Author's response to reviews

Title: The information and support needs of patients discharged after a short hospital stay for treatment of low-risk Community Acquired Pneumonia: implications for treatment without admission.

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Author's response to reviews: see over
Exploring the information and support needs of patients self-managing community acquired pneumonia at home

Dear Editorial Team,

Thank you for helpful feedback on this manuscript. We have now addressed the concerns raised by each of the reviewers. Please find below a point-by-point response to the specific comments.

We hope we have adequately addressed all of the points raised and look forward to hearing from you soon.

Sincerely

Deborah Baldie

Practice Development Nurse (NHS Tayside)/
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Information and support needs of patients self managing CAP at home
This paper addresses an important area. The methods are appropriate and the interpretation generally appears sound.
I did not detect any major problems with the paper, these comments describe minor essential changes and some discretionary suggestions to strengthen the paper.

Abstract – “Text for this section of the abstract” – this needs to be deleted
This has been removed.

The second issue in the conclusion of the abstract is confusing and does not reflect the data presented in the paper. Stating that low risk patients should receive oral therapy if admitted to hospital is not an appropriate conclusion to draw based on this data. The last sentence should be removed.
The concluding section of the abstract has been edited to avoid implying any recommendations about the route of administration of antibiotics.

The authors are ‘taking for granted’ that the patients had low risk CAP. We know that the initial diagnosis of CAP is often incorrect. More information should be provided about the inclusion and exclusion criteria used or this study. Who diagnosed the patient as having CAP. Were any particular criteria applied (eg did the researchers confirm that all patients had CXR infiltrates). What were the exclusion criteria – eg were immunosuppressed patients excluded from the study? What about patients with chronic suppurative lung diseases? Did you check that the patient had not recently been hospitalised to exclude nosocomial cases. Did you only consider patients who had been admitted for 3 days or less.

Did the inclusion criteria specify that all patients had a CURB65 score of 0 or 1 to be considered ‘low risk’. The authors seem to slip between CURB65 and CURB – which one was used. Was the PSI class of these patients known.
I presume you only recruited patients from Mon – Fri during working hours, this should be stated. [patients seen at weekends or overnight might get even less information than those you studied]

Did you exclude any patients requiring inpatient care for co-morbidities e.g. concurrent unstable diabetes or cardiac failure etc
We took care to ensure that the patients sampled did have a medically confirmed low-risk CAP. Our inclusion criteria are now explained more fully on page 5, and on page 6 we describe the
steps taken to ensure (as much as is possible) participants had a confirmed diagnosis of low-risk CAP. We did not specifically check that patients had not recently been in hospital, so there is a small possibility that some of the participants had a nosocomial infection. However, none of the patients’ recollections of events and description of “becoming ill” indicated that they had been in hospital previous to their admission for pneumonia therefore we feel confident that participants in the study had low-risk CAP.

The statement that CURB65 0 or 1 patients could be treated at home should be re-worded to say ‘some of’ or ‘many of’ these patients can be treated at home – We know that some these patients cannot be safely be treated at home. Severity scores are not perfect [we still see CURB65 0 or 1 patients going to ICU]. We have made the change and on page 3 it now reads “many of those categorised as being low-risk CAP (CURB 65 0 or 1) can be treated without admission to hospital…”

I think that the methods section should describe what you set out to do, and the results should say what actually happened. Therefore, the methods section should say that you recruited patients from the A&E or assessment units who had been admitted for 3 days or less – (I assume this was a cut off ). In the results you should then describe that none of the same day admission patients were recruited.

We have made the necessary changes to ensure that what we sought to achieve and did is described in the methods section and what we achieved in practice is described in the results section.

Results – age should be reported as median not mean

Change has been made

We need some data to demonstrate how well the recruited patients reflected your general patient population. I would like to know how many patients with CAP who stayed 3 days or less came through the department in the study period (to give some idea of how many declined participation). If possible, you should describe the median age and sex distribution of those not recruited so we can compare them to those recruited – how well does your sample reflect the population seen. We are unable to provide data that reflects the volume of patients who were seen and/or treated within the assessment units during the time of the study due to the limitations of hospital data. We have however reported the number of patients whom we identified as eligible to participate in the study, and have described the age and sex distribution for these.

Do you know how many were excluded based on non English speaking status - do these patients constitute a large proportion of patients seen at your hospital?

We only identified one individual who had limited English. This person was offered the
opportunity to take part but declined. We have stated in the Results section that no-one was excluded from the study on the grounds that they had insufficient English.

Rather than ‘most’ I’d like to know how many lived with their spouse.
This is now detailed.

I’d like more information on what you mean by pre-existing long term conditions – this is too vague. Do you mean chronic respiratory illnesses? Do you mean any medical problem – could you provide some examples e.g. diabetes, cardiac failure.
We have now provided details of the various long term conditions that participants reported having (page 8).

Do you know how many had previously had pneumonia
Narratives from patients did indicate that a small number had previously had pneumonia. We did not collect this information systematically therefore are unable to say with any degree of certainty how many had previous experience of pneumonia.

Do you know how many had ever been hospitalised before
Again, we did not collect this systematically therefore can state this with any degree of certainty.

You need to define GP and NHS24
These have now been defined.

We need more information about the setting – were these tertiary hospitals, teaching hospitals, public or private hospitals
Both were teaching hospitals. This has been made explicit in the first paragraph of sampling and recruitment section.

Could you explain whether in Scotland all patients usually have access to GPs – did these patients all have regular GPs
We have now indicated that all patients had regular GPs and that this is typical for Scotland.

Do you know what follow up was in place for these patients – did they leave hospital with a discharge letter for a GP. How many had outpatient appointments made at the hospital. Is it common practice to fax notification of A&E presentation and a discharge summary to GPs
Patients varied in terms of the follow up that was arranged for them and in relation to the contact that had been made between the hospital and their GP. However regardless of arrangements, common concerns were found amongst all patients so we have not attempted to explore potential differences.
Could you tell us how many actually saw a GP and how soon after discharge
We have now detailed on page 12 the number who contacted their GP (10/15).

Do you know how many required supplementary oxygen – clearly this does
determine whether home care is a practical possibility or not
A few patients did have supplementary oxygen in the A&E unit or in the admission unit, but
Specialist Registrars and Consultants differ in their beliefs about patients’ needs for oxygen,
and many who had received it in the initial hours of admission had it discontinued after having
been reviewed by senior medical personnel. It was therefore unclear whether those who had
been given oxygen did actually “need” it. In a number of cases senior medical staff
hypothesised that patients could have received oral antibiotics and been managed at home, but
were admitted by a junior member of the team who could be relatively unfamiliar with current
treatment pathways.

In general throughout the results I’d like more proportions provided if possible
e.g. 10/15 patients reported that…. Rather than ‘most’ or ‘some’
Because this qualitative study was designed primarily to investigate types of experience and
views that people had, and not the distribution of these types, we are wary of giving the false
impression of numeric certitude. We have, however, provided numbers to help characterise the
sample and to identify views that we can reasonably suggest are apparently widely held.

Could you clearly tell us how many had IV therapy and how many had oral
antibiotic therapy
This has now been noted on page 9.

In the section – ‘Information needs of patients’ the use of referencing is not
appropriate. Rather than use a numbered reference in the middle of a sentence,
the authors name could be used
eg: “Smith et al demonstrated that… [18]”
rather than
“[18] showed that….”
We have now made the necessary amendments to referencing.

In your figure, an important omission seems to be information about what
symptoms or signs should prompt representation to hospital. Patients initially
assessed as low risk can deteriorate, and patients need to know that new clinical
features might require re-assessment.
This figure summarises what patients told us were their concerns and information needs. We
have changed the figure title to reflect this more clearly.
Version: 1 Date: 15 April 2008
Reviewer: Dee Mangin
Reviewer's report:
This is an important area for study. Eliciting patients experiences, needs and views around increasing moves towards community treatment of a range of conditions is an important area, particularly in conditions that are perceived to be serious such as pneumonia. I have made some suggestions below that I hope will be helpful in improving the paper.

- Major Compulsory Revisions
1. The abstract background section is incomplete and the aim of the study needs including.
The abstract has been altered and now includes the aim of the study.

2. The biggest difficulty for the authors is that the group interviewed are not the ideal sample for the questions posed. All had spent 2-3 days in hospital prior to discharge home. This difficulty does not reflect a design fault, but simply the logistical difficulty of trying to recruit via an ED. It also does not mean the data is not a useful addition to the literature, but relating the conclusions and recommendations needs to be more clearly set in the context of the participants actually interviewed. This could take the form of a ‘lessons to be learned from patients experiences of early discharge with CAP: implications for treatment without admission’ approach. The lack of assessment of the views of location of care of those who had been assessed at hospital but went home directly from the hospital needs to be more explicitly acknowledged. It is difficult to elicit views of a particular pathway of care from those who have not experienced it. These interviews canvass views of post hospital care rather than outpatient care without admission. Might the information given on discharge from the ED different to that for patients leaving a ward for example?

In a RCT of home vs hospital treatment for CAP CURB Age score 0-2, we found that those who have experienced home care after having been assessed and then sent home directly from the ED have a greater preference for home care than those in hospital who have not experienced it. This was despite the use of IV antibiotics in both arms.


We were aware of the limitations of the sample but recognise that we may not have reflected
these sufficiently in the manuscript. We have therefore made it explicit both in the revised title and at various points in the paper that all the patients in our study had experienced a short stay in hospital (see particularly results pages 8,9, discussion p17 and 20).

We agree that it is difficult to elicit views from patients who have not experienced a particular pathway of care. In our discussion section we have now highlighted that patients’ stated preferences may have been influenced by other variables and we have cited the Richard et al (2005) study.

3. More detailed description of how the themes were canvassed as part of the semi-structured interview should be included.
We have now included a list of the topics covered in the interviews in the data collection section (page 7).

4. It would be usual to validate the analysis by checking the analysis of each transcript with the interviewee. If this was done it should be described.
Our understanding is that the appropriateness of this practice is disputed, and that there are arguments against as well as for it. We did not undertake to do this.

5. The scientific basis for the recommendation about avoiding IV therapy can be reinforced but should not be overstated on the basis of the data. While it is possible that IV therapy changed location of treatment preference, there might be other confounding reasons why these patients preferred hospital that are related to the reasons why IV Abs were given in the first place. There is a scientific basis for recommending oral antibiotics at the outset. The interpretation of this qualitative study can support or suggest but does not have predictive value.
Within the discussion and the abstract we have altered the recommendations to more closely reflect our findings. We acknowledge that preference can be influenced by a number of variables but further exploration into the experiences and concerns of patients who go home to self-manage without admission to hospital will help us better understand their information and support needs. Indeed it should help us understand if having IV antibiotics as first line treatment influences perceptions about safety, illness severity etc.

- Minor Essential Revisions

6. P12 “we think’ would read better as ‘it is possible that...’
We have changed this sentence to reflect your comment.

7. p17 it is not clear who ‘community staff’ are – is this the patients usual primary care team? P18 it is not clear who ‘practitioners’ are – is this medical practitioners, nurse practitioners primary and/or secondary care?
Both of these points have now been clarified in the text.

8. In the references to the literature there are a number of sentences that use reference numbers as part of the text. This is not standard and makes it harder to read (e.g. "[11] highlighted that a locally...") It would read more smoothly as ‘Smith and Harmon highlighted...’ or a US study in 2002 highlighted... ‘ or something similar.
The format of the relevant sentences and the reference citations have been corrected.

- Discretionary Revisions
9. The authors refer to the range of participant characteristics in their purposive sample but do not comment on similarities and differences with regard to these characteristics in the analysis and results. (Age sex, comorbid conditions including long term respiratory conditions) Some comments on any similarities and differences in views would be interesting to readers.
Due to the small sample size we feel it would be inappropriate to undertake comparisons of this type. The purposive sampling was undertaken with the aim of developing a sample with adequate diversity but not to be statistically representative. Sample characteristics are given to provide the reader with an understanding of its diversity.