Reviewer’s report

Title: Extra upper limb practice after stroke: a feasibility study

Version: 0 Date: 11 Jul 2019

Reviewer: Jannette Blennerhassett

Reviewer's report:

R/v Pilot and Feasibility

General

This paper outlines feasibility to deliver additional UL practice to people with stroke in a subacute rehabilitation setting. It is clearly presented as a stepping-stone for a larger trial. The information is generally clear and includes important points regarding feasibility to inform clinical practice and research design. Indeed, the structure used to break down feasibility is well considered. There are a few minor points that may assist in improving clarity of the presentation. These are listed below.

Background.

Line 63. The term financial constraints would benefit from detail that is more explicit. (eg staff availability, other resources eg ABLEX, other?).

Line 65: Is Cost-effective the most suitable term given the limited evaluation of cost-effectiveness in rehab studies?

Largely self-directed: eg lines 69-76/ 111-128. A little more detail is needed (re the level of staff involvement) and it would be helpful to make explicit mention of the model of care/delivering in the first research question (line 74-76).

Participants:

Line 103-4. Selecting people likely to have LOS &gt; 4 weeks is an interesting decision, (as evident in the data). The study has made note of this, but worth careful consideration given the move to have shorter LOS. The facility data seems to suggest that the cohort may be quite different to other settings (private/ different countries etc.).

Line 114: Do you need a supplier for Able_X?

Intervention and recording practice: Was the supervision part of the study design, (to measure dose), or part of the intervention (setting up groups etc), who initiated the self-practice (ie was it therapist or the patient driven). It would be good to clarify these points.
Line 130-1: Please clarify who dose of UL was recorded in usual care. The data implies you have that in minutes but seems to be collected from timetables. How can you determine the amount of UL intervention delivered within an OT session for instance? (Especially as 20% did not have any UL intervention, line 186-7.)

Outcome measures:

Line 136-139: Sentence seems a little wordy. Please review.

Line 163-164. Sentence is not clear and may be missing a word. Please review.

Results:

Well-presented and clear. The points on feasibility and acceptability are very helpful.

Table 1: Please outline how sensation was assessed (Was the NIHSS?); and what Modified Tardieu Scale means (and interpretation of scores)

Line 228-230. Expressing P values to four decimal points seems unnecessary, given the design of the study. Please review.

Table 3: Please explain what Ref value means.

Discussion:

Line 243-246. This statement on magnitude of effect could be misleading, especially as there was no control nor blinding of assessments. Please review and modify this sentence to suit the study design and data.

Line 250. This point about when people did their practice is interesting. Where are the data presented that supports this statement. Also, refer to points above re more detail on the intervention.

Line 263: Is the Schneider et al paper referenced in the appropriate style?

Line 273; Please supply a reference(s) for other studies.

Line 278. Or does this mean clinicians need to encourage self-directed practice and setting up programs for people to continue with when they leave hospital. I appreciate the 4 week intervention is pragmatic and was selected for this study, but that seems to be an arbitrary duration. This point is important given shorter LOS and getting people out of places where they are inherently inactive and alone.

Limitations: Need to also to discuss non-blinded assessments as a limitation.
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An article of importance in its field

**Quality of written English**
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