PEER REVIEW HISTORY

ARTICLE DETAILS

TITLE (PROVISIONAL)	Maximising comfort - how do patients describe the care that matters? A two-stage qualitative descriptive study to develop a quality improvement framework for comfort-related care in inpatient settings
AUTHORS	Wensley, Cynthia; Botti, Mari; McKillop, Ann; Merry, Alan

VERSION 1 – REVIEW

REVIEWER	Marit Leegaard Oslo Metropolitan University Faculty of Health Sciences Dept og Nursing and Health Promotion
REVIEW RETURNED	23-Aug-2019

GENERAL COMMENTS	1. The objective is described OK, but the title is to long - is it possible to only have Maximising Comfort - how do patients describe the care that matters? 2. Participants - you should add the accurate number (N=). Results and conclusion: more or less the same result as in your previous published synthesis, what is new here? 4. Methods - how many data coders coded the data? only one? How is this discussed in the paper (strength and limitations) 6 & 10. Outcomes and results. It is difficult for the reader to differentiate between study one and two - how did the framework describing end defining comfort-related care emerge from the interview data. The researchers need to present the findings in a more reader-friendly manner - Table 1-4 are to long. Findings (the framework) should be presented as main text With Focus on the main themes, using tables with transcribed text and codes and themes as illustrations of how the framework emerged

REVIEWER	Professor Anne M. Williams Murdoch University, Australia
REVIEW RETURNED	02-Oct-2019

GENERAL COMMENTS	This manuscript was a pleasure to read. Patient comfort has been researched and written about over many years, however, this study provides the clearest interpretation I have seen, taking into account context, patient condition, as well as cultural influence. The study also differentiates the definition of comfort from the process of comforting, which will assist the translation of this work. The two-stage design of this study strengthens the results. An initial synthesis of 62 international studies, followed by informed qualitative data collection exploring patients' perspectives of comfort in the acute care setting, has been described in detail and

	is in my opinion methodologically sound. The results of this research are clearly presented in the CALM framework and readily applicable and meaningful to all health disciplines. This research provides a solid foundation and clear directions for future work in this vitally important area of healthcare.

REVIEWER	Mary Carter University of Bath, UK
REVIEW RETURNED	29-Oct-2019

GENERAL COMMENTS	METHODS: More detail on the authors' approach to data saturation would be helpful. RESULTS: The authors have organised the large amount of qualitative data collected by presenting some of the findings in the main text of the article (definitions of 'comfort', summary of patient perspectives and the 'four senses of comfort') and more detailed information about the factors influencing patients' comfort in separate tables. Tables 1-4 were quite dense and difficult to read; the authors may consider presenting some of the tabular information - eg the operational definitions of each influence - as narrative text, which may improve clarity for the reader. (I understand that the authors may have been constrained by word count).

VERSION 1 – AUTHOR RESPONSE

Reviewer 1	
1. The objective is described OK, but the title is to long - is it possible to only have Maximising Comfort - how do patients describe the care that matters?	The title cannot be shortened as suggested because it would not meet the preferred format of the journal.
2. Participants - you should add the accurate number (N=).	Changes as follows: • The number of patient interviews has been added to the abstract. • Methods section: the description of the interview location was absent for two participants. This is corrected by increasing the number of participants interviewed in a quiet room to 13 (from 11).
Results and conclusion: more or less the same result as in your previous published synthesis, what is new here?	What is new? Differences in the two papers are described more clearly in the revised manuscript, as follows: • 'The two-stage approach enabled development (Stage one) and then refinement (Stage two) of themes and their operational definitions to capture the broad influences on comfort in one unifying framework, refer Strengths and limitations of this study, p1 • Focused patient inquiry led to a deeper, more nuanced understanding of the ten themes previously identified. All theme definitions and one theme name were refined accordingly, refer to Results, Factors influencing patients' comfort.

	• Clarified in the Article Summary, this manuscript reports on the first study that sets out to explore a cultural dimension of comfort via purposive sampling of culturally diverse patients. Note that the need to explore a cultural dimension of comfort was identified in the previous publication[1]. • Overall, the theme definitions presented in this manuscript are more accurate to (1) the care that matters to patients, (2) the integrated nature of that care, and (3) aspects of culturally responsive care that had not been previously identified. The theme related to family influences was also renamed to reflect important ethnocultural differences in the way family comfort. • Unfortunately, word count restrictions meant that detailed description of differences between stage one and stage two themes is not possible. However, readers may refer to the online thesis[2] for this analysis. Why we believe this manuscript is important to publish • Consistency of findings between stage one and stage two adds credibility to the CALM framework. Further, the manuscript reports on findings that are more certain and more accurate to patients' perspectives as a result of second stage patient inquiry. Therefore, theme definitions represent current knowledge on the definition of comfort and the ten influences identified. • Publication provides guidance for application of the framework as well as suggestions for ongoing research that may lead to further refinement of the CALM framework.
4. Methods - how many data coders coded the data? only one? How is this discussed in the paper (strength and limitations)	1. The original transcript stated, 'One researcher (CW) coded all data'. 2. How is the limitation of one coder addressed in the paper? Authors stated in the original manuscript that a limitation of this paper was not asking participants to comment on the findings. We recognise that doing so may have given some reassurance that data were coded in a way that was faithful and accurate to patients' perspectives. The underlying concern associated with one coder may be about whether the data coding process was accurate, reliable and potentially replicable; has correct analysis of the data occurred? Patient interview data were analysed using thematic analysis[3] and Framework method[4]. Testing for coder reliability between multiple coders is one method for thematic analysis, most recently described by Braun and Clarke[5]. However, we favoured an approach that Braun and Clarke[3, 5] suggest is more interpretive, which involves reaching agreement amongst the research team over how the data

	should be coded and interpreted as analysis progresses[5]. Detail of these steps have now been added, as follows:
	• Refer to Data Analysis:
	  ○ "coding decisions were discussed at regularly scheduled meetings (MB, AM, CW)"
	  ○ "Codes were developed using inductive and deductive analysis. Some were derived from the a priori theme definitions[1], other codes developed inductively from the data"
	• Refer Discussion section, strengths and limitations: "Peer debriefing by experienced qualitative researchers throughout all stages of the analysis"
	
	Aspects aiding interpretation not included in the manuscript because of word count were:
	• The coder taking care to ensure data were interpreted and coded in a way that represented patients' perspectives. Truthful interpretation of patients' perspectives was aided by listening to the recordings for patients' tone of voice and pace of responses (for example reflecting indecision) and reading notes jotted down in the transcripts related to non-verbal clues for meaning such as gestures and facial expressions.
	• Being careful not to extrapolate meaning or over-interpret patients' responses. All effort was made to code responses in relation to the context in which they applied to prevent distorted interpretation of ideas at a later stage of analysis[6, 7].
	• The coder frequently returned to the full interview transcript to check context. Areas of uncertainty were set aside for discussion.
	• Being open to the way patients perceived and experienced comfort. The coder's multidimensional perspective on comfort is now clear. However, at the time of analysis, some person-centred frameworks described comfort within a physical dimension only. Therefore, the coder was not fixed on the notion that comfort and the factors that influence it were indeed multidimensional.

6 & 10. Outcomes and results. It is difficult for the reader to differentiate between study one and two - how did the framework describing and defining comfort-related care emerge from the interview data.	The steps involved in analysing patient interview data have been clarified, refer Data Analysis section.
The researchers need to present the findings in a more reader-friendly manner - Table 1-4 are too long. Findings (the framework) should be presented as main text With Focus on the	Agreed. Expanded discussion of each of the themes is now provided in the results section. The reader is referred to Tables 1-4 (as originally submitted) for theme definitions, subthemes and illustrative quotes.

main themes, using tables with transcribed text and codes and themes as illustrations of how the framework emerged	
Reviewer 2	
This manuscript was a pleasure to read. Patient comfort has been researched and written about over many years, however, this study provides the clearest interpretation I have seen, taking into account context, patient condition, as well as cultural influence. The study also differentiates the definition of comfort from the process of comforting, which will assist the translation of this work. The two-stage design of this study strengthens the results. An initial synthesis of 62 international studies, followed by informed qualitative data collection exploring patients' perspectives of comfort in the acute care setting, has been described in detail and is in my opinion methodologically sound. The results of this research are clearly presented in the CALM framework and readily applicable and meaningful to all health disciplines. This research provides a solid foundation and clear directions for future work in this vitally important area of healthcare.	No changes
Reviewer 3	
METHODS: More detail on the authors' approach to data saturation would be helpful.	Detail has been added summarising our approach to data saturation, refer Strengths and limitations.
RESULTS: The authors have organised the large amount of qualitative data collected by presenting some of the findings in the main text of the article (definitions of 'comfort', summary of patient perspectives and the 'four senses of comfort') and more detailed information about	Agreed. We have partially followed this recommendation as much as word count will allow. The results section now has an expanded discussion of each of the themes, including the integrated nature of these themes. Agreed, the tables are difficult to read (also noted by reviewer 1). We were concerned about this when submitting. Tables now follow on from discussion of the results for each theme, which reduces the impact of the dense tables on the reader. We have decided against removing data from the tables as this

the factors influencing patients' comfort in separate tables. Tables 1-4 were quite dense and difficult to read; the authors may consider presenting some of the tabular information - eg the operational definitions of each influence - as narrative text, which may improve clarity for the reader. (I understand that the authors may have been constrained by word count).	would mean losing the detail for subthemes and verbatim quotes.

VERSION 2 – REVIEW

REVIEWER	Marit Leegaard Oslo Metropolitan University, Faculty of Health Sciences Norway
REVIEW RETURNED	02-Dec-2019

GENERAL COMMENTS	The authors have made the approriate imrovements of the manuscript - excellent work!

REVIEWER	Mary Carter University of Bath, UK
REVIEW RETURNED	05-Dec-2019

GENERAL COMMENTS	The authors have addressed most of my concerns in the revised document, but I have a few remaining comments: The approach to data saturation should appear in the Methods as well as the Strengths and Limitations section Table 1 should be signposted from the Results text It should be clear that Figure 1 is the CALM framework Each of the influences spread over Tables 1 - 4 should be numbered and the numbering should also appear in the narrative of the Results for clarity.

VERSION 2 – AUTHOR RESPONSE

Thank you very much for these suggestions and comments. The changes made in response to this feedback are as follows:

Reviewer 3.We agree with these points and have made the following changes:

• Approach to data saturation has been added to the Methods Section

• Table 1 is now signposted from the text

• Fig 1 title now refers to the CALM framework

• We clarified the links between each influence discussed in tables 1-4 and the narrative of the results by specifying table and theme description, for example, See Table 3, Symptom Management. We chose not to use continuous numbering as it became a bit confusing when discussing the number of themes in each separate layer, i.e. five themes in the staff layer seemed better discussed as theme one, two three etc not theme five, six, seven, etc

The full review history (both submissions) is described in a word document uploaded to the resubmission file.