# PEER REVIEW HISTORY

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## ARTICLE DETAILS

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| **TITLE (PROVISIONAL)** | Protocol for a participatory study for developing qualitative instruments measuring the quality of long-term care relationships |
| **AUTHORS** | Scheffelaar, Aukelien; Hendriks, Michelle; Bos, Nanne; Luijkx, Katrien; van Dulmen, Sandra |

## VERSION 1 – REVIEW

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| **REVIEWER** | Heather Davila<br>University of Minnesota, USA |
| **REVIEW RETURNED** | 15-Apr-2018 |

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| **GENERAL COMMENTS** | This an important topic. The researchers have designed an innovative research approach for addressing an existing gap and are using a participatory approach in order to ensure the values and perspectives of LTC consumers/clients are represented. I have several recommendations to strengthen this paper:<br>● The link between Aims A and B could be more clearly stated throughout the paper. (The purpose of interviewing clients/conducting focus groups with professionals is to understand the factors that influence the quality of the care relationship in LTC. Then, existing qualitative instruments are reviewed to examine the extent to which these factors are covered in the instruments?)<br>● Setting (lines 113-120, page 5). This section is confusing as written, second sentence in particular.<br>● Are there any concerns about involving client-researchers in interviewing their peers? The issues clients may discuss during these interviews could be very personal. Trust and the absolute assurance of confidentiality seem critical. Involving client-researchers in other aspects of the study makes sense. Similarly, although client-researchers could be great champions for the study, should they be the ones who recruit other clients to participate? (I assume the researcher(s) perform informed consent.)<br>● Recruiting 3-4 client-researchers per organization. Given the length of the study and characteristics of the client populations, you might consider recruiting an additional client-researcher per site in anticipation of some attrition over the course of the study.<br>● Section 2.3, Selection of up to six instruments (page 11) - similar as noted earlier, clarify link between previous interviews/focus groups and literature review/instrument evaluation<br>● Study limitations - discuss the potential issues related to involving client-researchers in recruiting and/or interviewing other clients. Also discuss likely attrition in client-researcher group.<br>Best wishes in your work. |

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| **REVIEWER** | Nabil Natafgi |

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| | The PATIENTS Program, University of Maryland, USA |
| **REVIEW RETURNED** | 17-Apr-2018 |

**GENERAL COMMENTS**

Overall, this paper present and interesting and important question with important practical implications on the quality of long-term care (LTC) provided in the Netherlands. The authors follow participatory approach for their proposed research, which adds a lot of value and meaningfulness to the questions they ask and the outcomes of the study, from the clients' (or patients'/residents') perspective. I believe it is important step that the authors are determined in sharing their protocol and binding to it, as this will help ensure the validity of the reported results as well as inform other researchers/funders/policymakers of ongoing research in this area. Though, this protocol probably should have been published earlier earlier as it seems the study phase started in 2016.

As a disclaimer, I am not very familiar with the LTC literature so I will not dwell on that. Also, I understand that part of the protocol outlined includes carrying systematic review and scoping reviews on the topic. Nonetheless, it would be nice to see more focused explanation of how is this research novel (i.e. how is it filling a gap in the literature). A note that I have noted a couple of articles that might be relevant to the topic addressed and not included in the reference list (e.g. van Soest-Poortvliet, Mirjam C., et al. "Measuring the quality of dying and quality of care when dying in long-term care settings: a qualitative content analysis of available instruments." Journal of pain and symptom management 42.6 (2011): 852-863; Bowers, Barbara J., Sarah Esmond, and Nora Jacobson. "The relationship between staffing and quality in long-term care facilities: Exploring the views of nurse aides." Journal of nursing care quality 14.4 (2000): 55-64; Murphy, Kathy. "A Qualitative study explaining nurses' perceptions of quality care for older people in long-term care settings in Ireland." Journal of Clinical Nursing 16.3 (2007): 477-485) .

In this review I will focus on the qualitative methodology and patient-centeredness (participatory) approach. Below are few remarks for authors' consideration:

Strength and limitation of this study:
1. Points 2 and 3 seems to be the flip sides of the coin. I think if you are following a "participatory" research approach, the main pillar is the client-researchers' authentic engagement in the research. This process as much as it depends on the client-researchers depends on the academic researchers to actively and authentically engage the client-researchers in the process in a meaningful manner.

Introduction
1. Very good and comprehensive overview of the significance of the topic being addressed and the methodological approach (participatory research).
2. On page 5 (lines 65 - 69) discussing the stages of client involvement: you are right that the clients can and should be involved in all stages of the research process, but the order was confusing to me. Clients should be involved from before the conception of the idea (e.g. identifying/prioritizing the questions and topics of interest) throughout the dissemination phase. in line 66 you seem to ague that the clients role start with data collection,

but then you seem to acknowledge their role in design and topic list.

Methods and analysis
1. Setting: you indicate that for the purposes of this research, you are focusing only on people with intellectual disabilities (for the third client group). Can you explain the rationale behind the exclusion of people with physical and audio-visual disability?
2. On page 6 (line 130), you indicate including care professionals who "see clients most often to...". Can you be more specific in how often they should be seeing clients to be included in the study?
3. I suggest adding exclusion criteria to Table 1 (e.g. informal caregivers, and other exclusion criteria if present).
4. can you clarify the LTC facility types currently in operation in Netherlands (if the focus of the paper is on Netherlands)? also clarify the differences in the functions in the different facilities. For example, is nursing home the same as residential elderly care and home care? how are they different from assisted living facility? from disabled care? etc...
5. Patients and public involvement - page 7 (line 153): client-researchers should be encouraged (as opposed to optionally help) to part of the dissemination process. Opportunities for involvement / partnership include partnering in academic dissemination (e.g. as coauthors, co-presenters at conferences) and non-academic dissemination (co-writing of lay summaries, co-presenting findings to LTC condescension and other policymakers, communicating the study findings back to LTC clients - those who particpated and those who did not).
6. Will client-researchers and clients be compensated? If so, how? If not, why not.
7. Five Phases - page 7 (line 167): the first research phase started in 2016, why publishing the protocol in 2018?
8. Supervisory committee: be specific on number of members, their representation, and their role. Also clarify the term client organization - what do you mean? are they advocacy groups for LTC residents? or are they the LTC facilities? This is very crucial. Do you plan to have clients that are not part of an organization? how are you planning to have representation of the 3 different client groups you mentioned earlier? do you plan to include representation of other community members or policymakers? how are you distributing the seats on the supervisory committee (i.e. how many seats for each of the groups)? (i understand you said you plan to have 3-4 client researchers from each client group - is that for the supervisory committee? - if so that means 12 members of client researchers in addition to other representations - then how would you address challenges with such a large committee?)
9. Preparation - how are the three care organizations selected? If convenient sample, discuss representatives and potential bias in selection (how different / similar are they from other organizations in the country).
10. Literature Study - Page 9 (line 210): you might want to consider Cochrane as database for systematic reviews. Also, to my understanding Medline is a subset of PubMed, so do you consider searching PubMed instead? Also are you involving a librarian in the systematic search strategy?
11. Literature Study - can you provide a little more details and specificity on the systematic review protocol you plan to follow, following PRISMA guidelines?
12. Why is systematic review limited to English while scoping review include English or Dutch?

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|  | 13. How are you going to address 'fear' factor or 'social desirability' particularly when you will have care organization representatives and client researchers from the same organization on the same supervisory board?<br>14. I think you might want to consider the numbers of participants, particularly in terms of saturation as you indicate.<br>15. Page 10 (line 255): you state that 25% of the interviews will be analyzed by two researchers. This is confusing. What happens to the remaining 75%? Or is this only for quality purposes and the remaining 75% will be analyzed by only 1 researcher? If so, are all interviews analyzed by the same single researcher? if not, how are you ensuring inter-researcher validity?<br>16. Dissemination: can you elaborate on how are you planning to develop the toolbox and training modules? involvement of clients, care professionals, and other stakeholders in the process?<br>17. Ethics: how will you ensure informed consent for particularly vulnerable group? also will you need (be able to) secure written consent from all participants? how are you ensuring anonymity (particularly in relation to my previous point on "fear" or "social desirability")?<br><br>Discussion and conclusion<br>1. Page 14 (line 360): I understand the rationale provided for exclusion of specific LTC groups, but i strongly believe that more efforts should exerted to include minority groups and undeserved populations even if that means more resources and efforts on the researcher part as well impracticality. But this is also at the core of patient-centered outcomes research (PCOR) efforts: inclusion "hard-to-reach" or minority groups, particularly people with physical disabilities.<br>2. I did not see enough attention given to limitations of the study protocol.<br>3. The conclusion section includes reference to new points never mentioned before in text (e.g. creation of LinkedIn group) - this should have been mentioned earlier and not appear first time in the conclusion. Also, is there any rationale for the use of LinkedIn as the (sole?) social media dissemination platform? |

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| **REVIEWER** | Vahe Kehyayan<br>University of Calgary in Qatar, Qatar |
| **REVIEW RETURNED** | 24-Apr-2018 |

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| **GENERAL COMMENTS** | **General Comments**<br><br>Thank you for the opportunity to review this manuscript on the quality of care relationships between long-term care (LTC) clients and care providers. The quality of care relationships for this population is very important because of their vulnerability arising from their dependence on care providers for their daily lives and care. The manuscript describes the steps involved in the proposed participatory research described in detail. However, I have identified several areas that require clarification. My comments are cross-referenced to the consecutive line numbers in the manuscript.<br><br>**Abstract: Strengths and Limitations** |

Lines 26 – 33: The abstract lists the study’s strengths and limitations. However, the manuscript does not list nor elaborates on these.

Line 32: the success of implementation. I wondered why not ask the care organisations at the outset if they would be interested in using optimised instruments. Adoption/implementation of a new instrument would have significant implications for the organisations; it would signify change with all of its ramifications, training, and cost. The manuscript does not address these potential concerns.

**Introduction**

The introduction explains the importance of care relationships and justifies the choice of qualitative instruments in LTC. However, it fails to define a care relationship. In line 41, the authors describe what constitutes “good”care relationship, but do not explain what “care relationship” is.

Lines 82 – 83: The authors do not explain the rationale for “the call for qualitative instruments in the Netherlands”.

Lines 84 – 87: What is the perspective of the care organisations, clients, and formal and informal care providers about the usefulness of existing qualitative instruments? A needs assessment would strengthen the proposed research and, of course, the manuscript.

**Aim**

Line 105: I assume the toolbox will contain several qualitative instruments for the use of professionals and clients. Have the authors considered the implications of the use of *several* instruments from the perspective of standardization, quality improvement, benchmarking across care organisations?

**Methods and analysis: Setting**

Lines 113 – 116: Lines 113-115 three target populations are specified. However, in lines 115 – 116, the authors state “for this research, we focus within the client group of people with a disability solely on clients with intellectual disabilities”. This is inconsistent with the statement in lines 113 – 116. Also, if the latter group of clients will be involved, how would informed consent be obtained?

**Setting**

This section could be better labelled as “Setting and Participants”.

Line 117: “One delivering care to one client group”. This sentence is not clear. Does this mean that each of the three care organisations serves only one client group? Also, how many centres or facilities do each of the organisations have or manage?

Line 119: what do “intramural and extramural care” mean? It is not clear if the three client groups are residents in the facilities or centres, or also reside at home and are receiving home care services from the care organisations.

Line 136: Table 1. It is not clear why the inclusion criteria for the respondents do not include: “able to generalise from their own experiences; able to hold a conversation without assistance of a close relative or friend; has a fairly stable health situation”.

It would be helpful if a description of the care organisations is provided. For example, size, number of facilities operated, number of employees, programs, profile of the populations they serve. Also, a description of the professionals working in each. Are they multidisciplinary teams? Which disciplines?

**Respondents**

Line 122: This subheading would be better if also included “client researchers” because Table 1 includes both groups of client participants.

As well, it would have been helpful if the authors explained or described in the text the two groups.

Lines 123 – 133: In these lines, inclusion and exclusion criteria are not clearly described. In the text, it would be helpful if the authors described these categorically. For example, describe all the inclusion criteria first and then the exclusion criteria. In lines 124 – 128, the authors describe the three populations. It would be better if these descriptions were moved to “setting”, which could be relabelled as “Settings and Participants”.

**Patients and public involvement**

Line 140: This heading is confusing. By patients do the authors mean the client researchers? What does “public” refer to? Otherwise, this section is well described about the role and responsibilities of client-researchers.

**Five phases of selection and development of a qualitative instrument**

Line 167: The timeframe for the project would need to be adjusted.

Line 168: As I understand from the description under “setting” there are three organisations. It is not clear what is meant by ““recruitment of care organisations”.

Line 168 & Line 203: The term “literature study” would be better if reworded as “literature review”.

**Preparation: inviting three care organisations**

Line 188: What if any one or all three care organisations refuse to participate or later withdraw from the study? Or any of their facilities?

Lines 194 – 195: Selection of the client-researchers. Their inclusion criteria are well outlined in Table 1. However, how will the clients be approached? Who will approach them?

Line 200: Training will be tuned to the needs of the client-researchers. But, I suggest, also their literacy.

Line 202: The term “capacities” implies mental capacity. Do the authors mean capabilities?

**Literature Review**

The literature review strategy specifies the databases to be searched. However, it does not specify the search terms or keywords used for the search. This is essential if other researchers will attempt to replicate the search.

Line 213: What is the rationale for not including Dutch articles in the first (A) studies as it is in the second and third studies? I was expecting that the scientific search should include Dutch language as well.

Lines 213 – 214, 224: The timeframe for the literature search, 2006 – 2016, is too wide. The literature prescribes timeframes for searches to be five years. As it is now 2018, I wonder why at the very least 2017 was not included.

Lines 215 – 219: Rating or evaluating the articles. How will the two researchers rate the retrieved articles? On what bases?

Line 226: Products of preparation phase. How about inclusion of care professionals. Would they not be active participants in the selection of the determinants?

Line 229: “A systematic review article on determinants…”. Should this state “systematic review of the literature”?

Line 230: How will the overview of existing qualitative instruments in LTC in the Netherlands be done? Would these be done on the basis of the determinants of quality of care relationships identified from the systematic search? Who will decide on determinants? How? These questions are answered to some extent in the “consultation” section, but it would be helpful if a reference was made to guide the reader.

Are the existing instruments in Dutch? How were they developed? How are they used? These last three questions could be addressed under the “Setting” section.

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| | It is not clear what the outcome of the literature review will be. Once determinants are identified from the retrieved articles, who will compile them and how? How would they be decided upon?<br>**Consultation**<br>Lines 233- 234: It is not clear how the determinants be verified? Who are the “clients”? Are these the “respondents”?<br>Line 235: How will the face-to-face interviews be conducted? Using a structured set of questions to guide the interviews?<br>Line 236: 8 – 10 clients. Are these from each organisation? Each facility within an organisation?<br>Lines 233 – 259: The consultation process description mixes the interviews with the clients and the focus groups involving the professionals. It would be better if the process for each group is described sequentially: clients first; then the professionals.<br>Lines 242 – 243: what would be the bases for professional selection? Inclusion criteria?<br>Line 245: Focus groups. How will they be conducted? Use of structured questions to guide the discussion?<br>For both client interviews and professionals’ focus groups, what is their purpose? To verify the determinants? How would these sessions be conducted?<br>Line 248: Informed consent. Please see my comment above about consent from clients with intellectual disabilities. Also, the other groups. How will determine clients’ “capacity” to give informed consent?<br>Line 255: What is the rationale for the 25% of the interviews to be analysed by two researchers? How about the rest? Is the 25% for reliability of the coding?<br>Line 259: who will transcribe the interviews and focus groups?<br>Line 262: Following the consultations, how would the determinants be decided upon?<br>**Selection of up to six instruments**<br>Lines 268 – 271. This sentence is not clear. Wouldn’t the choice of the instruments be based on the outcome of the interviews/focus groups and the decision on determinants to use? This is a critical step that requires elaboration. How about the care organisations? Would they have a say in the choice of instruments?<br>It is still not clear to me how these instruments will be used by care professionals and clients, and what purpose. To evaluate the care relationship? To guide the care relationship? |

**Evaluation of qualitative instruments**

Line 281: It is not clear how the instruments will be tested with the clients. This requires elaboration. And what would the results of the testing be used for?

Lines 290 - 291: Is it conceivable that each care group may need a specific instrument tailored to their needs/profile or purpose of use?

Line 299: is the number “32 clients” correct?

Line 301: would the recruited clients be required to provide informed consent? Please see above my comments about capacity to consent.

**Dissemination**

This section discusses the toolbox development and implementation. But fails to discuss dissemination.

Line 320: What does health procurement mean? Monitoring for external accountability? Accountability to whom and for what purpose?

See lines 379 – 380 related to dissemination.

**Discussion**

Lines 365 – 367: Risks of implementation. Please see above my comment about needs assessment. I suggest that a needs assessment and prior engagement of the care organizations at the outset may minimize this risk.

**Conclusion**

Line 375: “Good care relationships have not been set up everywhere yet”. On what basis is this statement made?

**References**

Four references in the reference list are older than 2006. One, about Delphi Technique, is dated 1975. There is a newer, 2002 version of this book.

**Other Comments**

I was thinking about the term or concept of “care relationship”. And I wondered about a “caring relationship”. Interestingly I found a published study on “caring relationship”. Britt-Marie Wälivaara,* Stefan Sävenstedt, and Karin Axelsson. “Caring relationships in home-based nursing care – registered nurses’ experiences”, Open Nurs J., 2013. 7: 89 – 95.

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| | Another document, however, from Victoria, Australia speaks to care relationships. I wondered if these are the same or similar concepts. |

## VERSION 1 – AUTHOR RESPONSE

| **Comment reviewer 1** | **Response of the authors** |
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| This an important topic. The researchers have designed an innovative research approach for addressing an existing gap and are using a participatory approach in order to ensure the values and perspectives of LTC consumers/ clients are represented. | Thank you for this positive remark. |
| The link between Aims A and B could be more clearly stated throughout the paper. (The purpose of interviewing clients/conducting focus groups with professionals is to understand the factors that influence the quality of the care relationship in LTC. Then, existing qualitative instruments are reviewed to examine the extent to which these factors are covered in the instruments?) | We think this is a very good suggestion. Two new paragraphs are inserted in the manuscript under 2.4 ‘Evaluation of qualitative instruments’<br>*The purpose of the systematic review and consultation phase is to understand the determinants that influence the quality of the care relationship in long-term care. In the evaluation phase, the selected instruments will be reviewed to know whether they are useful for evaluating the quality of individual care relationships in long-term care (line numbers 308-311).*<br>And:<br>*A. **(If necessary) supplementing questions of selected instruments***<br>*The selected qualitative instruments might need some adaptions in order to be useful for the purpose of this study: to create insight in the experienced quality of the care relationship from a client perspective. Some instruments cover a broader focus on quality of life and quality of care. Therefore, the determinants of the care relationship quality coming forward in the consultation of clients and professionals and the systematic review, will be used to supplement the questions whenever the instrument does not cover all relevant determinants of the quality of care relationships yet. The instrument might also be adjusted to be suitable for client participation of client-researchers. For example, the instructions may be rewritten in easier words, and the training might be adapted to their literacy. Furthermore, the selected instruments will be adjusted to the specific client group if the instrument is normally used for another client-group (line numbers 312-322).*<br>An explanation is also inserted in the manuscript under ‘aim’:<br>*The purpose of the first research question is to understand the determinants that influence the* |

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| | *quality of the care relationship in long-term care. The second and third research question are aimed to evaluate qualitative instruments to know whether they are useful for evaluating the quality of individual care relationships in long-term care across client groups line numbers 106-109).* |
| Setting (lines 113-120, page 5). This section is confusing as written, second sentence in particular. | We adjusted the setting description:<br>*The study will take place in the Netherlands. In the Netherlands, long-term care consists of three client groups: physically or mentally frail older adults, people with mental health problems and people with an intellectual, physical or audio-visual disability. For this research, we focus within the last client group of people with a disability solely on clients with intellectual disabilities. Three Dutch care organisations will be invited to be involved in this multicentre study, each of the three care organisations serves care to one client group. To make sure that we can reach a diverse group of clients, we will select care organisations that provide care to a large client population with a diversity of recurring care needs and receiving both inpatient and outpatient care and that comprise multiple locations (line numbers 118-126).* |
| Are there any concerns about involving client-researchers in interviewing their peers? The issues clients may discuss during these interviews could be very personal. Trust and the absolute assurance of confidentiality seem critical. Involving client-researchers in other aspects of the study makes sense. Similarly, although client-researchers could be great champions for the study, should they be the ones who recruit other clients to participate? (I assume the researcher(s) perform informed consent.) | The concerns and risks are indeed very important to bear in mind in this study. The exact concerns will be identified in the scoping review to collect best practices of client participation in order to take these into account in the study.<br>The invitation process of clients will be carried out by client-researchers in cooperation with the researcher. The researcher is responsible that the inform consent form is signed. This was however not stated clearly in the manuscript yet, and changed.<br><br>*Clients who meet the inclusion criteria (see Table 1) will be approached by the client-researchers together with the researcher (line numbers 255-256).*<br>And:<br>*Clients will be asked to give informed consent prior to the start of the interview. In some instances the legal representatives of persons with intellectual disabilities will be asked for permission first. It is the responsibility of the researcher that the inform consent form is signed (line numbers 262-264).* |
| Recruiting 3-4 client-researchers per organization. Given the length of the study and characteristics of the client populations, you might consider recruiting an additional client-researcher per site in anticipation of some attrition over the course of the study. | This is indeed a matter of concern. After the consultation phase and selection of up to six instruments, we added a moment to evaluate the process so far with client-researchers and to ask them whether they want to continue. In the evaluation phase, the client-researchers who will continue will form a bigger team with some new client-researchers. In total, the research team in the evaluation phase will consist of six client-researchers and two researchers in each care organisation. The amount of client-researchers are depicted in figure 3 ‘Research respondents’. |

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| | In the paragraph ‘patient and public involvement’, two sentences were added:<br>*Client-researchers can always quit or call off participation during the research process. We also added a moment to evaluate the process so far with client-researchers and to ask them whether they want to continue (line numbers 178-181).* |
| Section 2.3, Selection of up to six instruments (page 11) - similar as noted earlier, clarify link between previous interviews/focus groups and literature review/instrument evaluation | A new paragraph is inserted in the manuscript under 2.4 ‘Evaluation of qualitative instruments’ to make this link clearer. |
| Study limitations - discuss the potential issues related to involving client-researchers in recruiting and/or interviewing other clients. Also discuss likely attrition in client-researcher group. | Study limitations concerning potential issues are already described in sentence 397-410 in the discussion.<br>*According to Roberts (2012), participatory research is more time-consuming than conventional research methods. It takes time to achieve the desired level of trust in a community, and extra time is also needed for the joint process for thinking about the research results. This extra time will be taken into account in the time schedule of this study. In order to create backing in the environment and thereby increase the probability of participation of clients, client-researchers, care organisations, client councils and client organisations are cooperating in this study [42]. Their willingness to join is an important prerequisite to perform this research. The study depends on the close cooperation of client-researchers, and it is therefore important to work together in an equal, respectful, attentive and open way [42, 43]. Lessons learned in previous participatory research will be used to prevent repetition of avoidable errors, such as tokenism, client-researchers facing difficult situations, experienced workload, and proto-professionalisation [44] [45]. A scoping review will be conducted for this purpose. In order to make the project practically feasible, we will exclude some specific groups in long-term care, such as people with physical or sensory disabilities or people receiving palliative care.* |
| **Comment reviewer 2** | **Response of the authors** |
| Overall, this paper presents an interesting and important question with important practical implications on the quality of long-term care (LTC) provided in the Netherlands. The authors follow participatory approach for their proposed research, which adds a lot of value and meaningfulness to the questions they ask and the outcomes of the study, from the clients' (or patients'/residents') perspective. I believe it is important step that the authors are determined in sharing their protocol and binding to it, as this will help ensure the validity of the reported results as well as inform other researchers/ funders/ policymakers of ongoing research in this area. | Thank you for this positive remark. |

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| Though, this protocol probably should have been published earlier as it seems the study phase started in 2016 | The research project has indeed already started. In the Netherlands, the financing system in research is structured in such a way that the protocol is written at the beginning of the grant, when the study itself starts as well. The article was first submitted elsewhere and rejected in a late stadium which caused a substantial delay. We hope that the protocol will be published on short-term. For this reason, we chose your journal BMJ Open, as it is famous for the rapid procedures of the publication process.<br>We did not make changes in the protocol paper on the basis of the performance of the study. To us, the advantage of publishing a study protocol is the availability of a basic description of the research process for academic readers. If changes occur during the study execution, we will describe these in relation to the recorded process in the protocol paper. |
| As a disclaimer, I am not very familiar with the LTC literature so I will not dwell on that. Also, I understand that part of the protocol outlined includes carrying systematic review and scoping reviews on the topic. Nonetheless, it would be nice to see more focused explanation of how is this research novel (i.e. how is it filling a gap in the literature). A note that I have noted a couple of articles that might be relevant to the topic addressed and not included in the reference list (e.g. van Soest-Poortvliet, Mirjam C., et al. "Measuring the quality of dying and quality of care when dying in long-term care settings: a qualitative content analysis of available instruments." Journal of pain and symptom management 42.6 (2011): 852-863; Bowers, Barbara J., Sarah Esmond, and Nora Jacobson. "The relationship between staffing and quality in long-term care facilities: Exploring the views of nurse aides." Journal of nursing care quality 14.4 (2000): 55-64; Murphy, Kathy. "A Qualitative study explaining nurses' perceptions of quality care for older people in long-term care settings in Ireland." Journal of Clinical Nursing 16.3 (2007): 477-485) . | Thank you very much for the literature suggestions. The systematic review did provide us many useful studies on the quality of care relationships in LTC. We did not aim to provide a complete picture in the study protocol, as the systematic review is an essential part of the preparation phase described in our research process.<br>Although the three references are of worth, they were not included in the systematic review. The first suggestion was excluded from the systematic review as it is focused on palliative care or end of life care. The second reference was outside the time scope of the study. The third was focused on quality of care broadly and not specific on care relationships between clients and professionals. |
| Strength and limitation of this study:<br>1. Points 2 and 3 seems to be the flip sides of the coin. I think if you are following a "participatory" research approach, the main pillar is the client-researchers' authentic engagement in the research. This process as much as it depends on the client-researchers depends on the academic researchers to actively and authentically engage the client-researchers in the process in a meaningful manner. | This is indeed both inherent to the involvement of client-researchers in research. In the paragraph 'Patient and public involvement' the following is written on this issue:<br>*Earlier studies show there are several barriers for participatory research [11] and sharing responsibilities is not always easy for researchers [33]. Studies underline the importance to start the research process really open and flexible to make true client participation, empowerment and a valuable collaboration process possible [11, 34]. The intensity and manner of participation will be agreed in a group meeting with the client-researchers of each client group. To ensure meaningful cooperation between client-* |

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| | *researchers and researchers, we will provide a training and introduction at the start of the research, create an safe working environment, and make basic agreements for our cooperation with the client-researchers at the start. During the research phases, we will discuss the conditions for cooperation of the research team regularly. Furthermore, we will communicate on a clear manner, tailored to the literacy and coping level of the client-researchers. Moreover, we will have a researcher available for questions continuously, and take availability of client-researchers into account when meetings will be planned (line numbers 166-177).* |
| Introduction<br>1. Very good and comprehensive overview of the significance of the topic being addressed and the methodological approach (participatory research).<br>2. On page 5 (lines 65 - 69) discussing the stages of client involvement: you are right that the clients can and should be involved in all stages of the research process, but the order was confusing to me. Clients should be involved from before the conception of the idea (e.g. identifying/prioritizing the questions and topics of interest) throughout the dissemination phase. in line 66 you seem to argue that the clients role start with data collection, but then you seem to acknowledge their role in design and topic list. | 1. Thank you for the compliment.<br>2. The large comprehensive project was submitted and approved by a Dutch research fund in 2015. Dutch client organizations contributed to this writing stage, as representatives of the client perspective.<br>In addition, the small micro-studies within the research project will be carried out from the start until the end by the three research teams. Client-researchers will be part of preparation activities such as drafting the topic list and writing the invitation and information letter for respondents.<br>To avoid confusion, we added 'preparation activities' line 66. In the paragraph on patient and public involvement, preparation activities are described more extensively:<br>*Client-researchers will be asked to be involved in preparation activities such as developing the design of the study and drafting the topic list for interviews and focus groups and selection of the qualitative instruments that will be tested (line numbers 158-161).* |
| Methods and analysis<br>1. Setting: you indicate that for the purposes of this research, you are focusing only on people with intellectual disabilities (for the third client group). Can you explain the rationale behind the exclusion of people with physical and audio-visual disability? | *1.* It would indeed be better when also clients with an audio-visual or physical disability would be involved as well. But this would make the target population too broad to include in this research within the limitations of budget and time. we therefore chose to focus on people with intellectual disabilities, as this is by far the largest group of clients with a disability receiving long-term care (based on the facts and numbers on the website of the Dutch branch organisation https://www.vgn.nl/feitenencijfers). |
| 2. On page 6 (line 130), you indicate including care professionals who "see clients most often to...". Can you be more specific in how often they should be seeing clients to be included in the study? | 2. We added some examples of the function types from participating care professionals, and the minimum amount of care clients receive:<br>*For instance, care aids, personal carers, and different types of nurses. Clients* |

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| | *receive care for at least once a week (line numbers 139-140).* |
| 3. I suggest adding exclusion criteria to Table 1 (e.g. informal caregivers, and other exclusion criteria if present). | 3. To us, describing the exclusion criteria in the table on top of the inclusion criteria are the flip side of the same coin and therefore not necessary. |
| 4. can you clarify the LTC facility types currently in operation in Netherlands (if the focus of the paper is on Netherlands)? also clarify the differences in the functions in the different facilities. For example, is nursing home the same as residential elderly care and home care? how are they different from assisted living facility? from disabled care? etc... | 4. Long-term care covers in the Netherlands nursing and care of the elderly and the disabled, and certain categories of mental health care. It includes care for people with chronic limitations resulting from permanent physical, intellectual or mental health conditions. However, each client group is part of a separate care structure and care organisation.<br>Nursing home is the same as residential elderly care or inpatient care, clients who live in a care facility. Home care is part of outpatient care, clients who live in their own house.<br>We refer to the more description in the manuscript:<br>*In the Netherlands, long-term care consists of three client groups: physically or mentally frail older adults, people with mental health problems and people with an intellectual, physical or audio-visual disability (line numbers 118-120).* |
| 5. Patients and public involvement - page 7 (line 153): client-researchers should be encouraged (as opposed to optionally help) to part of the dissemination process. Opportunities for involvement / partnership include partnering in academic dissemination (e.g. as coauthors, co-presenters at conferences) and non-academic dissemination (co-writing of lay summaries, co-presenting findings to LTC condescension and other policymakers, communicating the study findings back to LTC clients - those who particpated and those who did not). | 5. Thank you for the suggestions. We will take these into account, on top of the findings of the scoping review focused on client participation possibilities in research. The following sentence covers the involvement of client-researchers in the dissemination process:<br><br>*At the end of the research, client-researchers can optionally help in the dissemination phase of the research.* |
| 6. Will client-researchers and clients be compensated? If so, how? If not, why not. | 6. Client-researchers receive an allowance for their contribution, based on the maximum compensation allowed for volunteers in the Netherlands. The allowance depends on the invested amount of time. We added a sentence in the manuscript: *Client-researchers receive a small allowance for their contribution, depending on the invested amount of time*.<br>Clients or respondents will receive a small gift of approximately 10,- euros for participation in an interview. They will be able to choose one present out of three options. These options will be decided on by the client-researchers. |
| 7. Five Phases - page 7 (line 167): the first research phase started in 2016, why publishing the protocol in 2018? | 7. Please read our earlier answer to the question:<br><br>The research project has indeed already started. In the Netherlands, the financing system in research is structured in such a way that the protocol is |

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| | written at the beginning of the grant, when the study itself starts as well. The article was first submitted elsewhere and rejected in a late stadium which caused a substantial delay. We hope that the protocol will be published on short-term. For this reason, we chose your journal BMJ Open, as it is famous for the rapid procedures of the publication process.<br>We did not make changes in the protocol paper on the basis of the performance of the study. To us, the advantage of publishing a study protocol is the availability of a basic description of the research process for academic readers. If changes occur during the study execution, we will describe these in relation to the recorded process in the protocol paper. |
| 8. Supervisory committee: be specific on number of members, their representation, and their role. Also clarify the term client organization - what do you mean? are they advocacy groups for LTC residents? or are they the LTC facilities? This is very crucial. Do you plan to have clients that are not part of an organization? how are you planning to have representation of the 3 different client groups you mentioned earlier? do you plan to include representation of other community members or policymakers? how are you distributing the seats on the supervisory committee (i.e. how many seats for each of the groups)? (i understand you said you plan to have 3-4 client researchers from each client group - is that for the supervisory committee? - if so that means 12 members of client researchers in addition to other representations - then how would you address challenges with such a large committee?) | 8. We tried to create a good balance between different types and groups of stakeholders. We added some more information on this topic in the paragraph 'Supervisory committee'. *The stakeholders involved are representatives of care providers and branch organisations, client (council) organisations with a nationwide scope, contact persons of the involved care organisations, and health insurers.*<br>And: *The whole research team will be present at the meetings, including two professors.*<br>Client-researchers do not participate in the supervisory committee, and gather in work meetings of each research team. |
| 9. Preparation - how are the three care organizations selected? If convenient sample, discuss representatives and potential bias in selection (how different / similar are they from other organizations in the country). | *9.* We invited three large care organisations with a broad scope within the client group, providing both inpatient and outpatient care. It concerned a convenience sample of care organisations of which contacts already were made:<br>*Three Dutch care organisations are willing to be involved in this multicentre study, each of the three care organisations serves care to one client group. A convenience sample technique was used. To make sure that we can reach a diverse group of clients, we selected care organisations that provide care to a large client population with a diversity of recurring care needs and receiving both inpatient and outpatient care and that comprise multiple locations. The three care organisations provide care to more than 2000 clients, and have more than 2000 care employees (line numbers 121-127).* |
| 10. Literature Study - Page 9 (line 210): you might want to consider Cochrane as database | 10. We will only include empirical studies in the systematic review. Therefore, Cochrane was |

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| for systematic reviews. Also, to my understanding Medline is a subset of PubMed, so do you consider searching PubMed instead? Also are you involving a librarian in the systematic search strategy?<br>11. Literature Study - can you provide a little more details and specificity on the systematic review protocol you plan to follow, following PRISMA guidelines?<br>12. Why is systematic review limited to English while scoping review include English or Dutch? | not included in the search strategy. We searched only in Cochrane outside the systematic review. Indeed, Medline and PubMed do overlap very much. Since the account of Radboudumc will be used, we use Medline as this is the database they usually use and have access to. A librarian will be consulted by writing the search strategy. We added a sentence in the manuscript:<br>*When necessary, a librarian will be consulted during this process (line number 229).*<br>11. The specific terms and key words of the search strategy will be published in a table in the systematic review itself. Furthermore, we will use the Mixed Methods Assessment Tool [MMAT] for the quality assessment of included studies.<br>12. The second and third scoping reviews are focused on finding country-specific methods and good practices in- and outside the Netherlands in scientific and grey literature. The systematic review is aimed at gathering material on known determinants of the quality of care relationships in Western countries. The search strategy is based on English scientific databases to make cross-country replicability possible and relevant for Western countries worldwide. Besides that, scientific articles in the Netherlands are most likely to be published in English, as the country is small. |
| 13. How are you going to address 'fear' factor or 'social desirability' particularly when you will have care organization representatives and client researchers from the same organization on the same supervisory board? | 13. The supervisory committee does not include client researchers, but representatives of client (council) organisations with a nationwide scope. Client researchers are actively involved by the researcher in other ways, e.g. the work meetings. |
| 14. I think you might want to consider the numbers of participants, particularly in terms of saturation as you indicate. | 14. The minimum numbers of participants at each phase and client group are included in figure 3 research respondents. |
| 15. Page 10 (line 255): you state that 25% of the interviews will be analyzed by two researchers. This is confusing. What happens to the remaining 75%? Or is this only for quality purposes and the remaining 75% will be analyzed by only 1 researcher? If so, are all interviews analyzed by the same single researcher? if not, how are you ensuring inter-researcher validity? | 15. By carrying out a part of the observations double by two researchers, we try to decrease the researcher bias and to create one generic interpretation framework. This was recommended as a check for the inter-researcher reliability in the coding process (see: Catherine Pope, Sue Ziebland, Nicholas Mays (2000) Analysing qualitative data).<br>The remaining interviews will be observed by one of the researchers. |
| 16. Dissemination: can you elaborate on how are you planning to develop the toolbox and training modules? involvement of clients, care professionals, and other stakeholders in the process? | 16. We made some changes in the Dissemination paragraph in the manuscript according to a comment of reviewer 3, as we think it makes the text more clear (line numbers 354-370). |
| 17. Ethics: how will you ensure informed consent for particularly vulnerable group? also | 17. Informed consent will be asked in three ways: verbal, signing an informed consent paper |

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| will you need (be able to) secure written consent from all participants? how are you ensuring anonymity (particularly in relation to my previous point on "fear" or "social desirability")? | (adapted to the target group), and by adopting a process consent as described in line 251-253: “*In interviews we will adopt a ‘process consent’ approach, meaning that we constantly observe during the interview whether consent is still present by paying attention to verbal and nonverbal indications of reluctance or hesitation to participate (line numbers 264-267).”* When a client is not able to provide informed consent by himself, his legal representative will be asked to give informed consent:<br>*In some instances the legal representatives of persons with intellectual disabilities will be asked for permission first (line numbers 262-*263).<br>Furthermore, we will make basic agreements for our cooperation with the client-researchers at the start of the research, as is described in the manuscript. Reliability and privacy will be two of the core themes that will be discussed. |
| Discussion and conclusion<br>1. Page 14 (line 360): I understand the rationale provided for exclusion of specific LTC groups, but i strongly believe that more efforts should exerted to include minority groups and undeserved populations  even if that means more resources and  efforts on the researcher part as well impracticality. But this is also at the core of patient-centered outcomes research (PCOR) efforts: inclusion "hard-to-reach" or minority groups, particularly people with physical disabilities.<br>2. I did not see enough attention given to limitations of the study protocol.<br>3. The conclusion section includes reference to new points never mentioned before in text (e.g. creation of LinkedIn group) - this should have been mentioned earlier and not appear first time in the conclusion. Also, is there any rationale for the use of LinkedIn as the (sole?) social media dissemination platform? | 1. We agree with the reviewer. At the same time, every study has its limits somewhere. Within the chosen (broad) client groups, inclusion is an important theme for us, which we try to achieve by the involvement of client-researchers throughout the study. In the discussion there was written:<br>*In order to make the project practically feasible, we will exclude some specific groups in long-term care, such as people with physical or sensory disabilities or people receiving palliative care (line numbers 408-410).*<br>2. We added one limitation in the discussion of the manuscript:<br>*From a quantitative point of view, this study protocol might be interpreted as limited as some details are still left open. To make client participation meaningful, we feel it is not good to define every detail beforehand and make decisions during the process as well. Therefore, the global structure and decision moments of the research process are described while there is still space left open to fill in aspects later on. This is certainly not unusual in qualitative research (line numbers 420-424).*<br>3. The linkedin group is deleted in the conclusion. |
| **Comment reviewer 3** | **Response of the authors** |
| **General Comments**<br>Thank you for the opportunity to review this manuscript on the quality of care relationships between long-term care (LTC) clients and care providers. The quality of care relationships for this population is | Thank you for your detailed comments to improve the manuscript. |

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| very important because of their vulnerability arising from their dependence on care providers for their daily lives and care. The manuscript describes the steps involved in the proposed participatory research described in detail. However, I have identified several areas that require clarification. My comments are cross-referenced to the consecutive line numbers in the manuscript. | |
| **Abstract: Strengths and Limitations**<br>1. Lines 26 – 33: The abstract lists the study's strengths and limitations. However, the manuscript does not list nor elaborates on these.<br>2. Line 32: the success of implementation. I wondered why not ask the care organisations at the outset if they would be interested in using optimised instruments.<br>3. Adoption/implementation of a new instrument would have significant implications for the organisations; it would signify change with all of its ramifications, training, and cost. The manuscript does not address these potential concerns. | 1. The strengths and limitations are added to the discussion of the manuscript (line numbers 445-453).<br>2. A needs assessment was carried out by the governmental organisation 'Het Zorginstituut' before the research project grant came available. Therefore, it was not needed to do a needs assessment within the research project. Care organisations will be involved in choosing the instruments via a Delphi method, what is described more clearly now: *For the selection of instruments, the supervisory committee may be supplemented with other stakeholders, such as representatives of cooperating care organisations.*<br>3. A needs assessment of the Zorginstituut showed a need for 1 generic instrument in long-term care. This does indeed have the consequence that organizations have to make costs to implement a new instrument. In the selection of qualitative instruments in the Delphi study, stakeholders will be involved to create sufficient support for the final instrument. |
| **Introduction**<br>1. The introduction explains the importance of care relationships and justifies the choice of qualitative instruments in LTC. However, it fails to define a care relationship. In line 41, the authors describe what constitutes "good" care relationship, but do not explain what "care relationship" is.<br>2. Lines 82 – 83: The authors do not explain the rationale for "the call for qualitative instruments in the Netherlands".<br>3. Lines 84 – 87: What is the perspective of the care organisations, clients, and formal and informal care providers about the usefulness of existing qualitative instruments? A needs assessment would strengthen the proposed research and, of course, the manuscript. | 1. The definition of a care relationship will be defined on a later stadium, together with the client-researchers. In the protocol, we believe this description provides enough information.<br>*Client-researchers will be asked to be involved in preparation activities such as developing the design of the study, compose a definition of a high quality care relationship, and drafting the topic list for interviews and focus groups and selection of the qualitative instruments that will be tested (line numbers 158-161).*<br>2. The rationale is described in the previous paragraph of the introduction:<br>*Clients' experiences with the care relationship can be explored using qualitative instruments [16]. One advantage of qualitative research is that it aims to understand social phenomena in natural settings, giving due emphasis to the meanings, experiences and wishes of* |

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| | *people [17]. Qualitative procedures give clients freedom to respond, allowing direct expression of their own concerns rather than those of the researchers [18]. As a result, qualitative research can tackle aspects of complex behaviours, attitudes and interactions that are not amenable to quantitative research [17]. It has also been shown that care organisations can translate qualitative results more easily into improvement actions, as such results are capable of including the nuances and complexity of care practices [19, 20] (line numbers 70-78).*<br>3. Most important needs will be inventoried in the supervisory committee, whereafter all mentioned partners will be invited to take part in the Delphi study, aimed at selecting the most promising instruments to test in this research.<br>We added the sentence in paragraph 'Selection of up to six instruments': *The supervisory committee will have input in the formulation of criteria on which the qualitative instruments will be assessed and selected.*<br>Informal caregivers are not included in the study, see lines 142-143). |
| **Aim**<br>1. Line 105: I assume the toolbox will contain several qualitative instruments for the use of professionals and clients. Have the authors considered the implications of the use of *several* instruments from the perspective of standardization, quality improvement, benchmarking across care organisations? | 1. The reviewer raises an interesting topic, and implicitly seems to suggest that one generic instrument would be most desirable in regard to standardization and benchmarking implications. This is indeed the most desirable outcome of this research project. However, we do not know whether this is possible on account of possible differences and preferences between the three client-groups. As stated in lines 335-336). "I*n the case of equal suitability, instruments with generic elements are preferred over instruments that are solely applicable to one specific client group."* |
| **Methods and analysis: Setting**<br>**1.** Lines 113 – 116: Lines 113-115 three target populations are specified. However, in lines 115 – 116, the authors state "for this research, we focus within the client group of people with a disability solely on clients with intellectual disabilities". This is inconsistent with the statement in lines 113 – 116. Also, if the latter group of clients will be involved, how would informed consent be obtained? | *1.* This sentence is adjusted to: *For this research, we focus within the last client group of people with a disability solely on clients with intellectual disabilities (line numbers 120-122)*<br>Informed consent will be asked in three manners: verbal, signing an informed consent paper (adapted to the target group), and by adopting process consent as described in lines 264-267): "*In interviews we will adopt a 'process consent' approach, meaning that we constantly observe during the interview whether consent is still present by paying attention to verbal and nonverbal* |

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|  | *indications of reluctance or hesitation to participate."*<br>And: "*In some instances the legal representatives of persons with intellectual disabilities will be asked for permission first*. (line numbers 263-264)" |
| **Setting**<br>1. This section could be better labelled as "Setting and Participants".<br>2. Line 117: "One delivering care to one client group". This sentence is not clear. Does this mean that each of the three care organisations serves only one client group? Also, how many centres or facilities do each of the organisations have or manage?<br>3. Line 119: what do "intramural and extramural care" mean? It is not clear if the three client groups are residents in the facilities or centres, or also reside at home and are receiving home care services from the care organisations.<br>4. Line 136: Table 1. It is not clear why the inclusion criteria for the respondents do not include: "able to generalise from their own experiences; able to hold a conversation without assistance of a close relative or friend; has a fairly stable health situation".<br>5. It would be helpful if a description of the care organisations is provided. For example, size, number of facilities operated, number of employees, programs, profile of the populations they serve. Also, a description of the professionals working in each. Are they multidisciplinary teams? Which disciplines? | 1. Adjusted as suggested.<br>2. We changed line 117 in: *Three Dutch care organisations will be invited to be involved in this multicentre study, each of the three care organisations serves care to one client group.* The care organisations that are approached are large, and some information on is added to show the size: *The care organisations that provide care to more than 2000 clients, and have more than 2000 care employees. The care organisations provide care in both an inpatient and outpatient care setting*.<br>3. We changed the terminology of intramural and extramural in inpatient and outpatient throughout the text in the manuscript. With inpatient care we mean care provided to residents in the facilities or centres. With outpatient care we mean home care services.<br>4. Respondents only need to tell their experiences from their own perspective, may or may not have support in the interview from a close relative, and for 1 interview a fairly stable health situation is not necessarily needed, as this would narrow down the target group too much. A new sentence is added:<br>*Different inclusion criteria apply for clients as respondents and client-researchers, for the reason that participating client-researchers need to have more skills for participating actively. It is important to realise that the client-researchers may not be fully representative of the target group of respondents (line numbers 147-149).*<br>5. The care organisations that cooperate are large, and some information on is added to show the size: *To make sure that we can reach a diverse group of clients, we selected care organisations that provide care to a large client population with a diversity of recurring care needs and receiving both inpatient and outpatient care and that comprise multiple locations. The three care organisations provide care to more than 2000 clients, and have more than 2000 care employees (line numbers 123-127).* |
| **Respondents**<br>1. Line 122: This subheading would be better if also included "client researchers" because Table 1 | 1. We changed the heading to 'Setting and participants', the subheading was changed in 'respondents and client-researchers'. |

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| includes both groups of client participants.<br>2. As well, it would have been helpful if the authors explained or described in the text the two groups.<br>3. Lines 123 – 133: In these lines, inclusion and exclusion criteria are not clearly described. In the text, it would be helpful if the authors described these categorically. For example, describe all the inclusion criteria first and then the exclusion criteria. In lines 124 – 128, the authors describe the three populations. It would be better if these descriptions were moved to “setting”, which could be relabelled as “Settings and Participants”. | 2. We feel this would be a copy of information in the table 1. With regard to the word count, we made the decision to hold on to the original description here. We included some information on the differences between client-researchers and respondents:<br>*Different inclusion criteria apply for clients as respondents and client-researchers, for the reason that participating client-researchers need to have more skills for participating actively. It is important to realise that the client-researchers may not be fully representative of the target group of respondents (line numbers 147-149).*<br>3. We made some structure adaptations in order to describe the inclusion criteria at first, and thereafter exclusion criteria. |
| **Patients and public involvement**<br>1. Line 140: This heading is confusing. By patients do the authors mean the client researchers? What does “public” refer to? Otherwise, this section is well described about the role and responsibilities of clientresearchers. | 1. We agree with the reviewer that ‘client involvement would be a better heading. However, the exact formulation ‘patients and public involvement’ is obligatory for the journal BMJ open. |
| **Five phases of selection and development of a qualitative instrument**<br>1. Line 167: The timeframe for the project would need to be adjusted.<br>2. Line 168: As I understand from the description under “setting” there are three organisations. It is not clear what is meant by ““recruitment of care organisations”.<br>3. Line 168 & Line 203: The term “literature study” would be better if reworded as “literature review”. | 1. The research project has indeed already started. In the Netherlands, the financing system in research is structured in such a way that the protocol is written at the beginning of the grant, when the study itself starts as well. The article was first submitted elsewhere and rejected in a late stadium which caused a substantial delay. We hope that the protocol will be published on short-term. For this reason, we chose your journal BMJ Open, as it is famous for the rapid procedures of the publication process.<br>We did not make changes in the protocol paper on the basis of the performance of the study. To us, the advantage of publishing a study protocol is the availability of a basic description of the research process for academic readers. If changes occur during the study execution, we will describe these in relation to the recorded process in the protocol paper.<br>2. We removed the extra paragraph ‘Inviting three care organisations, as this overlapped with ‘setting’ and led to confusion for the reviewer.<br>Adjusted sentence under ‘setting’: ‘Three Dutch care organisations are willing to be involved in this multicentre study’ (line numbers 121-123).<br>3. Adjusted as suggested. |

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| **Preparation: inviting three care organisations**<br>1. Line 188: What if any one or all three care organisations refuse to participate or later withdraw from the study? Or any of their facilities?<br>2. Lines 194 – 195: Selection of the client-researchers. Their inclusion criteria are well outlined in Table 1. However, how will the clients be approached? Who will approach them?<br>3. Line 200: Training will be tuned to the needs of the client-researchers. But, I suggest, also their literacy.<br>4. Line 202: The term "capacities" implies mental capacity. Do the authors mean capabilities? | 1. If a care organisation refuses to participate, or withdraw later, we will invite another care organisation to become part of the research project.<br>We added this sentence in the text in the paragraph setting: *If a care organisation withdraws later, we will invite another care organisation to become part of the research project (line numbers 127-128).*<br>2. Client-researchers will be invited in a personal way by the researcher. The researcher will ask client councils and professionals if they know clients who would be interested to participate. One sentence is added in the text:<br>*The invitation of client-researchers starts on a small scale from a personal approach, in cooperation with members of client councils and care professionals. An individual acquaintance meeting is held with every client who shows interest to participate (line numbers 208-210).*<br>3. Adjusted as suggested.<br>4. We added capabilities to the sentence. By capacities, we do not only mean their mental capacity but also the amount of workload someone can bear. For example, one interview or meeting every week of a maximum of one and a half hour every meeting. |
| **Literature Review**<br>1. The literature review strategy specifies the databases to be searched. However, it does not specify the search terms or keywords used for the search. This is essential if other researchers will attempt to replicate the search.<br>2. Line 213: What is the rationale for not including Dutch articles in the first (A) studies as it is in the second and third studies? I was expecting that the scientific search should include Dutch language as well.<br>3. Lines 213 – 214, 224: The timeframe for the literature search, 2006 – 2016, is too wide. The literature prescribes timeframes for searches to be five years. As it is now 2018, I wonder why at the very least 2017 was not included.<br>4. Lines 215 – 219: Rating or evaluating the articles. How will the two researchers rate the retrieved articles? On what bases?<br>5. Line 226: Products of preparation phase. How about inclusion of care professionals. Would they not be active participants in the selection of the determinants? | 1. The specific terms and key words will be published in a table in the systematic review itself.<br>2. The second and third scoping reviews are focused on finding country-specific methods and good practices in- and outside the Netherlands in scientific and grey literature. The systematic review is aimed at gathering material on known determinants of the quality of care relationships in Western countries. The search strategy is based on English scientific databases to make cross-country replicability possible and relevant for Western countries worldwide. Besides that, scientific articles in the Netherlands are most likely to be published in English, as the country is small.<br>3. We did not know a specific time span of five years is usual. As there was no systematic review carried out on this particular topic, we want to cover a time frame as broad as possible. The search will therefore be carried out in the end of 2016 over de last ten years.<br>4. This will indeed be described more detailed in the systematic review article.<br>5. Clients and care professionals are respondents, and have therefore a less active role in this research project. |

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| 6. Line 229: “A systematic review article on determinants…”. Should this state “systematic review of the literature”?<br>7. Line 230: How will the overview of existing qualitative instruments in LTC in the Netherlands be done? Would these be done on the basis of the determinants of quality of care relationships identified from the systematic search? Who will decide on determinants? How? These questions are answered to some extent in the “consultation” section, but it would be helpful if a reference was made to guide the reader.<br>8. Are the existing instruments in Dutch? How were they developed? How are they used? These last three questions could be addressed under the “Setting” section.<br>9. It is not clear what the outcome of the literature review will be. Once determinants are identified from the retrieved articles, who will compile them and how? How would they be decided upon? | Therefore, we believe that client and care professionals can be submerged under ‘cooperation with the 3 care organisations’.<br>6. Adjusted as suggested.<br>7. Based on a comment of reviewer 2, we added one paragraph in the manuscript on the link between the consultation and evaluation phase (see A. (if necessary) supplementing questions of selected instruments). We think this paragraph also makes the study more clear on this aspect (line numbers 312-323).<br>8. And 9. : Please see the previous answer. |
| **Consultation**<br>1. Lines 233- 234: It is not clear how the determinants be verified? Who are the “clients”? Are these the “respondents”?<br>2. Line 235: How will the face-to-face interviews be conducted? Using a structured set of questions to guide the interviews?<br>3. Line 236: 8 – 10 clients. Are these from each organisation? Each facility within an organisation?<br>4. Lines 233 – 259: The consultation process description mixes the interviews with the clients and the focus groups involving the professionals. It would be better if the process for each group is described sequentially: clients first; then the professionals.<br>5. Lines 242 – 243: what would be the bases for professional selection? Inclusion criteria?<br>6. Line 245: Focus groups. How will they be conducted? Use of structured questions to guide the discussion?<br>7. For both client interviews and professionals’ focus groups, what is their purpose? To verify the determinants? How would these sessions be conducted? | 1. Adjusted as suggested, *‘clients involved as respondents’* is added in the sentence’.<br>2. We added ‘in semi-structured interviews’ in the sentence. This means we will use a topic list, and ask more to a client depending on the answer of a client using variable follow up questions.<br>3. We added ‘8-10 clients *of each care organisation’ (line number 254).*<br>4. Adjusted as suggested.<br>5. This is described in more detail in the paragraph ‘respondents’.<br>6. We added the sentence: *A topic list will be made in advance to lead the group conversations in a semi-structured manner (line number 272-273)*.<br>7. This will be described in more detail in the scientific article focused on the findings later on.<br>8. Please read our earlier answer on this issue:<br>Informed consent will be asked in three manners: verbal, signing an informed consent paper (adapted to the target group), and by adopting process consent as described in line 251-253: “*In interviews we will adopt a ‘process consent’ approach, meaning that we constantly observe during the interview whether consent is still present by paying attention to verbal and nonverbal indications of* |

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| 8. Line 248: Informed consent. Please see my comment above about consent from clients with intellectual disabilities. Also, the other groups. How will determine clients’ “capacity” to give informed consent?<br>9. Line 255: What is the rationale for the 25% of the interviews to be analysed by two researchers? How about the rest? Is the 25% for reliability of the coding?<br>10. Line 259: who will transcribe the interviews and focus groups?<br>11. Line 262: Following the consultations, how would the determinants be decided upon? | *reluctance or hesitation to participate.” (line numbers 264-267)*<br>We also added the sentence*: It is the responsibility of the researcher that the inform consent form is signed (line number 263-264).* And: *‘ In some instances the legal representatives of persons with intellectual disabilities will be asked for permission first. (line numbers 262-263)’* This is standard procedure in the Netherlands when clients have a legal representative.<br>9. By carrying out part of the observations double by two researchers, we try to decrease the researcher bias and to create one generic interpretation framework. This was recommended as a way to check the inter-researcher reliability in the coding process (see: Catherine Pope, Sue Ziebland, Nicholas Mays (2000) Analysing qualitative data).<br>10. The interviews and focus groups will be transcribed by an independent transcription agency. This was also added in the manuscript: ‘*The focus groups and interviews will be audio-recorded, transcribed verbatim by an independent transcription agency and analysed in three phases: open coding, axial coding and selective coding. (line numbers 275-276)’*<br>11. Based on a comment of reviewer 2, we added one paragraph in the manuscript on the link between the consultation and evaluation phase (see A. (if necessary) supplementing questions of selected instruments). We think this paragraph also makes the study more clear on this aspect. |
| **Selection of up to six instruments**<br>1. Lines 268 – 271. This sentence is not clear. Wouldn’t the choice of the instruments be based on the outcome of the interviews/focus groups and the decision on determinants to use? This is a critical step that requires elaboration. How about the care organisations? Would they have a say in the choice of instruments?<br>2. It is still not clear to me how these instruments will be used by care professionals and clients, and what purpose. To evaluate the care relationship? To guide the care relationship? | 1. Based on a comment of reviewer 2, we added one paragraph in the manuscript on the link between the consultation and evaluation phase (see A. (if necessary) supplementing questions of selected instruments) (line numbers 312-322). We think this paragraph also makes the study more clear on this aspect. Moreover, a phrase is included ‘For the selection of instruments, the supervisory committee may be supplemented with other stakeholders, *such as representatives of cooperating care organisations.’*<br>2. Indeed, the qualitative instrument will be used by professionals and clients to evaluate the quality of a care relationship, and find areas for improvement. |
| **Evaluation of qualitative instruments** | 1. We hope the new structure of the paragraph 2.4 Evaluation of the qualitative |

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| 1. Line 281: It is not clear how the instruments will be tested with the clients. This requires elaboration. And what would the results of the testing be used for?<br>2. Lines 290 - 291: Is it conceivable that each care group may need a specific instrument tailored to their needs/profile or purpose of use?<br>3. Line 299: is the number “32 clients” correct?<br>4. Line 301: would the recruited clients be required to provide informed consent? Please see above my comments about capacity to consent. | instruments makes this more clear for the reviewer (line numbers 307-339).<br>2. As the reviewer suggests, it is indeed possible that one specific instrument for each client group may be needed and preferred above one generic instrument.<br>3. Yes, this number is correct: 10 (method A) + 10 (method B) + 6 (method C/D intersectorally tested) + 6 (method E/F) intersectorally tested) = at least 32 clients per care organisation. See also figure 3 Research respondents.<br>4. Informed consent will be asked in three ways: verbal, signing an informed consent paper (adapted to the target group), and by adopting process consent as described in line numbers 264-267: “*In interviews we will adopt a ‘process consent’ approach, meaning that we constantly observe during the interview whether consent is still present by paying attention to verbal and nonverbal indications of reluctance or hesitation to participate.”*<br>When a client is not able to provide informed consent by himself, his legal representative will be asked to give informed consent (line numbers 263-267). |
| **Dissemination**<br>1. This section discusses the toolbox development and implementation. But fails to discuss dissemination.<br>2. Line 320: What does health procurement mean? Monitoring for external accountability? Accountability to whom and for what purpose?<br>See lines 379 – 380 related to dissemination. | 1. We have added some more information about the dissemination of the research products:<br>*Moreover, we will look for opportunities to present the research findings and research products such as the toolbox to interested care organisations and client councils. The owner of the qualitative instrument will stay responsible for further implementation and dissemination. The National Health Care Institute might also play a role in the dissemination of the instrument (line number 368-370).*<br>2. The original sentence is changed to make this sentence more clear for international readers. Health procurement is usually done by health insurers in the Netherlands, and external accountability of care organisations is required to the National Health Care Institute, on issues such as quality measurement and improvement:<br>*We will also examine whether the results of the qualitative instruments can be used for other purposes, such as healthcare procurement of health insurances and monitoring for external accountability on quality measurement and improvement, primarily to the National Health Care Institute (In Dutch: Het Zorginstituut). Several meetings will be held with stakeholders, the research team and care organisations in order to disseminate and* |

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| | *discuss the results of the project and the implementation plan. Moreover, we will look for opportunities to present the research findings and research products such as the toolbox to interested care organisations and client councils. The owner of the qualitative instrument will stay responsible for further implementation and dissemination.* |
| **Discussion**<br>1. Lines 365 – 367: Risks of implementation. Please see above my comment about needs assessment. I suggest that a needs assessment and prior engagement of the care organizations at the outset may minimize this risk. | 1. Please see the earlier explanation on this issue, in response to the question written under the abstract section. |
| **Conclusion**<br>1. Line 375: “Good care relationships have not been set up everywhere yet”. On what basis is this statement made? | 1. A reference is added. |
| **References**<br>1. Four references in the reference list are older than 2006. One, about Delphi Technique, is dated 1975.<br>There is a newer, 2002 version of this book. | 1. We changed the reference to the newer version of this book. While we believe the other three references from before 2006 are well useable for the study protocol, the systematic and scoping reviews will be focused on recent literature. |

## VERSION 2 – REVIEW

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| **REVIEWER** | Heather Davila<br>University of Minnesota |
| **REVIEW RETURNED** | 11-Jul-2018 |

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| **GENERAL COMMENTS** | Thank you for addressing the detailed comments raised by the reviewers. I look forward to reading how your study turns out. |

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| **REVIEWER** | Nabil Natafgi<br>University of Maryland School of Pharmacy, Baltimore, United States |
| **REVIEW RETURNED** | 08-Jul-2018 |

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| **GENERAL COMMENTS** | Thank you for addressing the different comments and feedback. Overall, I think your changes strengthened the paper. Few additional suggestions based on authors' response:<br>1. Add a sentence to briefly describe your rationale for focusing only on intellectual disabilities (as per your response to Reviewer 2 Methods and Analysis comment 1). This can be added in the "Setting and Population" section. |

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| | 2. Reviewer 2 - Methods and analyses comment #5 (about client researchers involvement in dissemination): I am not sure this was adequately addressed in the revised version.<br>3. Reading the response to comments 5 and 8, particularly "client researcher do not participate in the supervisory committee" and their role as "volunteers" with "small allowance", makes me confused about their roles. My understanding was that as client-researchers they will be as active in the project as the academic researchers. And this what I gathered from the "Patient and public involvement" where you outline all the responsibilities of the client-researcher. Having said that, with your response to the comment 8, I am not sure how they are represented on the supervisory board (while the whole research team is present, including 2 professors) and also in terms of their compensation as "volunteers". While this may sound trivial, client researchers technically should be compensated in a manner similar to any other expert (e.g. biostatician or clinician) when invited to provide their expertise for the project. This is important to give positive signals to client researchers that they are held equal in terms of both benefits and responsibilities, especially the effort to "counteract the social distance between client and researchers" (as outlined in the manuscript).<br>4. Comment 15 (re analysis). I think I understand what you are aiming to do, but I still believe it is not clear to the reader. It seems that 25% (or a portion) of the interviews will be be analyzed by two researchers to reach consensus on coding and interpretation framework. And then, the remaining interviews will be analyzed by one of the researchers only. That is ok! But, what do you mean by "observed"? Do you mean analyzed? Also, you did not address the other aspect of the comment (is same researcher analyzing all the remaining interviews after a single interpretation framework is constructed by both researchers?) Maybe a little clarification in the revised version can help.<br>5. Reviewer 3 Literature Review comment 3. I think even if the literature review is ongoing, I think expanding the search to 2017 can and should be done as suggested by Reviewer 3 (especially if the results of the review will not be published before 2019).<br>6. Study Limitations: I see your comments (lines 397-410) more as challenges of conducting participatory research than limitations of your methodology. Limitations may relate to issues like generalizability of your findings or subjectivity inherent in qualitative research methodologies (quality of the data collected is dependent on the researchers' skills and observation as well as the participants' experiences).<br>7. The paper may benefit from some editing. For example, line 309: This evaluation consists of three parts.<br>8. The "Strength and Limitations" section appear twice (after abstract and towards the end). |

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| **REVIEWER** | Vahe Kehyayan, PhD<br>University of Calgary in Qatar, Doha, Qatar |
| **REVIEW RETURNED** | 27-Jun-2018 |

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| **GENERAL COMMENTS** | I have a few comments to the authors. |

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| | 1) thank you for addressing most of my comments in the first round and the responses you have prepared and used tracking for the revisions.<br>2) I am still not clear about the client groups. You describe three client groups, but you are interested in the group with intellectual disabilities (not physical or audio-visual). And you also say each of the three organizations serves only one client group. So, the organization you have selected must be providing care to the intellectual disability (ID) clients. Yet, throughout your paper you refer to three client groups. ID has a distinct definition and diagnostic criteria. It also has critical implications in the conduct of your proposed research, such as capacity, ability to give informed consent, capacity to use the instrument. If you mean involving the three groups, then clearly state that at the outset and avoid using the term ID. Please see my detailed comments in the paper.<br>3) It was not clear to me how the instrument will be used. I am not sure you have answered your fourth research question about "How can the most suitable qualitative instruments be used by the various user groups...". You must address this.<br>4) Language. I suggest that someone with a mastery of the English language review and edit the paper. Also, as this is a proposal, using the future tense where appropriate would be must suitable. In several sections, i edited the tense, but one must review the whole paper to make sure the appropriate tense is used.<br>Please review my comments/questions and suggested edits for your consideration. |

## VERSION 2 – AUTHOR RESPONSE

| **Reviewer 1** | **Response of the authors** |
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| Thank you for addressing the detailed comments raised by the reviewers. I look forward to reading how your study turns out. | Thank you for this positive remark. |
| **Reviewer 2** | |
| Thank you for addressing the different comments and feedback. Overall, I think your changes strengthened the paper. Few additional suggestions based on authors' response:<br>1. Add a sentence to briefly describe your rationale for focusing only on intellectual disabilities (as per your response to Reviewer 2 Methods and Analysis comment 1). This can be added in the "Setting and Population" section. | We added the sentence *'However, as regards the third group (people with a disability), we only aim to include clients with intellectual disabilities, as this is by far the largest group of clients with a disability receiving long-term care in the Netherlands'* (line numbers 119-121). |
| 2. Methods and analyses comment #5 (about client researchers involvement in dissemination): I am not sure this was adequately addressed in the revised version. | We added two sentences in the description of the dissemination phase:<br>*"Client-researchers will be asked to share their experiences by co-presenting at various platforms. In this way they will have an essential role in the implementation and application of the qualitative instruments."* (line numbers 372-374). |

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| | Furthermore, we added a sentence in the discussion focused on the importance of the client-researchers for the dissemination and implementation of the qualitative instruments:<br>*“Moreover, the willingness and enthusiasm of client-researchers to be involved in the performance of the instruments will be essential for the implementation and application of the qualitative instruments.”* (line numbers 421-423). |
| 3. Reading the response to comments 5 and 8, particularly "client researcher do not participate in the supervisory committee" and their role as "volunteers" with "small allowance", makes me confused about their roles. My understanding was that as client-researchers they will be as active in the project as the academic researchers. And this what I gathered from the "Patient and public involvement" where you outline all the responsibilities of the client-researcher. Having said that, with your response to the comment 8, I am not sure how they are represented on the supervisory board (while the whole research team is present, including 2 professors) and also in terms of their compensation as "volunteers". While this may sound trivial, client researchers technically should be compensated in a manner similar to any other expert (e.g. biostatician or clinician) when invited to provide their expertise for the project. This is important to give positive signals to client researchers that they are held equal in terms of both benefits and responsibilities, especially the effort to "counteract the social distance between client and researchers" (as outlined in the manuscript). | It is beyond dispute that the cooperation of client-researchers is expected to be very meaningful for this research project. We will explain the two points being questioned further.<br>Members of the supervisory committee are expected to speak for their own branch and stakeholder organisation on a nationwide level to create support for the research products. It mainly has a diplomatic content on completely different matters than the issues we ask client-researchers to contribute to. For example, we will ask the supervisory committee about the developments and requirements regarding quality measurement in their branches, and the implementation issues of the qualitative research method on the level of care organisations. The supervisory committee will include representatives of two client council organisations on national level. Client-researchers will be more closely involved in the research performance, and think along with more detailed issues in work meetings of their sub study. For example, which clients are receiving long-term care and which do not, the recruitment strategy of respondents, and the interpretation of research findings. The supervisory committee will not be involved in these issues.<br>As most client-researchers are disapproved from the labour market, they are receiving monthly payment from the Dutch government. The restrictions of such an income are a maximum allowance of other activities such as voluntary work. They are only allowed to receive a certain payment each year for their volunteering work, otherwise this money will be deducted from their benefit. We pay the maximum payment that is permitted. In that sense, their payment is as much as is possible. So we removed ‘small’ and adjusted the text to<br>*“Client-researchers will receive an allowance for their contribution, depending on the amount of time invested, and not exceeding the maximum payment allowed for those receiving a long-term care benefit.”* (line numbers 180-182).<br>Care professionals do not receive payment for their contribution to the research project, as |

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| | participation is part of their job at the care organisation in which they work. |
| 4. Comment 15 (re analysis). I think I understand what you are aiming to do, but I still believe it is not clear to the reader. It seems that 25% (or a portion) of the interviews will be be analyzed by two researchers to reach consensus on coding and interpretation framework. And then, the remaining interviews will be analyzed by one of the researchers only. That is ok! But, what do you mean by "observed"? Do you mean analyzed? Also, you did not address the other aspect of the comment (is same researcher analyzing all the remaining interviews after a single interpretation framework is constructed by both researchers?) Maybe a little clarification in the revised version can help. | We changed the word 'observed' by 'analysed'. We also clarified the sentence to<br>"*After the construction of the final coding tree, the remaining interviews will be analysed by the first author."* (line numbers 284-286). |
| 5. Reviewer 3 Literature Review comment 3. I think even if the literature review is ongoing, I think expanding the search to 2017 can and should be done as suggested by Reviewer 3 (especially if the results of the review will not be published before 2019). | We agree with the reviewer that the review will be outdated with the earlier described timeframe. We decided to extend the literature search to the timeframe 2006- august 2018. We changed this timeframe in the manuscript.<br>"*Eligible articles need to be written in English and published in the last twelve years (between 2006 and 2018) due to time constraints."* (line numbers 231-232). |
| 6. Study Limitations: I see your comments (lines 397-410) more as challenges of conducting participatory research than limitations of your methodology. Limitations may relate to issues like generalizability of your findings or subjectivity inherent in qualitative research methodologies (quality of the data collected is dependent on the researchers' skills and observation as well as the participants' experiences). | We added an elaboration on limitations focused on the methodology as suggested:<br>*"The qualitative and participatory research method was chosen to study the experiences of participants and interactions between respondents and client-researchers in natural settings. The research relies heavily on the observational and interviewing skills of researchers and client-researchers and reflectivity on 'our' perspectives on the findings. In qualitative research, studying the perspectives of multiple stakeholders and interpreting the results with different client-researchers and researchers is likely to result in an increased understanding of complex phenomena such as care relationships between clients and professionals. This will diminish possible limitations inherently attached to the qualitative research method [16] [43]. Also, this research takes place on a small scale in three care organisations focused on three client groups within their own contexts. The generalisability to other client groups in other care settings, such as clients with a severe intellectual disability or dementia, might be limited."* (line numbers 426-436) |

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| 7. The paper may benefit from some editing. For example, line 309: This evaluation consist<b><i>s</i></b> of three parts. | The original paper was already edited by a professional language editing service. As requested, the adjusted sections are also edited by an editing service. |
| 8. The "Strength and Limitations" section appear twice (after abstract and towards the end). | As suggested, we removed the second section. |
| **Comment reviewer 3** | |
| I have a few comments to the authors.<br>1) thank you for addressing most of my comments in the first round and the responses you have prepared and used tracking for the revisions. | We were in turn grateful for the good advice. |
| 2) I am still not clear about the client groups. You describe three client groups, but you are interested in the group with intellectual disabilities (not physical or audio-visual). And you also say each of the three organizations serves only one client group. So, the organization you have selected must be providing care to the intellectual disability (ID) clients. Yet, throughout your paper you refer to three client groups. ID has a distinct definition and diagnostic criteria. It also has critical implications in the conduct of your proposed research, such as capacity, ability to give informed consent, capacity to use the instrument. If you mean involving the three groups, then clearly state that at the outset and avoid using the term ID. Please see my detailed comments in the paper. | Clients with intellectual disability are one of the three client-groups which we refer to. The other two client-groups we focus on in this research, are mental health clients and physical or mentally frail elderly.<br>The paragraph is rephrased to make it clear in the manuscript as well:<br>*"In the Netherlands, long-term care is provided primarily to three client groups: 1) physically or mentally frail older adults, 2) people with mental health problems and 3) people with an intellectual, physical or sensory disability. Our study focuses on these three client groups. However, as regards the third group (people with a disability), we only aim to include clients with intellectual disabilities, as this is by far the largest group of clients with a disability receiving long-term care in the Netherlands. Three Dutch care organisations are willing to be involved in this multicentre study. Each of the three care organisations delivers care to one of the three client groups: one care organisation provides care to physically or mentally frail older adults, another care organisation provides mental health care, and the third organisation focuses on people with an intellectual disability.* (line numbers 116-125). |
| 3) It was not clear to me how the instrument will be used. I am not sure you have answered your fourth research question about "How can the most suitable qualitative instruments be used by the various user groups...". You must address this. | In the dissemination phase, the fourth research question is described, whether the qualitative instruments can be used for other purposes and users. We added some text to make this paragraph more clear.<br>*"The toolbox will also describe the levels at which the results of the instrument are expected to be useful, such as the individual care relationship, reflection at the team level, or at the organisational level of a care organisation.*<br>*We will also examine whether the results of the qualitative instruments can be used for other purposes, such as healthcare procurement by health insurers and monitoring for external accountability on quality measurement and improvement, primarily by the National Health* |

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| | *Care Institute. Several meetings will be held with stakeholders, the research team and care organisations in order to disseminate and discuss the results of the project and the implementation plan."* (line numbers 363-370).<br>Moreover, we would like to refer to the following phrase in the manuscript. This phrase refers to the main usage of the instrument:<br>*"If client-researchers in care organisations use one of the optimised instruments from the toolbox, it will provide useful information and feedback for clients and care professionals on the care relationship in long-term care."* (line numbers 415-417). |
| 4) Language. I suggest that someone with a mastery of the English language review and edit the paper. Also, as this is a proposal, using the future tense where appropriate would be must suitable. In several sections, i edited the tense, but one must review the whole paper to make sure the appropriate tense is used. | The original paper was already edited by a professional language editing service. As requested, the adjusted sections are also edited by an editing service. |

## VERSION 3 – REVIEW

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| **REVIEWER** | Nabil Natafgi<br>University of Maryland, Baltimore, Maryland, United States |
| **REVIEW RETURNED** | 12-Sep-2018 |

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| **GENERAL COMMENTS** | Thank you for addressing the comments raised by the reviewers. I have no additional comments. Looking forward for the actual study. |

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| **REVIEWER** | Dr. Vahe Kehyayan, PhD<br>University of Calgary in Qatar, Doha, Qatar |
| **REVIEW RETURNED** | 21-Sep-2018 |

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| **GENERAL COMMENTS** | **General Comment and Recommendation**<br>Thank you for the opportunity to re-review this manuscript for the 3rd time. The revised manuscript shows a substantial improvement over the previous two versions. I recommend accepting it for publication with minor revisions as outlined below. My comments are cross-referenced to the consecutive line numbers in the R2 manuscript.<br>Lines 241 and 249: change study to review to be consistent with line 241.<br>Line 248: change Cinahl to CINAHL<br>Line 259: change studies to reviews |

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| | Line 261: change 2016 to 2018 to be consistent with line 251<br>Line 345: change consist  to will consist<br>Line 346: Suggest deleting (If necessary). It is explained in the body of the paragraph<br>Line 346: I wonder if “items” is a better substitute to “questions. A qualitative instrument, specially a semi-structured one, may have statements (so items) rather than questions. Also, in Line 352.<br>Line 349: change have a broader … to may have …<br>Line 351: at the end of the line, change in to from<br>Line 364: We will use the same evaluation ..<br>Line 368: change from to for<br>Line 371: at the end of line, change are to will be<br>Line 410: change stay to remain<br>Line 411: change might to may. There are several instances of the use of “might”; better to change these to “may”<br>Line 414: insert “optimized” before qualitative instruments; delete “adjusted if necessary”. This would be consistent with line 434.<br>Line 415: delete the period, and instead use a comma and insert “and”.<br>Line 416: delete “is part of toolbox”.<br>Line 441:change backing to support<br>Line 453: I think “client-researchers” should be “clients”. Because the optimized instruments will be used by clients, not client-researchers.<br>Line 458: insert will before depends and change depends to depend<br>Line 475: change might to may<br>Line 476: insert design after quantitative<br>Line 476: change might to may<br>Line 486: insert clients, client-researchers<br>Line 491 – Line 492: change sentence to: Support for the set of qualitative instruments developed will be generated through …..<br>Line 497: change monitoring to “evaluation of” to be consistent with line 96 |

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| | Line 500: change could to may<br>Lines 503 to 511 (strengths and limitations): Why was this section deleted? I thought the strengths were nicely summarized. It also identified some challenges re adoption and implementation. It should also include some potential limitations. I strongly recommend to re-insert this section and also include some possible limitations. |

## VERSION 3 – AUTHOR RESPONSE

Dear editor,

Please find enclosed our revision of the manuscript “Protocol for a participatory study for developing qualitative methods measuring the quality of long-term care relationships”, by Aukelien Scheffelaar, Michelle Hendriks, Nanne Bos, Katrien Luijkx and Sandra van Dulmen.

We would like to thank the reviewers again for their comments, and their recommendation for publication. We changed the spelling and grammar of the manuscript as requested according to the suggestions of the reviewers.

Furthermore, we asked the editor’s opinion on the last comment of the third reviewer. Reviewer two and reviewer three proposed two opposite ideas in their comments in the previous revisions. Reviewer two stated that the "Strength and Limitations" section appeared twice (after the abstract and after the discussion) and suggested to remove the last “Strength and Limitations” section. However, this section was included according to the suggestion of the third reviewer in the first revision round. We agree with the second reviewer, that it is superfluous to let the same text return twice. The editor agreed that the Strengths and Limitations section should only appear after the abstract. The strengths and limitations are also discussed in the discussion of in the manuscript, so it is not needed to include this exact same section twice.

We hope the manuscript is suitable for publication, and we are looking forward to your coming response.