PEER REVIEW HISTORY

ARTICLE DETAILS

TITLE (PROVISIONAL)	Hospital staff's, volunteers', and patients' perceptions of barriers and facilitators to communication following stroke in an acute and rehabilitation private hospital ward: A qualitative description study.
AUTHORS	D'Souza, Sarah; Godecke, Erin; Ciccone, Natalie; Hersh, Deborah; Janssen, Heidi; Armstrong, Elizabeth

VERSION 1 – REVIEW

REVIEWER	Claire Mitchell University of Manchester
REVIEW RETURNED	11-Nov-2020

GENERAL COMMENTS	Thanks for this interesting study on such an important and relevant topic. It was clearly written and well explained. I have a few minor points that you might want to consider to improve clarity and to be clear about the potential impact of these findings. Abstract: participants, why do you give a number for the patients recruited but not the staff? It looks as though you decided you would only recruit 7 and did this consecutively but I see that is not the case. It would be good if you could use the same information for both staff and patients. Abstract results: you talk about hospital, staff and patient barriers. It then looks odd when you talk about hospital, staff facilitators but don't mention patient facilitators here. Were there none? You should say whatever it was - none or otherwise. Main body of paper is clearly explained and easy to follow. It is clear how this smaller study fits into the wider, overarching study as well which is helpful. Figure 2 - it would be helpful if you could expand or explain what the 'individual patient factors' means. This is on the figure twice and it doesn't tell the reader very much, what does this mean? Discussion: I would have been interested to hear more about the predominance of single rooms and how this compares to public institutions. More information about this would be helpful for those thinking about how the results could be of use to those working outside of this private sector where there may be a greater emphasis on private rooms. There is discussion about the important role of the nurse, often a key link person in terms of communication between staff, patients, family etc as you mention. I thought you may discuss here why

	you had so few acute nurses as participants - what the restrictions were for them to get involved or what might be your thoughts on lack of involvement in this study. This seemed to be an important point that you didn't really address in terms of your study. In terms of making the findings accessible (where a patient, public involvement group could have helped) I thought you could have been clearer about the potential facilitators. Describe what could be done to make immediate practical changes and what could be considered when developing stroke rehabilitation facilities. Perhaps a final discussion paragraph pulling out the key barrier and facilitators would be a helpful addition for the reader. This could almost go in your conclusions where you repeat (probably unnecessarily) 'identification of factors...'. You could clearly say what key facilitators you found to improve communication making it very specific and less generic conclusions.

REVIEWER	Leslie B. Glickman, PT, PhD University of Maryland, School of Medicine, Department of Rehabilitation Science Baltimore, Maryland, US
REVIEW RETURNED	17-Nov-2020

GENERAL COMMENTS	Thank you for your important study that documented seemingly obvious shortcomings to existing rehabilitation settings. Revisions suggested: 1. Excessive narrative and repetition of patient responses to various questions. suggest one example to highlight the table. 2. Expand "limitations to research" to include use of patient perceptions. 3. What are areas for future research? Next steps? 4. Please use patient-first language. 5. What are the implications for these findings during the pandemic/ What has changed? What could change and with what consequence? Perhaps, this is a separate paper, but mention here is appropriate as a sign of the times!

REVIEWER	Pauline Boland University of Limerick, Rep of Ireland
REVIEW RETURNED	24-Nov-2020

GENERAL COMMENTS	Thank you for the opportunity to review this work. This is a timely study in an important area for those working in, and designing spaces for, rehabilitation for people after stroke. **Areas for review** Abstract - Conclusion is quite short and a little vague given the amount of findings presented – can some more definitive conclusion points be made? Similarly in actual conclusion of paper Introduction is relatively short and focused understandably on communication – could/would mood not also factor in terms of lack

	of stimulation? This is something that would strengthen the argument for this study (which is otherwise reasonably made). **Methods** Clearly reported and appropriate to address the research question If it is possible, a diagram showing layout of ward space would help with understanding and reduce some text on pg 9. Less than 21 days post stroke could mean many were potentially fatigued and/or communication difficulties were still emerging – was there a justification for this time period? ?Justification for aphasia and non-aphasia stroke patients and numbers of same? Member checking was reportedly carried out during interviews – while it is indeed best practice to check out understanding with participants, it is more typical that member checking of collated themes would/could take place after or while themes are being developed. This does not seem to have taken place – this is not necessarily a weakness as this would have been an arduous task, however the authors cannot really claim to have completed member checking in the most used sense of the term. Lincoln and Guba (1986) describe member checks as: *The process of continuous, informal testing of information by solidifying reactions of respondents to the investigator's reconstruction of what he or she has been told or otherwise found out* ***and to the constructions offered by other respondents or sources, and a terminal, formal testing of the final care report with a representative sample of stakeholders*****.** (p. 77) **Results** Figure 2 is clarifying in having a visual of the themes and the (not uncommon) aspect where a feature can be a barrier or an enabler – for example, individual patient factors. Themes are multiple and thinly described to some extent – less themes with perhaps greater interpretation across and between stakeholders could have led to a more cohesive and deeper reflection on the phenomenon of interest. However, as a basic qualitative description, this is adequate. *Theme Hospital environment does not encourage socialising* The narrative here refers to distraction and noise but then the quote refers to dark and lonely rooms – seems at odds with the text preceding it? *Theme Hospital policies restrict the development of communication-promoting ideas and initiatives*

	A 'for example' would be helpful here as otherwise this seems a bit vague and therefore difficult to make changes in relation to this sub-theme. Similarly with the sub-theme about available resources which patients do not access to aid communication – like what? Theme about staff's *perception* of time pressures – is there any way to validate this perception – it might be true! Was this ward more or less staffed appropriately for the client group there? The quote from a rehabilitation nurse that communication was someone else's job was quite powerful – it seems this is a cohort of nurses who do not see themselves as rehabilitating communication. ?Patient related facilitators missing in abstract **Discussion** Well constructed and clearly links existing literature to key findings of this study. Notable that fatigue and management of same (with scheduled and un-scheduled low stimulus breaks) was absent from discussion. Not essential that this goes in if it did not come up in the results section but is something I would have thought was a factor, particularly at the early stage post stroke the people with stroke were at in this study. Pg 23 - *helping mobilise wheelchair bound patients* – recommend 'wheelchair users' *Time limitations and pressures on the wards may be facilitated by developing staff knowledge of and skills in using communication promoting strategies*…and possibly advocating for greater nursing staffing for complex patients beyond mobility and medical needs, it seems? Otherwise the time limitation will remain – the communication promoting strategies mentioned will need to be super easy to learn and apply and be auditable. ?champions of communication within nursing tasks within nursing cohort? If these are the key demographic group for change to practice being targeted by the researchers, thinking about the realities of implementation of change is required here. Does their manager value this initiative? Will training be reflected in their CPD portfolio? How to maintain these skills with staff turnover? **Limitations** Large no. of AH will have undoubtedly contributed and may speak implicitly to 'whose job it is to communicate' which was brought up by nurses in this study.

	Private hospital setting and relatively homogeneous group linguistically and ethnically –cultural issues are unexplored in this work **Recommendations** The conclusion is abrupt and comes to what the authors are conducting anyway in the larger study (implementation of a CEE) – recommend 1 – 2 nuanced recommendations, taking into account the realities of culture and practice change in healthcare environments. **Appendix/supplementary information** COREQ checklist is mentioned in methods but does not seem to be included in appendices

VERSION 1 – AUTHOR RESPONSE

Reviewer: 1 Dr. Claire Mitchell, Manchester University Comments to the Author: Dear Author Thanks for this interesting study on such an important and relevant topic. It was clearly written and well explained. I have a few minor points that you might want to consider to improve clarity and to be clear about the potential impact of these findings.	
Abstract: participants, why do you give a number for the patients recruited but not the staff? It looks as though you decided you would only recruit 7 and did this consecutively but I see that is not the case. It would be good if you could use the same information for both staff and patients.	*Abstract changed to report staff and patients in the same manner (page 4).* Data collection was completed for acute and rehabilitation doctors, nurses, allied health staff and volunteers (n=51) and patients following stroke (n=7), including three with aphasia. Staff participants were purposively recruited. Patients were consecutively recruited.
Abstract results: you talk about hospital, staff and patient barriers. It then looks odd when you talk about hospital, staff facilitators but don't mention patient facilitators here. Were there none? You should say whatever it was - none or otherwise.	*There were no patient related facilitators to communication were reported. The first author reviewed the transcription data to ensure this was accurate. A sentence was added to the abstract to explicitly state this (page 4).*

	No patient related facilitators to communication were reported by staff, volunteers or patients. *Patient related facilitators in Figure 2. was removed.*
Main body of paper is clearly explained and easy to follow. It is clear how this smaller study fits into the wider, overarching study as well which is helpful	
Figure 2 - it would be helpful if you could expand or explain what the 'individual patient factors' means. This is on the figure twice and it doesn't tell the reader very much, what does this mean?	*Patient related facilitators in Figure 2. was removed.* *A definition of patient factors is provided in a short paragraph in the results under the title 'patient related factors' (page 22).* Patient related factors reflected their functional and medical status, personality, mood and motivation, which were perceived by staff and patients to often act as a barrier to engaging in communication interactions during their hospital admission early after stroke.
Discussion: I would have been interested to hear more about the predominance of single rooms and how this compares to public institutions. More information about this would be helpful for those thinking about how the results could be of use to those working outside of this private sector where there may be a greater emphasis on private rooms.	*Two sentences have been added to the discussion regarding the high proportion of single rooms on the ward which was likely the result of the study site being a private hospital, however there has been a perceived trend towards building new public hospitals with higher proportions of single rooms (page 25).* The acute and rehabilitation wards had a large proportion of single rooms, which could have been considered the

	result of this study being conducted at a private hospital. However, there has been a perceived trend towards increased proportions of single rooms in newly built public hospitals to promote infection control and patient privacy which may have a detrimental effect on communication. The predominance of single rooms and limited opportunities to access shared spaces may have increased the effect of other barriers on communication opportunities for patients.
There is discussion about the important role of the nurse, often a key link person in terms of communication between staff, patients, family etc as you mention. I thought you may discuss here why you had so few acute nurses as participants - what the restrictions were for them to get involved or what might be your thoughts on lack of involvement in this study. This seemed to be an important point that you didn't really address in terms of your study	*Two sentences have been added in the discussion to capture this (page 26).* It is interesting to note that this study recruited a limited number of acute nurses in comparison to rehabilitation nurses. This could be interpreted as a reflection of differences in nurses' capacity for additional activities within the demands and time restrictions of the acute and rehabilitation ward contexts.
In terms of making the findings accessible (where a patient, public involvement group could have helped) I thought you could have been clearer about the potential facilitators. Describe what could be done to make immediate practical changes and what could be considered when developing stroke rehabilitation facilities. Perhaps a final discussion paragraph pulling out the key barrier and facilitators would be a helpful addition for the reader. This could almost go in your conclusions where you repeat (probably unnecessarily) 'identification of factors...'. You could clearly say what key facilitators you found to improve communication making it very specific and less generic conclusions. Best wishes Claire Mitchell	*The conclusion has been updated to draw together recommendations of changes that could be made to promote patient communication in the hospital setting (page 28).* The barriers and facilitators to communication appear to be interconnected and likely to influence one another, suggesting that the level of communication access may vary from patient to patient within the same setting. Results of this study highlight a number of practical changes that could be implemented to promote communication opportunities for patients admitted to hospital early after stroke. However, implementation of

	behaviour and cultural change strategies may be pertinent to promote meaningful and sustainable change within the hospital setting. Consideration of areas for co-location for patients such as therapy spaces, dining areas or shared rooms as well as access to private spaces may potentially address the need for social opportunities with other patients as well as access to privacy when required. The promotion of visitors attending the wards may facilitate communication opportunities for patients between therapy times by providing socialisation in patients' rooms as well as facilitating and advocating for patient access to communal areas. This has the potential to mitigate the effect of social isolation in single rooms, staff time restraints and limitations as a result of patients' medical status. Strategies to promote patient autonomy in hospital may promote their ability to freely explore the environment beyond their room may help address the power imbalance that can occur between patients and hospital staff. Additionally, health staff and volunteer education in using communication promoting strategies may increase opportunities for interactions between patients, and staff or volunteers and promote communication exchange within those interactions. These factors will be explored in a Communication Enhanced Environment, which aims to increase patients' opportunities to engage in language activities during early stroke recovery in hospital.
Reviewer: 2 Dr. Leslie Glickman, University of Maryland Baltimore Comments to the Author: Thank you for your important study that documented seemingly obvious shortcomings to existing	

rehabilitation settings. Revisions suggested:	
Excessive narrative and repetition of patient responses to various questions. suggest one example to highlight the table.	*The authors are unsure of what this aspect of feedback refers to and would respectfully like to seek further clarification of this feedback. Does it relate to the sub-theme titles being a description of the theme? If so, we can collapse the sub-themes to only reflect the main themes such as 'hospital related facilitators to communication'.*
Expand "limitations to research" to include use of patient perceptions	*Study limitations expanded to include the use of participant perceptions within the limitations (page 5).* The results in this study reflect the perceptions of a small number of medical (n=2) and nursing staff (n= 11) compared to allied health staff (N= 32) which may be reflected in the results. This study involved exploring the perceptions a small number of stroke participants; a broader range of perspectives may have been expressed with a larger number of participants.
What are areas for future research? Next steps?	*The next steps in relation to this study has now been discussed in the conclusion (page 28).*
Please use patient-first language	*Stroke patient has been changed to patient or patient with and without aphasia.*
What are the implications for these findings during the pandemic/ What has changed? What could change and with what consequence? Perhaps, this is a separate paper, but mention here is appropriate as a sign of the times!	*This sub-study was completed in 2017 and the larger study was completed in 2019, therefore did not encounter or address issues related to communication opportunities impacted by COVID-19. It therefore does not appear appropriate to highlight issues surrounding COVID-19 that were not explored, or addressed in the development and implementation of the CEE model (publication under review).*

Miss Pauline Boland, University of Limerick	
Thank you for the opportunity to review this work. This is a timely study in an important area for those working in, and designing spaces for, rehabilitation for people after stroke. **Areas for review** Abstract - Conclusion is quite short and a little vague given the amount of findings presented – can some more definitive conclusion points be made? Similarly in actual conclusion of paper	*Changes made to abstract conclusions however this takes the word count for abstract to 339 words (page 4-5).* **(Abstract) Conclusions:** Barriers and facilitators to communication appeared to be interconnected and likely to influence one another. This suggests communication access may vary from between patients within the same setting. Results of this study highlight a number of practical changes that could be implemented to promote communication opportunities for patients admitted to hospital early after stroke such as providing areas for co-location as well as areas for privacy, the encouragement of visitors to facilitate communication, strategies to enhance patient autonomy, and access to communication trained health staff and volunteers. *Changes have been made to the main body conclusions (page 28).* **(Main body) Conclusions** The barriers and facilitators to communication appear to be interconnected and likely to influence one another, suggesting that the level of communication access may vary from patient to patient within the same setting. Results of this study highlight a number of practical changes that could be implemented to promote communication opportunities for patients admitted to hospital early after stroke. However, implementation of behaviour and cultural change strategies may be pertinent to promote meaningful and sustainable change within the hospital setting. Consideration of areas for co-location for patients such as therapy spaces,

	dining areas or shared rooms as well as access to private spaces may potentially address the need for social opportunities with other patients as well as access to privacy when required. The promotion of visitors attending the wards may facilitate communication opportunities for patients between therapy times by providing socialisation in patients' rooms as well as facilitating and advocating for patient access to communal areas. This has the potential to mitigate the effect of social isolation in single rooms, staff time restraints and limitations as a result of patients' medical status. Strategies to promote patient autonomy in hospital may promote their ability to freely explore the environment beyond their room may help address the power imbalance that can occur between patients and hospital staff. Additionally, health staff and volunteer education in using communication promoting strategies may increase opportunities for interactions between patients, and staff or volunteers and promote communication exchange within those interactions. These factors will be explored in a Communication Enhanced Environment, which aims to increase patients' opportunities to engage in language activities during early stroke recovery in hospital.
Introduction is relatively short and focused understandably on communication – could/would mood not also factor in terms of lack of stimulation? This is something that would strengthen the argument for this study (which is otherwise reasonably made).	*Introduction expanded to include the consequences of inactivity on boredom, and its effects. This provides a rationale to include patients without aphasia (page 6).* Patients with and without aphasia have described time outside therapy as "dead" and "wasted", reporting a lack of stimulation and inactivity in hospital impacting their ability to self-direct their rehabilitation outside of

	therapy. They report the experience of boredom is worse in the evenings and weekends when there are less structured activities. They also perceive that boredom negatively influences their mood, motivation, and contributes to their experience of post-stroke fatigue. Boredom is associated with a loss of autonomy and sense of control and contributes to patients becoming passive recipients of care, which may have negative implications for stroke recovery.
Methods Clearly reported and appropriate to address the research question	
If it is possible, a diagram showing layout of ward space would help with understanding and reduce some text on pg 9.	*This can be addressed with extra time however we were unable to complete this within the allocated timeframe to re-submit this manuscript. If this is required, we can provide this with additional time.*
Less than 21 days post stroke could mean many were potentially fatigued and/or communication difficulties were still emerging – was there a justification for this time period?	*A sentence has been added into the manuscript introduction to explain the rationale for selecting patients within 21 days stroke (page 6).* Aphasia research supports the theory that commencing aphasia rehabilitation in the early phase post-stroke (<1-month post-stroke) results in better outcomes than therapy commenced in the chronic phase (>6-months post stroke).
?Justification for aphasia and non-aphasia stroke patients and numbers of same?	*Introduction expanded to include implications of social isolation and communication inactivity for both patients with and without aphasia to provide rationale for including patients without aphasia (page 6).*

	Patients following stroke with and without aphasia have described time outside therapy as “dead” and “wasted”, reporting a lack of stimulation and inactivity in hospital impacting their ability to self-direct their rehabilitation outside of therapy. They report the experience of boredom is worse in the evenings and weekends when there are less structured activities. They also perceive that boredom negatively influences their mood, motivation, and contributes to their experience of post-stroke fatigue. Boredom is associated with a loss of autonomy and sense of control and contributes to patients becoming passive recipients of care, which may have negative implications for stroke recovery.
Results Figure 2 is clarifying in having a visual of the themes and the (not uncommon) aspect where a feature can be a barrier or an enabler – for example, individual patient factors.	
Member checking was reportedly carried out during interviews – while it is indeed best practice to check out understanding with participants, it is more typical that member checking of collated themes would/could take place after or while themes are being developed. This does not seem to have taken place – this is not necessarily a weakness as this would have been an arduous task, however the authors cannot really claim to have completed member checking in the most used sense of the term. Lincoln and Guba (1986) describe member checks as: *The process of continuous, informal testing of information by solidifying reactions of respondents to the investigator’s reconstruction of what he or she has been told or otherwise found out* ***and to the constructions offered by other respondents or sources, and a terminal, formal testing of the final care report with a representative sample of stakeholders*****.** (p. 77)	*Removed ‘member checking’ and instead described what occurred (page 11).* During the interviews and focus groups, clarifying questions and paraphrasing participant comments were used to confirm and clarify their perspectives and insights.

Themes are multiple and thinly described to some extent – less themes with perhaps greater interpretation across and between stakeholders could have led to a more cohesive and deeper reflection on the phenomenon of interest. However, as a basic qualitative description, this is adequate.	
Theme Hospital environment does not encourage socialising The narrative here refers to distraction and noise but then the quote refers to dark and lonely rooms – seems at odds with the text preceding it?	*This quote was removed during editing process which is now added back in the text to capture this description (page 19).* They [patients] can hear other people talking... there is [sic] a lot of voices going on which is going to impact on their understanding as well. (PT3)
Theme Hospital policies restrict the development of communication-promoting ideas and initiatives A 'for example' would be helpful here as otherwise this seems a bit vague and therefore difficult to make changes in relation to this sub-theme. Similarly with the sub-theme about available resources which patients do not access to aid communication – like what?	*Detail included regarding hospital policies that were identified by staff to act as a barrier to communication (page 19-20).* … This included policies regarding leaving patients unattended in dining areas without patient care assistants supervising them, and requiring nurses to supervise patients if they are eating; and reported limitations around food related activities as a result of food hygiene policies and occupational health and safety. *Staff were unsure about what resources were available to help them, therefore this has now been added to the description of the theme and a quote has been added to demonstrate this (page 21).* Staff described the lack of accessible resources as a factor negatively affecting staff-patient communication. They described the need for resources

	when communicating with patients with aphasia and other communication impairments but felt unsure about what these were or how to access them. They also described a number of resources that they felt patients were not aware of and therefore did not utilise such as volunteer services that promote communication opportunities and facilitate patient access to outdoor areas. > I feel like I don't know where else to go. I don't know if other things that [sic] could help us, maybe there's things out there that I don't know about that would help us communicate with these patients. (PT2) *An example of an undertulised resource available to patients has been included in the theme description (page 21).* They also described a number of resources that they felt patients were not aware of and therefore did not utilise such as volunteer services that promote communication opportunities and facilitate patient access to outdoor areas.
Theme about staff's *perception* of time pressures – is there any way to validate this perception – it might be true! Was this ward more or less staffed appropriately for the client group there?	*Unfortunately, we are unable to address whether or not the staffing levels were appropriate. However, we have changed the wording to reflect that this theme may be a reflection of time restraints, or staff perceptions of their available time. Page 20.* This may be the reflection of actual time pressures, or staff perceptions of their available time.

The quote from a rehabilitation nurse that communication was someone else's job was quite powerful – it seems this is a cohort of nurses who do not see themselves as rehabilitating communication.	
?Patient related facilitators missing in abstract	*Patient related facilitators were not discussed by participants therefore has been removed from Figure 2 and stated in the abstract (page 4).*
Discussion Well constructed and clearly links existing literature to key findings of this study.	
Notable that fatigue and management of same (with scheduled and un-scheduled low stimulus breaks) was absent from discussion. Not essential that this goes in if it did not come up in the results section but is something I would have thought was a factor, particularly at the early stage post stroke the people with stroke were at in this study.	*We have included a staff quote that identifies patients' fatigue as a barrier influencing their engagement in communication opportunities (page 23).* > They need a break after OT [the occupational therapist] has done a shower. If they don't get that break then the physio isn't going the be as good for them because they're so tired, so we also have to look at break times in between each sessions… (OTA1) *The concept of rest periods for management of fatigue has been added into the discussion (page 26).* The patient's functional status and levels of fatigue may also limit their ability to initiate and engage in activities while they are in their room. Therefore, the combined effect of these barriers may significantly limit this patient's communication opportunities. These communication barriers may be mitigated by having scheduled rest periods, and periods allocated to

	encouraging visitors to provide opportunities for communication and socialisation within their room, and facilitate patient access to shared spaces, such as helping mobilise wheelchair users into communal dining areas or education to patients that they are allowed to explore the hospital ward environment.
Pg 23 - *helping mobilise wheelchair bound patients* – recommend 'wheelchair users'	*Changed to 'wheelchair users' (page 26).*
Time limitations and pressures on the wards may be facilitated by developing staff knowledge of and skills in using communication promoting strategies…and possibly advocating for greater nursing staffing for complex patients beyond mobility and medical needs, it seems? Otherwise the time limitation will remain – the communication promoting strategies mentioned will need to be super easy to learn and apply and be auditable. ?champions of communication within nursing tasks within nursing cohort? If these are the key demographic group for change to practice being targeted by the researchers, thinking about the realities of implementation of change is required here. Does their manager value this initiative? Will training be reflected in their CPD portfolio? How to maintain these skills with staff turnover?	*A sentence has been added to the discussion regarding the argument for increased nursing staff levels for patients with communication impairments (page 27).* Additionally, time limitations reported by staff may lend to an argument for additional nursing allocation for patients with communication impairments. *Sentence added into the discussion to highlight the need for implementation and behaviour change strategies to promote the uptake of the CEE model and communication partner training. We have not included nurse champion here as this is something that was not addressed in the larger study and was a gap highlighted as a result (page 27).* Implementation strategies will need to be considered to promote behaviour change as well as the uptake and maintenance of training including involvement of management and ward champions, and ensuring trained communication strategies are easy to

	learn, apply and audit in order to be applicable in this busy context.
Limitations Large no. of AH will have undoubtedly contributed and may speak implicitly to 'whose job it is to communicate' which was brought up by nurses in this study. Private hospital setting and relatively homogeneous group linguistically and ethnically –cultural issues are unexplored in this work	*This has been added to the 'Study limitations' (page 5).* The results in this study reflect the perceptions of a small number of medical (n=2) and nursing staff (n= 11) compared to allied health staff (N= 32) which may be reflected in the results. This study was conducted at a private hospital involving a mixed acute and a mixed rehabilitation ward, and a relatively homogenous groups of participants linguistically and ethnically, therefore these results reflect this context and may not be directly generalisable to hospitals in the public sector, nor did they explore cultural factors contributing to communication.
Recommendations The conclusion is abrupt and comes to what the authors are conducting anyway in the larger study (implementation of a CEE) – recommend 1 – 2 nuanced recommendations, taking into account the realities of culture and practice change in healthcare environments.	The conclusion has been expanded to capture recommendations, as well as acknowledge that implementation and behaviour change strategies may facilitate these changes in the hospital environment.
Appendix/supplementary information COREQ checklist is mentioned in methods but does not seem to be included in appendices	*The COREQ checklist has been added into the Appendices (Appendix C.).*

VERSION 2 – REVIEW

REVIEWER	Claire Mitchell University of Manchester, UK
REVIEW RETURNED	08-Feb-2021

GENERAL COMMENTS	The changes you have made in response to the reviewers comments have improved this paper adding clarity. No further comments or suggestions.

REVIEWER	Leslie B. Glickman, PT, PhD University of Maryland, Department of Physical Therapy and Rehabilitation Medicine, Baltimore, Maryland, USA
REVIEW RETURNED	09-Feb-2021

GENERAL COMMENTS	Thank you for addressing prior concerns. In addition, please double-check and confirm the use of patient-first language when referring to the "patients" (with stroke) versus the "patients." Replicating this study with a larger sample would make the results more important. Double check that you have updated your review of literature with any new publications that you might of missed in the time period since initial drafting of the paper.

REVIEWER	Dr Pauline Boland University of Limerick, Rep of Ireland
REVIEW RETURNED	08-Feb-2021

GENERAL COMMENTS	Thank you for considering my review suggestions, they have been considered and addressed well and I with the author's well with this paper going forward

VERSION 2 – AUTHOR RESPONSE

Reviewer: 3
Miss Pauline Boland, University of Limerick
Comments to the Author:
Thank you for considering my review suggestions, they have been considered and addressed well and I with the author's well with this paper going forward

Reviewer: 1
Dr. Claire Mitchell, Manchester University
Comments to the Author:
The changes you have made in response to the reviewers comments have improved this paper adding clarity.
No further comments or suggestions.

Reviewer: 2
Dr. Leslie Glickman, University of Maryland Baltimore
Comments to the Author:
Thank you for addressing prior concerns. In addition, please double-check and confirm the use of patient-first language when referring to the "patients" (with stroke) versus the "patients." Replicating this study with a larger sample would make the results more important. Double check that you have updated your review of literature with any new publications that you might of missed in the time period since initial drafting of the paper.

To the Editorial Office,

Thank you for considering our paper for publication in BMJ Open. The authors would like to respectfully seek clarification regarding feedback from reviewer 2 below:

Please double-check and confirm the use of patient-first language when referring to the "patients" (with stroke) versus the "patients."

In the previously submitted paper we changed ‘stroke patients’ to “patients following stroke” and “patients” (example highlighted below).

Baseline phase: observe and quantify levels of engagement in language activity in the acute and rehabilitation ward environment for patients following stroke, and explore hospital staff, volunteers, and patients’ perceptions of barriers and facilitators to communication in hospital;
Implementation phase: develop and implement the CEE model on the acute and rehabilitation wards;
Post-implementation phase: assess the impact of the CEE mode on patient engagement in language activity, and hospital staff, volunteers and patients’ perceptions of barriers to communication in hospital.

Does the feedback received indicate these changes should be ‘patients (following stroke)’ or ‘(with stroke)’ every time we refer to 'patients'? If we are referring to those with and without aphasia should this be referred to as 'patients (after stroke) with and without aphasia'?

Thank you for clarifying,

Sarah

Sarah D'Souza
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Dear Miss D'Souza,

Many thanks for your email below, I apologize for the delay in getting back to you.
To answer your question, it is our impression that the reviewer is asking to double check that person-centered language is used throughout and that all instances have been changed from "stroke patients" to "patients with stroke" or similar - perhaps she's come across one or two instances where this was not done. We don't think that any other changes are necessary in this respect, and the examples you provided don't need further revision.

Please do address the reviewer's other points though, and the editorial requests.

Please do get in touch if you have further questions.

Best wishes,
Dafne Solera
Editorial Production Assistant
BMJ, BMA House, Tavistock Square, London WC1H 9JR
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As guided by the Dafne Solera's response above, we have reviewed all submitted documents to ensure that patient first language has been incorporated in all elements of this publication submission. The Appendices and Figures have now also been updated.

Additional references have been added to the manuscript to incorporate publications that occurred while this paper has been under review.