Article details: 2022-0238
Title: Providing palliative and end-of-life care in long-term care during the COVID-19 pandemic: a qualitative study of clinicians' experiences
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Reviewer 1: Dr. Sarina Isenberg
Institution: Bruyere Research Institute, University of Toronto
General comments (author response in bold)

The study uses qualitative interviews to explore the experiences of LTC physicians and nurses regarding providing palliative care during the COVID-19 pandemic. I have flagged several limitations in the paper. I believe my suggestions would help strengthen the quality of their paper.

Overall
1. Throughout, it is unclear if the focus of the manuscript is about providing palliative care in LTC during the pandemic to all residents, or about providing palliative care in LTC to residents with COVID during the pandemic. Please clarify.
Thank you, this was clarified in response to comments #1, #2, and #3

2. COREQ table
3. The COREQ table should contain the page numbers for where each of the items are mentioned
This is now revised, thank you (See appended COREQ Table)

4. Several components of the COREQ table are checked off; however, they are not contained in the manuscripts.
This is now revised, thank you (See COREQ Table appended)

5. The authors state that table 2 represents their coding tree however, typically a coding tree is different from the final themes presented.
Reference to coding tree has been removed . We believe that describing the themes and subthemes along with providing an organized table (Table 2) is sufficient.

Abstract
6. The way the results in the abstract are structured is a bit confusing. First the four sub-themes are mentioned, then the sentences from "clinicians faced…mitigated the impact" seem a bit jumbled. Suggest restructuring those quoted sentences so that they follow the order of the four themes.
Thank you, the Abstract (Results), page 2 section has been revised

Methods

7. Page 4, line 5: clarify that you are referring to the third wave in Ontario.
Line clarified and corrected to fourth wave (See Methods, Study Design and Setting, page 3)

8. How were field notes used in the analysis?

Observations made by the interviewer were documented in field notes such as emotional tone of voice or facial expressions. Please see also response to comment #1 above.

9. The authors make reference to coding. I suggest incorporating a description of how you ensured consistency in coding? Did you calculate intercoder reliability kappas? Did you use consensus coding? Double coding?
We had removed the reference to coding so as not to confuse a reader who is not familiar with qualitative methods and instead focused on describing the process of thematic analysis and how consensus was researched in our study Methods, Data Collection Procedures, page 4. We provided a reference (Reference 19) which further describes the steps involved in this common qualitative approach. Calculating intercoder reliability kappa's is used in quantitative research and not appropriate for this qualitative research.

10. The concept of investigator triangulation should be further explained and not just cited.
Investigator triangulation is now explained in more detail in the Methods Section, Data Analysis, page 4-5.

11. Approaches for ensuring rigor (bracketing, reflexivity, audit trails, periodic consensus meetings) should be explained in further detail
Reflexivity, consensus meetings, and investigator triangulation have been explained in the paper (Methods, Data Analysis, page 4-5) to support overall rigor of the study and validity of the results. We feel it is outside of the scope of this paper to provide elaborative descriptions of all qualitative approaches which are commonly used in qualitative research. Readers are encouraged to read up on these approaches in well established manuals and publications on qualitative research methods. Adding detailed description of these to this paper would add considerably to the word count. Please also consider that we don't typically ask quantitative researchers to explain methods such as t-tests and unpaired analyses for examples. We hope that qualitative research is held up to the same standards. (See also our response to comment #14)

12. Be more explicit about what approach to thematic analysis is being used. The authors cited Vaismoradi's paper. I suggest mentioning the approach more clearly.
Thematic analysis is now explained further. Please also refer to our responses above. (See Methods, Data Analysis, page 4-5 and Reference 19)

Results

13. Page 5, lines 3-4 talk about visitor restriction policies. Suggest moving these to the "isolation and impact of visitor restrictions" section
Revision made as suggested (See Results, Providing a Palliative Approach to Care, page 5)

14. Throughout the results, the authors seem to periodically lose sight of the focus on palliative care in LTC, and rather instead describe care in LTC during COVID. I suggest going through the results and ensuring the focus stays sharply on palliative care. For example page 8, lines 35-40 talk a lot about non-palliative-related issues during covid.

The one truly relevant aspect to COVID are the injectable PC medications and the oxygen tanks.
We have revised the Results to make the link more direct between the emerging themes and palliative care and made references to more quotes now. (See Results section page 5-8)

15. Last line of the results seems more like the authors' judgement rather than information from a participant.
Revision made (See Results, last paragraph, page 8)

Discussion

16. The discussion needs to engage more with the existing literature. The authors briefly acknowledge on page 7, line 43 that the findings were "reported in other studies"; however, they do not elaborate upon what was found in these other studies. Similarly on page 7, lines 48-51 "the ability of LTC…self-efficacy", the concept of psychological capital should be explained further. This is an interesting point to bring up and the authors should dedicate more space to it.
This was done to respect word count. Further elaboration has now been added. The data in this study is rich and reflect the strength of using a qualitative research method with open ended questions. This publication captures the overall themes and aims to summarize of the main results.

17. Page 8, lines 6-8, the authors acknowledge that several of the palliative care strategies identified in their paper have been discussed in past studies—in particular 7 past studies. This makes me wonder that if so many studies have already identified these strategies, what is the net new contribution of this submitted manuscript? Is it just that these findings are the same during the COVID era? What did the authors uniquely find out about PC in LTC during Covid that other PC LTC studies did not find?
Initially, when the study was designed and then undertaken, there was very little literature on the experience of clinicians in LTC specifically, related to the COVID-19 pandemic. This was one of the earliest studies. Subsequent to that, some studies emerged (although few related to the clinician experience or palliative care). We included these to do due diligence to the discussion. We still stand by our experience that this was a very early study, was justified, and adds to the literature.

18. The authors do not mention any other studies on PC in LTC during COVID and yet I suspect there are other studies out there on this topic
While there were and now are an increasing number of papers related to the impact of the COVID-19 pandemic on LTC, few specifically looked at palliative and EOL care and specifically at the clinicians' lived experiences. We believe that we do refer to those papers that do, at least up until the manuscript was completed and submitted for review. We are beginning to see some work now emerging in this area, but still limited and this paper we believe will add to addressing the gap.

Reviewer 2: Dr. Lara Khoury
Institution: The Ottawa Hospital
General comments (author response in bold)

1-This is an important research topic and I always enjoy learning more about the provider experience in LTC homes during the earlier days of the COVID pandemic. I also enjoy learning about lessons learned that will help us better care for our frail older patient population in the future, particularly when faced with an illness impacting large numbers of residents of these homes.
Thank you!

2- In the background section, you mention that a "A large majority of persons living in long-term care (LTC) homes have physical frailty and multiple co-morbidities". While that is absolutely true, it is also important to note the high prevalence of cognitive impairment/dementia, which significantly contributes to the degree of frailty and the overall poor outcomes.
Thank you for highlighting this. We have changed the term from physical frailty to various degrees of frailty to reflect the multifactorial causes of total frailty. (See Background, page 3, first paragraph.)

3- With regards to the characteristics of participants, I would like to know the geographic location of those who responded. The answers provided to the questions may have been impacted by many factors, based on where these long-term care homes are located. In reviewing the characteristics provided, it is not clear what region/setting (rural or urban) the providers work in, etc. Additionally, there was a low response rate to the survey, and those who responded to the survey were over the age of 50, suggesting that they had more experience working in LTC and in providing palliative and EOL care, which would have had an impact on their responses. I would like the authors to comment on this.
Please see above our responses to similar questions by the other reviewers.

4- I really appreciated the mention of the positive impact that existing palliative approach strategies in the home pre-pandemic (including routine ACP and GoC discussions) had on pandemic preparedness. This further highlights the importance of integrating palliative care early on into everyday practice in all long-term care homes. This will not only close the existing gaps in the care provided to residents living in long-term care homes (and increase quality person-centered care), but will also improve provider wellness, reduce burnout, and increase personal and professional fulfillment in the work they do.
Thank you for this comment. We completely agree and believe sharing our results will add new perspective and stronger evidence emerging directly from the lived experiences of clinicians during the COVID-19 crisis