surgery	Obstetric surgery
Understanding wound dressing practice (Phase A)	44	7
Pilot trial (Phase B)	30	7

Table 2 – Number of patients by surgical specialty

PATIENTS (Pilot trial - Phase B)	Upper / Lower Gastro-intestinal Surgery	Obstetric surgery
Simple Dressing	4	1
No dressing	15	3
Glue-as-a-dressing	11	3

Table 3 – Number of patients in the external pilot RCT (Phase B) by surgical specialty and dressing allocation

Box 1 – Description of the Bluebelle study

Bluebelle was designed to investigate the feasibility and acceptability of conducting a randomised controlled trial (RCT) of post-surgical dressing use that included a no dressing group. Bluebelle was conducted in two phases: Phase A consisted of preparatory qualitative research exploring HCPs' and patients' perspectives on wound dressing use and practice, as well as their views regarding the proposed trial (Bluebelle Study Group et al, 2017_14). Findings from Phase A informed Phase B, an external pilot RCT, allocating patients to one of three groups: simple dressing, glue-as-a-dressing, or no dressing (Fig 1) (The Bluebelle Study Group et al, 2017_15). Qualitative data were collected during both Phase A and Phase B.

Box 2 – Quotes from participantsQuote 1

From my experience I would say a wound dressing is to protect the wound, and basically it's to prevent infection, that's what I would believe it to do from my nursing practice and midwifery. The whole reason they have a dressing is to protect that area from, you know, foreign bodies and bacteria and the environment (Midwife, Phase A)

Quote 2

I would imagine that if the skin flora can get under the dressing then all the dressing does is keep a nice warm moist growbag environment for whatever bugs are there (Obstetric surgeon, Phase A)

Quote 3

I like the idea that it's nice and sealed, particularly when we make stomas [...] The great thing about the superglue is that it glues it shut so it feels like it's sealed away from the muck (Registrar, General surgery, Phase A)

Quote 4

Especially when they're preoccupied with their babies and the last thing on their mind is hmm looking after their wound site (Midwife, Phase A)

Quote 5

It may do [prevent infection], but if it's left and you haven't got anything on and it was...to the air, it may do, I don't know. But otherwise, it's probably best without the dressing on and left how it is (Patient, Phase A)

Quote 6

We try and not disturb open wounds too frequently [...] Every time you take a dressing off, the natural body heat drops. So the temperature around that wound bed drops when you remove a dressing, because you're opening it to the air (Nurse, General surgery, Phase A)

Quote 7

When there's an overhang then it gets sweaty and wet and that's probably not conducive to the wound healing (Midwife, Phase A)

Quote 8

By having it [the wound] open [in the air] earlier would it mean it would heal quicker, or by having a dressing on, is it going to make the dressing, is the dressing going to keep it like moist and soft where it's not going to heal so quick? (Patient, Phase A)

Quote 9

I think specifically related to C-sections I would answer that, you know, they're (simple dressings) used again to, I keep reiterating: promote healing, prevent infection

[Later during the interview]

I don't think in terms of promoting healing [...] I don't think a wound dressing by itself can necessarily speed up healing. I don't know, it's interesting to (see) (Midwife, Phase A)

Quote 10

The day after, two days after, that's fine, I don't mind not having a dressing but straight after surgery, especially because it's leaking blood and all the rest of it, I would want it covered. It would worry me (Patient, Phase A)

Quote 11

If there is sufficient amount of pressure I suppose underneath that wound then that could probably break through [...] I don't know whether that's may be more delayed [...] so is a wound infection diagnosed or picked up earlier with a dressing simply because there isn't say a sealant on the skin as there is with a glue (Registrar, General surgery, Phase A)

Box 3 – Quotes from participants

Quote 12

Because your wound when it's new is very sensitive so if it brushes against something then in theory it might protect it. And some of our wounds are very big, particularly in my speciality, we're talking about things all across the abdomen, so our patients' pain issues are very important (General surgery registrar, Phase A)

Quote 13

When I'm sat up the wound is kind of tucked under because of my belly so big the wound actually pushes against my legs hmm so when I stand up I can feel the hmm the wound and when I'm hot as well peeling away from my legs. If I didn't have a dressing on it I think, I think the stitches would like stick to my leg and it would hurt a lot more (Obstetric patient, Phase A)

Quote 14

I mean that's just my bias view but you know when you do a ward round and you take the dressing off to have a look at the wound for example they are always very anxious about having the wound exposed and they're you know very keen for the wound to be dressed and covered up quite quickly (General surgeon, Phase A)

Quote 15

Maybe if I did not have a dressing [...] maybe I would have been a little more, I would say a little more careful and more concerned about how I did things around my daily chores, like having a shower or going to the toilet and stuff like that (Patient, Phase A)

Quote 16

I think it dried quicker [...] because the air was going to it [...] it healed quicker (Patient, no dressing, Phase B)

Quote 17

If we have got things like oozing or redness or something that doesn't look quite right, we are spotting it earlier (Nurse, general surgery, Phase B)

Quote 18

I'm just making sure I be careful at night time and [...] I'm making sure I'm wearing sort of tops and um so I don't knock it or rub myself or when I roll I don't pull (Patient, no dressing, Phase B)

Quote 19

Well that's where, that sort of having the baby stomach is actually a bit of help in that as well because then it just tends to keep everything away from... [clothes] (Obstetric patient, no dressing, Phase B)

Quote 20

Um... to be honest, it didn't really bother me, um, it didn't affect me in any way being able to see it [my wound] (Patient, no dressing, Phase B)
I've been quite pleased with it actually, it's, it's quite neat (Patient, glue-as-a-dressing, Phase B)

Quote 21

It gave me a bit of confidence because the more I can see the more then I feel I'm in control and therefore I know what's going on with my body (Patient, glue-as-a-dressing, Phase B)

Quote 22

It was completely straightforward you know. I got home from hospital on... So I got there in the evening, the following day I had a shower and you know my wounds were absolutely fine, I had not, not an ounce of [...] bother or trouble (Patient, no dressing, Phase B)



